Pinnacle™ Incorporated

Quality and education plan 2019–2020

Thriving general practice

Quality goals at a glance

Practice goals 2019–2020

MANAGING DEMAND		POINTS
01	Participation in patient experience survey every quarter (assessed quarterly)	4

PROACTIVE CARE		POINTS
02	Representation from clinical staff at Pinnacle education session relating to severe mental illness and Equally Well OR complete an audit relating to mental health coding	6
03	Māori and youth goals of choice	5

PREVENTATIVE CARE		POINTS
04	95 per cent of enrolled children aged eight months are fully immunised by the end of each quarter (assessed quarterly)	4
05	95 per cent of enrolled children aged eight months who are Māori, Pacific peoples or other ethnicity living in quintile 5 are fully immunised by the end of each quarter (assessed quarterly)	4
06	92 per cent of enrolled coded smokers aged 15-75 years have been given brief advice to stop smoking (assessed quarterly)	6
07	92 per cent of enrolled coded smokers aged 15-75 years who are Māori, Pacific peoples or other ethnicity living in quintile 5 areas have been given brief advice to stop smoking (assessed quarterly)	6
08	75 per cent of enrolled eligible women aged 25-69 years have a current cervical smear result (assessed quarterly)	6
09	75 per cent of enrolled eligible women aged 25-69 years who are Māori, Pacific peoples or other ethnicity living in quintile 5 areas have a current cervical smear result (assessed quarterly)	6
10	[90 per cent of enrolled eligible population have had a CVRA within the last five years (assessed quarterly)	6
11	90 per cent of enrolled eligible high needs population have had a CVRA within the last five years (assessed quarterly)	6
12	70 per cent of enrolled coded diabetic patients aged 15 years and over have had a diabetes annual management review (assessed quarterly)	6
13	70 per cent of enrolled coded diabetic patients aged 15 years and over who are Māori, Pacific peoples or other ethnicity living in quintile 5 areas have had a diabetes annual management review (assessed quarterly)	6
14	70 per cent of enrolled coded diabetic patients aged 15 years and over have HbA1c ≤64mmol/mol (assessed quarterly)	5
15	70 per cent of enrolled coded diabetic patients aged 15 years and over who are Māori, Pacific peoples or other ethnicity living in quintile 5 areas have HbA1c ≤64mmol/mol (assessed quarterly)	5

BUSINESS		POINTS
16	Foundation Standard/CORNERSTONE® (assessed quarterly)	8
17	Practice development discussion (quarter one)	5
18	Practice offers a patient portal and 30 per cent of eligible patients are activated (quarter four)	6

* Please see the section on CVRA for explanation on the setting of this target.

Foreword

Kia ora koutou,
Over the past year we have actively sought feedback from practices on what has worked and what hasn't worked with our quality plans over the past 21 years.

You told us it was important you understood the logic of the goals and they were part of a future focussed plan.

We have put an explanation under each goal, detailing why it is there and how it fits into the foreseeable future.

You told us choice was something important to your practice.

We have given you options in the proactive care section where you can choose between education and audit.

You told us the plan should include a combination of quality assurance and improvement.

You will see a mixture of target focussed goals and those where practices reflect on their activities and look for areas of improvement.

You told us flexibility is important. Practices wanted to be able to localise their solution to a network issue.

The goals around Māori and youth health give you flexibility to design for the needs of your patients.

You told us listening to you is important.

We have funded your time to meet with us.

The Quality and Education Committee is made up of a collection of GPs, nurses and administrators from practices across the Pinnacle Network. We strongly believe given the right information practices will choose to do the right thing for their enrolled populations. Pinnacle is working hard on providing you with information relating to the quality of care you provide across a range of issues, not just those covered in this plan.

We look forward to supporting you and your teams in the year ahead and seeing what further improvements we can make to outcomes for our people.

Ngā mihi,
Dr Brendon Eade
Quality and Education
Committee chair

The goals in detail

01

Managing demand

Listening to what patients say about services is a key driver of change within teams. This is one way to practice "what matters to you" as opposed to "what's the matter with you" medicine.

What has changed from last year?

This is a new goal.

Goal 01: Patient experience survey

The Health Quality & Safety Commission's national patient experience survey allows patients to respond to several different areas of their healthcare.

Responses are seen in real time by the practice, it is modular (depending on services accessed) and the survey is standardised, meaning practices can look at changes over time.[1]

It is important for practices to ensure as many patients as possible who are seen during survey week are invited to complete the survey. This can be done by ensuring you have their email address and they are informed about the survey. Resources such as posters and leaflets are available from your practice support person.

This goal asks practices to access their patient feedback through the Cemplicity portal, have a standing agenda item at their staff meeting to discuss feedback, plan any changes as a result of the survey results and respond to patient feedback if applicable. Online education will be provided to support staff around the importance of the patient voice.

In future years the intention is to use the survey as one tool that practices can use to reflect on barriers in accessing timely healthcare and implement a plan to address these.

Notes

1. Health, Quality and Safety Commission. Primary Care Patient Experience Survey. https://www.hqsc.govt.nz/our-programmes/health-quality-evaluation/projects/patient-experience/primary-care-patient-experience/the-survey/

Proactive care

02

Goal 02: Equally Well

People with a severe and enduring mental illness and/or addiction die much earlier than people in the general population.

They have two to three times greater risk of premature death (defined as dying before the age of 65). Two-thirds of this premature mortality is due to cardiovascular disease, cancer and other physical illnesses.[2] The cause of this is thought to be multifactorial—including greater exposure to risk factors such as smoking or poor nutrition, psychotropic medications, or lack of access to quality healthcare.

Proactive screening alongside quality care and early recognition of red flag symptoms could improve these statistics. Having patients with a severe and enduring mental illness and/or addiction coded appropriately in our patient management system allows us to actively identify and manage these patients.

The quality plan includes two options.

1. An audit of current coding for patients known to secondary care services or identified as being on an antipsychotic medication to help improve practice ability to identify this group of patients. OR
2. Attendance by clinical staff at a Pinnacle education session on principles of Equally Well—the why and how of achieving equal physical health outcomes for those with severe and enduring mental illness and/or addiction.

The vision for this goal is to support the 2018 cardiovascular risk assessment (CVRA) guideline which recommends screening for people with severe mental illness from the year of diagnosis.

What has changed from last year?

Although this is a new goal, it is a continuation of the focus that began in 2017-18 through the audit of atypical antipsychotic medication.

Notes

2. Te Pou. The physical health of people with a serious mental illness and/or addiction. https://www.tepou.co.nz/uploads/files/resource-assets/the-physical-health-of-people-with-a-serious-mental-illness-andor-addiction-an-evidence-review.pdf

What has changed from last year?

There is no change to this goal. This year more information will be provided to support practices to meet this goal.

Goal 03: Māori and youth

We know practices have achieved some great things over the last two years to better engage youth in general practice and reduce the equity gap for Māori, but more can be achieved.

For Māori, practices are asked to focus on an activity related to access, outcomes (using the Māori health dashboard) or engagement (using tools such as the patient experience survey). For youth, practices are asked to focus on an activity related to access. Your practice support person can provide more specific detail around these goals.

Preventative care

04–07

Goals 04 and 05: Childhood immunisation

On time immunisation protects against the incidence of vaccine preventable diseases and can also reduce hospitalisations due to these diseases.

While many practices have excellent processes in place immunisation coverage still needs to increase.

The Ministry of Health target of 95 per cent coverage is designed to ensure communities stay well—when enough people in the community are immunised the infection can no longer spread.

This goal will remain in our quality plan while it continues to be a national health target. When it is removed from the national programme and there is equity in coverage, the Committee is keen to move onto measuring other childhood indicators.

What has changed from last year?

There are no changes to these goals; our commitment to proactive child health remains.

Goals 06 and 07: Brief advice for smokers

Being smokefree is still one of the biggest positive changes a person can make for their health. We know for every 40 smokers offered brief advice one person will quit.

If we have fewer people who smoke we will reduce the rate of some cancers and heart disease.

This goal will remain in our quality plan while it continues to be a national health target. After that time the focus will move to incentivising those who have had cessation or been referred to a cessation service and then those who have quit smoking.

What has changed from last year?

We strongly support the Smokefree Aotearoa 2025 movement; there are no changes to these goals.

08-11

What has changed from last year?

There are no changes to these goals.

Goals 08 and 09: Cervical screening coverage

The national cervical screening programme has been one of the most successful programmes in the world to reduce the incidence and death from cervical cancer.

Since the programme began we've seen a steady decline in cervical cancer deaths—by about 60 per cent.

The current goal is still to screen 75 per cent of eligible women. Although most practices are meeting this goal for their total population, there is still a gap for the high needs population. The current focus is to improve equity within practices and then focus on another area of inequity. Recommended outcome codes were released several years ago, work will continue to support practices to use these.

This year the age for commencing screening will be moved from 20 to 25 years.[3] Our indicators were changed last year from 20 to 25 years with this in mind.

What has changed from last year?

These are new goals. There is no target in place as this plan goes to print. We want to make the target fair to all practices so the target will be determined once the tool is in place.

Goals 10 and 11: Cardiovascular risk assessment coverage

Cardiovascular disease continues to be one of the largest burdens of disease for New Zealand.

Evidence shows many deaths caused by cardiovascular disease are preventable by modifying diet, lifestyle or adding medication.

New cardiovascular risk assessment (CVRA) guidelines were rolled out last year.[4] BPAC and indici tools are being modified this year to ensure practices can identify, screen and treat patients. The focus of goal 11 is the new age band for screening within the guideline.

Once this goal is embedded and there are no equity gaps the focus will move to management of those at high risk of an event.

Notes

3. National Screening Unit. https://www.nsu.govt.nz/health-professionals/national-cervical-screening-programme/age-range-change-cervical-screening
4. Ministry of Health Cardiovascular Disease Risk Assessment and Management for Primary Care. https://www.health.govt.nz/publication/cardiovascular-disease-risk-assessment-and-management-primary-care

12-15

What has changed from last year?

There are no changes to these goals.

Goals 12 and 13: Diabetic annual reviews

There are almost a quarter of a million people in New Zealand diagnosed with diabetes and another 100,000 who have it but don't know.

It is more common in some populations, particularly Māori, Pacific peoples and South Asian.[5]

Diabetic annual reviews (DARs) are a structured way of monitoring patients who have diabetes. A DAR can reduce the risk of complications for patients.

Note: practices using long term conditions (LTC) funding are still incentivised based on performance against DARs and CVRA targets.

There are almost a quarter of a million people in New Zealand diagnosed with diabetes.

Good blood glucose control can reduce the risk of some of the complications of diabetes.

What has changed from last year?

There are no changes to these goals.

Goals 14 and 15: HbA1c goals

This is about a planned and proactive approach for patients living with a long-term condition.

It's important patients try to develop good glucose control after diagnosis. For most people with Type 2 diabetes the closer they can get their HbA1c to the 'normal' range, the better the outcome will be for them.

In years to come some of the focus will move to prevention for pre-diabetic patients.

Notes

5. Ministry of health diabetes. https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/diabetes-data-and-stats?mega=Health%20statistics&title=Diabetes

Business

16–17

Goal 16: Foundation Standard and CORNERSTONE®

Foundation Standard and CORNERSTONE® are developed by the Royal New Zealand College of General Practitioners.

They include a variety of quality assurance and improvement goals relating to minimum patient safety and legal requirements, supporting New Zealand general practitioners and their teams.

All practices in New Zealand need to meet either Foundation Standard certification or CORNERSTONE® accreditation. Practices were clear that rather than paying registration costs they would prefer Pinnacle provided quarterly lump sum payments for use at their discretion in order to meet requirements.

In addition, Pinnacle provides support for Foundation Standard and CORNERSTONE® in the form of templates and education. More information can be found on the quality section of the Pinnacle website. MAS HealthyPractice® also provide templates through their website—remember Pinnacle will subsidise 50 per cent of your HealthyPractice® subscription.

Pinnacle, the Health Care Home Collaborative and the College continue to work together on acknowledging Health Care Home within their programmes.

What has changed from last year?

There are no changes to this goal.

Goal 17: Practice development

The successful consultation regarding the quality plan led us to think about how we could encourage practices to have more meaningful conversations with our teams.

We know practices have business plans, strategic goals and aspirations and think a conversation is a much better way for us to understand what these are than filling out templates.

We recognise taking time out to discuss your practice plans and aspirations with us has a cost to it, so we will support this with a financial incentive. From this meeting we will gain a deeper understanding of what drives your practice, supporting future interactions between Pinnacle and your practice to ensure our support is tailored to your needs.

What has changed from last year?

This is a new goal, in previous years we required a written plan.

Your practice support person can provide you with resources to promote portal uptake with patients. They can also help answer any queries you may have.

What has changed from last year?

The goal has increased from 20 to 30 per cent. We recognise for practices who have not started to use a portal yet this could be a daunting target. Therefore, payment is pro rata based on achievement from 0 per cent to 30 per cent enrolment. Each 1 per cent enrolment achieved will receive 3.33 per cent of the payment to a maximum of 30 per cent enrolment.

Goal 18: Patient portal

A patient portal is a secure online website for patients to access their health information and interact with their general practice team. Portal use encourages patient empowerment and self-management.

We believe practices benefit from a portal through:

- helping to meet growing patient demand
- supporting practice sustainability by increasing the number of contacts by a patient while decreasing face to face contact required
- reducing nurse and/or practice administration time communicating things such as laboratory results
- improving the patient experience
- offering more communication options with patients
- meeting the growing expectations of patients.

Funding and payment schedule

Practice goals 2019–2020

Funding remains at $11.09 exclusive of GST per enrolled patient.

The quality plan funding comes from a variety of different sources. The main fund is the DHB system level measures, for which we receive $5.33 per enrolled patient—this is passed on directly and in full to practices. The two other sources are flexible funding and contracts.

If you would like to know more about funding please contact the quality lead Michelle Bayley: michelle.bayley@pinnacle.health.nz.

Achievement to goals are assessed at the end of the quarter and payments made the following month on 31 October 2019, 31 January 2020, 30 April 2020 and 31 July 2020.

	ACHIEVE %	POINTS	PAYMENT FREQ.
MANAGING DEMAND			
01 Participation in patient experience survey every quarter	N/A	1	Quarterly
PROACTIVE CARE			
02 Representation from clinical staff at Pinnacle education session relating to severe mental illness and Equally Well OR complete an audit relating to mental health coding	N/A	6	Q4
03 Māori and youth goals of choice	N/A	5	Q3 or Q4
PREVENTATIVE CARE			
04 95 per cent of enrolled children aged eight months are fully immunised by the end of each quarter	< 90 90–94.99 ≥95	0 0.9 1	Quarterly
05 95 per cent of enrolled children aged eight months who are Māori, Pacific peoples or other ethnicity living in quintile 5 are fully immunised by the end of each quarter	< 90 90–94.99 ≥95	0 0.9 1	Quarterly
06 92 per cent of enrolled coded smokers aged 15–75 years have been given brief advice to stop smoking	< 90 90–91.99 ≥92	0 0.90 1.5	Quarterly
07 92 per cent of enrolled coded smokers aged 15–75 years who are Māori, Pacific peoples or other ethnicity living in quintile 5 areas have been given brief advice to stop smoking	< 90 90–91.99 ≥92	0 0.90 1.5	Quarterly
08 75 per cent of enrolled eligible women aged 25–69 years have a current cervical smear result	<70 70–74.99 ≥75	0 0.90 1.5	Quarterly
09 75 per cent of enrolled eligible women aged 25–69 years who are Māori, Pacific peoples or other ethnicity living in quintile 5 areas have a current cervical smear result	<70 70–74.99 ≥75	0 0.90 1.5	Quarterly
10 90 per cent of enrolled eligible population have had a CVRA within the last five years	<TBC TBC–TBC ≥TBC	0 0.9 1.5	Quarterly
11 90 per cent of enrolled eligible high needs population have had a CVRA within the last five years	<TBC TBC–TBC ≥TBC	0 0.9 1.5	Quarterly
12 70 per cent of enrolled coded diabetic patients aged 15 years and over have had a diabetes annual management review	<65 65–69.99 ≥70	0 0.90 1.5	Quarterly
13 70 per cent of enrolled coded diabetic patients aged 15 years and over who are Māori, Pacific peoples or other ethnicity living in quintile 5 areas have had a diabetes annual management review	<65 65–69.99 ≥70	0 0.90 1.5	Quarterly
14 70 per cent of enrolled coded diabetic patients aged 15 years and over have HbA1c ≤64mmol/mol	<50 50–59.99 60–64.99 65–69.99 ≥70	0 0.2 0.45 0.90 1.25	Quarterly
15 70 per cent of enrolled coded diabetic patients aged 15 years and over who are Māori, Pacific peoples or other ethnicity living in quintile 5 areas have HbA1c ≤64mmol/mol	<50 50–59.99 60–64.99 65–69.99 ≥70	0 0.2 0.45 0.90 1.25	Quarterly
BUSINESS			
16 Foundation Standard/CORNERSTONE®		2	Quarterly
17 Practice development discussion		5	From Q1
18 Practice offers a patient portal and 30 per cent of eligible patients are activated	Based on achievement	6	Q4