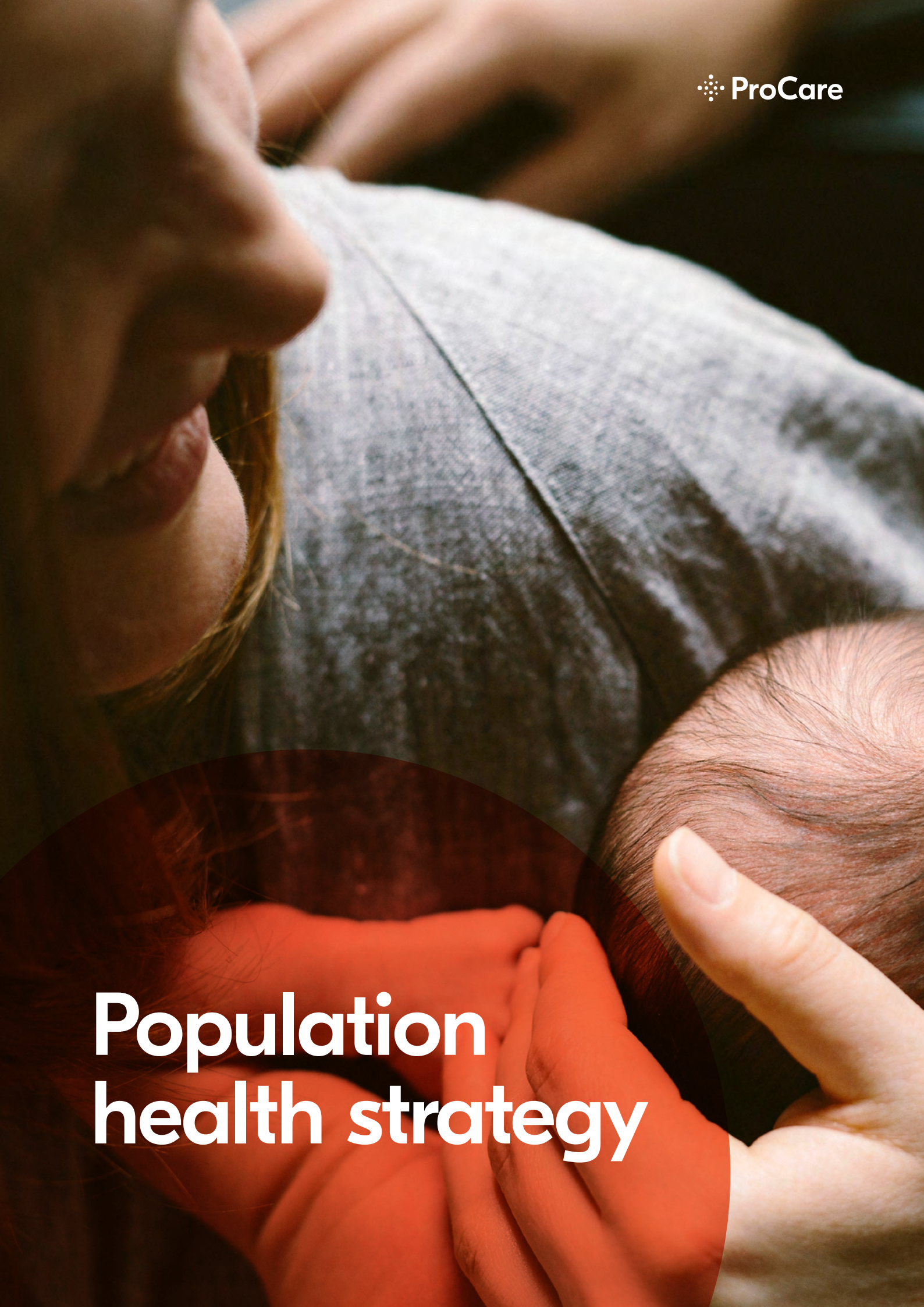


Population health strategy

He aha te mea nui o te ao,
he tāngata he tāngata he tāngata.

What is the most important thing in the world,
it is the people, the people, the people.

Introduction

Kei aku rau rangatira, koutou katoa e manaaki ana i ngā hapori huri noa, nei au ka mihi atu, tēnā koutou katoa.

Primary care has been moving steadily towards a population health approach — aiming to improve the health of the people we care for, and to weave Te Tiriti o Waitangi into everything we do, and bring about equity in access and outcomes for Māori and non-Māori.

What that involves across the ProCare network, is being able to use relevant, regularly updated information about what's happening in people's lives so we can provide the best possible care and support to help keep them well.

It's a very different approach to 'traditional' general practice where every enrolled patient is treated the same, and the focus is on reactive care for people who present when they're sick; instead, it's about combining acute and opportunistic care with targeted help for those whānau with the greatest needs.

"It's a proactive approach where it's about providing targeted health and wellbeing opportunities for those whānau with the greatest needs."

— Taima Campbell, Pare Hauraki, Chair, ProCare Health

ProCare's population health strategy is based on comprehensive community knowledge, sophisticated data collection and analysis that allows, a deep insight into the health status and health needs of the network's 800,000-strong population.

Populations are about people, and this strategy takes a population health approach down to the practice level, and then through to whānau and individuals, with each general practice able to drill down to the needs of each one of the people they care for. It enables practices to understand everything from emergency department attendances and respiratory hospitalisations of children, to medications prescribed for people with heart disease, to falls prevention and vaccination against shingles for older people.

The strategy provides a framework for understanding patterns, equity gaps and clinical need, and then targeting and developing clinical improvements in a systematic and culturally appropriate way. It supports a person-centred model of care that goes beyond the general practice with 'warm handovers' to other community carers and services.

ProCare's clinical activities have been reoriented around the strategy, providing a focus for innovation and improvement based on evidence about the needs of the community and putting in place interventions that are strongly aligned to Te Tiriti principles and foster strength and resilience. This ensures resources and interventions can be prioritised and focused on health gain.

An estimated 80% of health status is determined by socio-economic and environmental determinants, such as employment, education, or housing, and our aim is to ensure that our health interventions make the best possible impact for the remaining 20%, while also influencing those social factors where possible. The strategy behind a population health approach provides a fundamental tool to enable us to do that.

We're extremely proud of how far we've come in developing this approach to the care we can offer people, the difference it's already making to the wellbeing of Aucklanders, and the potential it has to contribute to better health equity and outcomes for Māori and non-Māori across Aotearoa New Zealand.

We have a real desire to not only share the information and learnings from our experiences across our health system but also learn from other providers and organisations. This is a journey for us all. I hope this summary of progress so far will encourage others to work with us to benefit our whole population.

Background: Our Picture of Health (health needs analysis)

With the largest population of any primary health organisation — including large Māori and Pacific communities — the journey towards ProCare's population health strategy started in 2017.

The network's general practices, staff and Board were increasingly aware that more needed to be done to meet the health needs of its approximately 800,000 enrolled patients in a targeted and systematic way.

Dr Sue Wells, Associate Professor in the School of Population Health at Auckland University, joined the team to lead the work which was initiated by a comprehensive assessment of health needs, Our Picture of Health, published in 2018. The document provided detailed information and analysis of the key health challenges facing ProCare's diverse enrolled population, as well as the service gaps and opportunities for interventions that would offer health benefits.

Using a range of data sources, the report set out the detailed health needs of the people enrolled in ProCare practices including:

- → **demographic information**
- → **utilisation of general practice services**
- → **use of secondary care services such as emergency department attendances and hospital admissions**
- → **risk modelling, including identifying those patients at highest risk of a hospital admission in the next six months**
- → **prevalence of long-term conditions**
- → **risk factors for long term conditions**
- → **preventive care measures being used**
- → **medical management, according to evidence-based best practice**
- → **access to and use of patient portals**
- → **patient experience measures.**

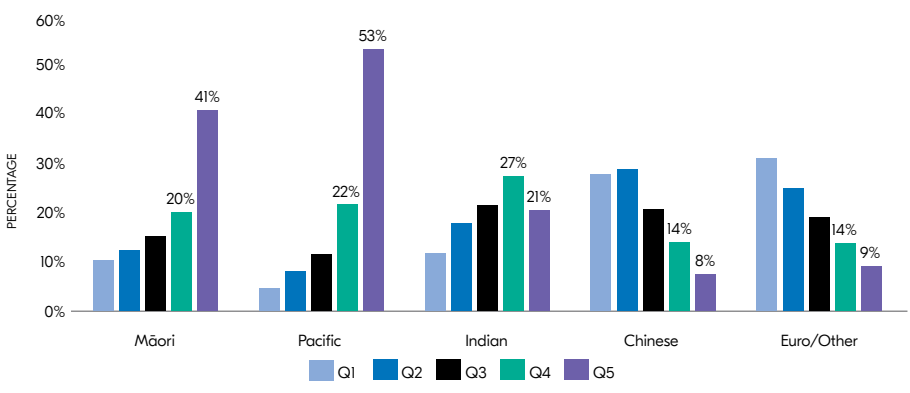
PROCARE POPULATION AS AT THE TIME OF THE HEALTH NEEDS ANALYSIS: 1 JAN 2017
(N = 824,735)

11%	Māori (89,912)
13%	Pacific (109,239)
7.5%	Indian (62,072)
6.5%	Chinese (53,618)
62%	European/Other (509,894)

At the time of the initial health needs analysis, ProCare had the largest enrolled high-needs patient population in New Zealand.

263,173

Fig 2. ProCare enrolled population according to NZDep Index quintile and ethnic group

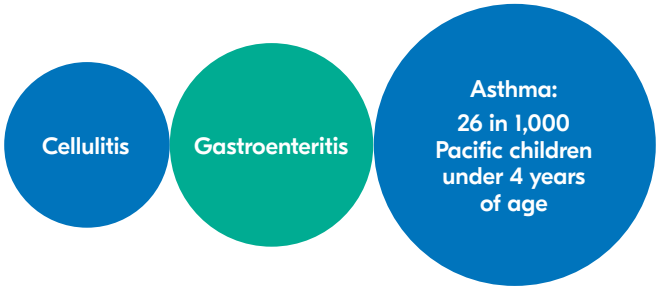


Data highlights, health status, outcomes, challenges

This analysis of ProCare's population starkly highlighted the inequities in health status and outcomes and where the challenges lay.

A key measure used as the basis of assessing health need was ambulatory sensitive hospitalisation (ASH) rates - acute admissions to hospital that are considered potentially avoidable. ASH rates reflect broader social and economic determinants of health and highlight where interventions from general practices, and primary care more broadly, can prevent ill health, avoiding the need for more complex secondary care and improving outcomes.

In Our Picture of Health, ASH rates showed that children 0-4 years in Aotearoa's biggest city were being hospitalised with:



"If you can see that there are ED or hospital admissions for a child with respiratory problems you can find out what's going on and how can you support whānau aspirations for the living environment — for example, having a home that is warm, dry, insulated and smokefree, and helping with other areas of stress that the whānau is experiencing, such as food and job security. Then you can look at helping to prevent further admissions, for example, by ensuring flu vaccination for the child and wider family members."

— Dr Allan Moffitt,
Clinical Director, ProCare

Table: Age specific ASH rates per 1,000 by condition and enthnicity: 0-4 years

		Age group (Ip) /Ethinicity Group 0 - 4 years					
ASH FLAG (group)	**ASH FLAG**	Māori	Pacific	Indian	Chinese	Euro/ other	**Grand Total**
Cardiovascular	Rheumatic fever/heart disease					**0.0 (1)**	**0.0 (1)**
Dental conditions	Dental conditions	5.1 (48)	6.3 (63)	3.0 (15)	2.6 (13)	2.1 (57)	**3.5 (196)**
Dermatalogical	Cellulitis	10.6 (100)	14.3 (143)	4.5 (23)	3.0 (15)	2.4 (66)	**6.1 (346)**
	Dermatitis and eczema	3.9 (37)	4.2 (42)	0.8 (4)	0.9 (5)	0.9 (24)	**2.0 (111)**
Diabetes	Diabetes		0.1 (1)	0.1 (1)		0.1 (2)	**0.0 (3)**
Epilepsy	Epilepsy	3.1 (29)	4.4 (44)	2.1 (11)	2.3 (12)	2.5 (69)	**2.9 (164)**
Gastrointestinal	Constipation	0.8 (8)	1.0 (10)	0.8 (4)	0.7 (4)	1.4 (39)	**1.1 (64)**
	Gastroenteritis/ dehydration	11.0 (104)	12.7 (147)	15.4 (78)	7.0 (36)	10.6 (289)	**11.2 (632)**
	GORD	0.3 (3)	0.3 (3)	0.2 (1)	0.3 (2)	0.8 (22)	**0.5 (30)**
	Nutrition deficiency and anaemia	0.2 (2)	0.3 (3)	0.3 (2)	0.1 (1)	0.2 (6)	**0.2 (13)**
Kidney/urinary infection	Kidney/ urinary infection	4.0 (38)	6.5 (65)	2.9 (15)	6.2 (32)	3.4 (93)	**4.3 (242)**
Other	Sexually transmitted infections					0.0 (1)	**0.0 (1)**
	Vaccine-preventable disease - Meningitis	0.1 (1)				0.0 (1)	**0.0 (1)**
	Vaccine-preventable disease - MMR			0.1 (1)			**0.0 (1)**
Respiratory	Asthma	17.5 (165)	26.0 (259)	15.2 (77)	9.8 (50)	11.1 (302)	**15.0 (851)**
	Respiratory infections - Pneumonia	9.5 (89)	17.4 (173)	5.0 (25)	5.2 (26)	5.4 (148)	**8.1 (461)**
	Unsp acute lower respiratory infection	4.2 (40)	7.0 (70)	1.8 (9)	1.7 (9)	2.3 (63)	**3.4 (190)**
	Upper respiratory tract and ENT infections	11.5 (109)	17.8 (178)	12.4 (63)	8.8 (45)	8.8 (239)	**11.1 (632)**
Grand total		**81.9 (771)**	**118.3 (1,177)**	**64.5 (325)**	**48.5 (245)**	**52.0 (1,417)**	**69.4 (3,934)**

As another example of the data in Our Picture of Health highlighting areas for action, ASH rates for those aged 45 - 64 years showed that Māori, Pacific and Indian were being hospitalised at much higher rates than other groups with angina and chest pain.

Table 48. Age specific ASH rates oer 1,000 by condition and ethnicity: 45-64 years

(Total average annual volumes in brackets)

		Ethnicity Group					
ASH FLAG (group)	**ASH FLAG**	Māori	Pacific	Indian	Chinese	Euro/Other	**Grand Total**
Cardiovasular	Rheumatic fever/heart disease	0.2 (3)	0.4 (10)			0.0 (3)	**0.1 (16)**
	Angina and chest pain	16.9 (295)	19.0 (410)	17.2 (215)	4.9 (56)	9.4 (1369)	**11.2 (2354)**
	Congestive heart failure	4.7 (83)	3.4 (75)	0.6 (8)		0.4 (58)	**1.1 (223)**
	Hypertensive disease	1.1 (19)	1.4 (30)	0.5 (6)	0.2 (3)	0.3 (43)	**0.5 (100)**
	Myocardial infarction	5.6 (98)	4.3 (93)	5.5 (69)	1.0 (14)	2.3 (333)	**2.9 (607)**
	Other ischaemic heart disease	1.0 (16)	0.9 (19)	1.0 (13)	0.1 (2)	0.3 (49)	**0.5 (101)**
Dental conditions	Dental conditions	0.4 (6)	0.1 (3)	0.1 (1)	0.0 (1)	0.3 (44)	**0.3 (55)**
Dermatological	Cellulitis	9.4 (164)	9.0 (195)	2.2 (26)	0.8 (11)	2.9 (426)	**3.9 (623)**
	Dermatitis and Eczema	0.7 (12)	0.4 (8)	0.2 (3)	0.2 (3)	0.3 (44)	**0.3 (70)**
Diabetes	Diabetes	2.3 (41)	2.2 (47)	0.9 (12)	0.2 (3)	0.6 (93)	**0.9 (195)**
Epilepsy	Epilepsy	2.3 (41)	1.1 (24)	0.7 (9)	0.1 (2)	1.0 (149)	**1.1 (224)**
Gastrointestinal	Constipation	1.7 (30)	1.1 (25)	0.6 (8)	0.3 (5)	0.8 (110)	**0.8 (177)**
	Gastroenterlitis/ dehydration	4.2 (73)	5.0 (108)	3.4 (42)	2.2 (29)	2.3 (342)	**2.8 (594)**
	GORD	1.5 (27)	1.2 (26)	1.4 (8)	0.7 (10)	0.9 (125)	**1.0 (205)**
	Nutrition deficiency and anaemia	1.3 (23)	1.5 (33)	1.4 (16)	0.5 (7)	0.9 (135)	**1.0 (216)**
	Peptic ulcer	0.9 (16)	1.1 (23)	0.1 (1)	0.5 (7)	0.2 (24)	**0.3 (70)**
Kidney/urinary infection	Kidney/ urinary infection	3.6 (64)	4.4 (96)	2.6 (33)	1.3 (18)	1.9 (284)	**2.3 (493)**
Other	Sexually transmitted infections	0.0 (1)	0.0 (1)			0.0 (5)	**0.0 (7)**
	Vaccine-preventable disease- Other	0.1 (1)	0.1 (2)		0.0 (1)	0.0 (6)	**0.0 (9)**
	Cervical cancer	0.0 (1)	0.0 (1)			0.0 (1)	**0.0 (3)**
Respiratory	Asthma	3.0 (53)	2.5 (55)	1.4 (16)	0.2 (3)	0.7 (95)	**1.1 (223)**
	Respiratory infections - Pneumonia	4.3 (75)	5.5 (119)	1.5 (19)	0.6 (8)	1.4 (209)	**2.0 (430)**
	Upper respiratory tract and ENT infections	1.3 (22)	1.7 (36)	0.9 (12)	0.5 (7)	0.5 (74)	**0.7 (150)**
	Bronchiectasis	0.9 (17)	0.7 (16)	0.3 (4)	0.0 (1)	0.1 (9)	**0.2 (45)**
	COPD	6.7 (117)	4.6 (99)	0.6 (7)	0.0 (1)	1.0 (150)	**1.8 (372)**
Stroke	Stroke	2.5 (44)	2.2 (46)	1.4 (17)	0.9 (12)	0.9 (130)	**1.2 (250)**
Grand Total		**76.5 (1339)**	**3.9 (1596)**	**44.6 (559)**	**15.4 (207)**	**29.5 (4304)**	**37.9 (8005)**

"You can immediately see where and for whom ill health is ocurring, the extent of these preventable conditions, like heart and respiratory disease increasing as people get older, and that these are happening earlier and in greater proportions for ProCare's Māori and Pacific communities. This is where general practice can make the difference for health gain — but, in particular, it's where we can address equity."

— Dr Sue Wells, Associate Professor, School of Population Health, Auckland University

What is the population health strategy?

Thanks to Our Picture of Health, the ProCare network knew it had an obligation to act, and started to develop the population health strategy that now guides all its clinical work.

ProCare's population health strategy underpins the work of its practices to improve wellbeing, equity and outcomes for the 800,000 Aucklanders in its care. The strategy is based on a comprehensive analysis of the health needs of Auckland's diverse population with priorities for action arising from hui and focus groups with the network, governance groups and the communities we serve. It provides the framework for general practice and the wider primary care system to focus on targeted and proactive care and support that improves people's health and wellbeing.

The strategy takes a life course approach based around five goals that are designed to improve the health of the population:

1. **Encouraging a healthy start to life**, focusing on pregnancy, newborns and children up to school age (0-4 years)

2. **Youth engagement** (15 - 24 years), focusing on encouraging young people to access primary care

3. **Supporting people of all ages** in their mental health wellbeing and preventive care

4. Improving the health experiences and wellbeing of **people living with long term conditions**

5. **Improving the quality of life of older people** (65yrs+ for Māori and Pacific and 75yrs+ for all others)

"It's not just about looking after the people who turn up to see us, but considering how we provide the best care for all of the people we're responsible for. We're funded to care for them and we have an obligation to do that as best we can. We have a relationship and responsibilities that go with it."

— Dr John Cameron

Developing the strategy

Our Picture of Health provided the framework for development of an informed and comprehensive population health strategy, focused on Māori health gain, reducing inequity and improving health and wellbeing.

Te Tiriti o Waitangi is the punga (anchor) for the whole strategy, with three key questions underpinning all interventions:

1. How will each intervention honour Te Tiriti obligations?
2. What is the evidence for effectiveness of the intervention?
3. Will it improve equity of outcomes?

Te Tiriti and equity in the ProCare network

Te Tiriti forms part of New Zealand's constitutional fabric for Māori and non-Māori and is fundamental to Māori development, health and wellbeing. But more than simply acknowledging the Treaty as an obligation, the challenge for each 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.

Tino rangatiratanga: the guarantee of tino rangatiratanga, which provides for Māori self-determination and mana motuhake in the design, delivery, and monitoring of health and disability services.

Kotahitanga or Oritetanga (Equity): the principle of equity, which requires the Crown to commit to achieving equitable health outcomes for Māori.

Kaitiakitanga (Active protection): The principle of active protection, which requires the Crown to act, to the fullest extent practicable, to achieve equitable health outcomes for Māori. This includes ensuring that it, its agents, and its Treaty partner are well informed on the extent, and nature, of both Māori health outcomes and efforts to achieve Māori health equity.

Whakamaramatanga (Options): the principle of options, which requires the Crown to provide for and properly resource kaupapa Māori health and disability services. Furthermore, the Crown is obliged to ensure that all health and disability services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care.

Whakawhanaungatanga (Partnership): the principle of partnership, which requires the Crown and Māori to work in partnership in the governance, design, delivery, and monitoring of health and disability services. Māori must be co-designers, with the Crown, of the primary health system for Māori.

The strategy is designed to empower whānau to 'be well' and takes a life course, with five overarching goals:

"In my view, Healthy Start to Life is possibly the most important domain. Creating population health improvements starts with our tamariki and will remain with them throughout their lives."

— Dr Sue Wells

The strategy was co-designed and developed by ProCare's community, Māori, Pacific and clinical governance groups, and its network of general practices after a series of workshops, hui and focus groups. The strategy was also aligned with the metro-Auckland DHBs System Level Measures Improvement Plans.

Data driven decision making

Using ProCare's sophisticated IT and data analysis systems, each of the network's 170 general practices receives a detailed report profiling the health of its enrolled patients, from immunisations to hospitalisations, as well as a breakdown of key demographic information, including ethnicity and deprivation.

Data is provided to practices with easy-to-read dashboards for a range of measures under each of the five goals, which are updated daily, weekly or monthly depending on the data source. This converts data to accessible information providing a picture of where unmet health needs and inequities exist, particularly among ProCare's large Māori and Pacific Island communities.

Practices access reports through ProCare's secure website on how they are tracking on key indicators such as CVD risk, diabetes or immunisation, which are displayed according to ethnicity or people in high needs (NZ Dep Quintile 5) groups — with the ability to view patient lists for follow-up care, which prioritise Māori, Pacific and Q5.

Practices track progress over time and are benchmarked against similar practices ('practices like me'), so they can monitor their performance. These health summaries enable practices to take control, prioritise their efforts and make a meaningful difference to improving population health.

"The information ensures practices can identify individuals and whānau with the greatest health needs and target their clinical resources where they can have the greatest benefit."

— Taima Campbell, Chair, ProCare Health

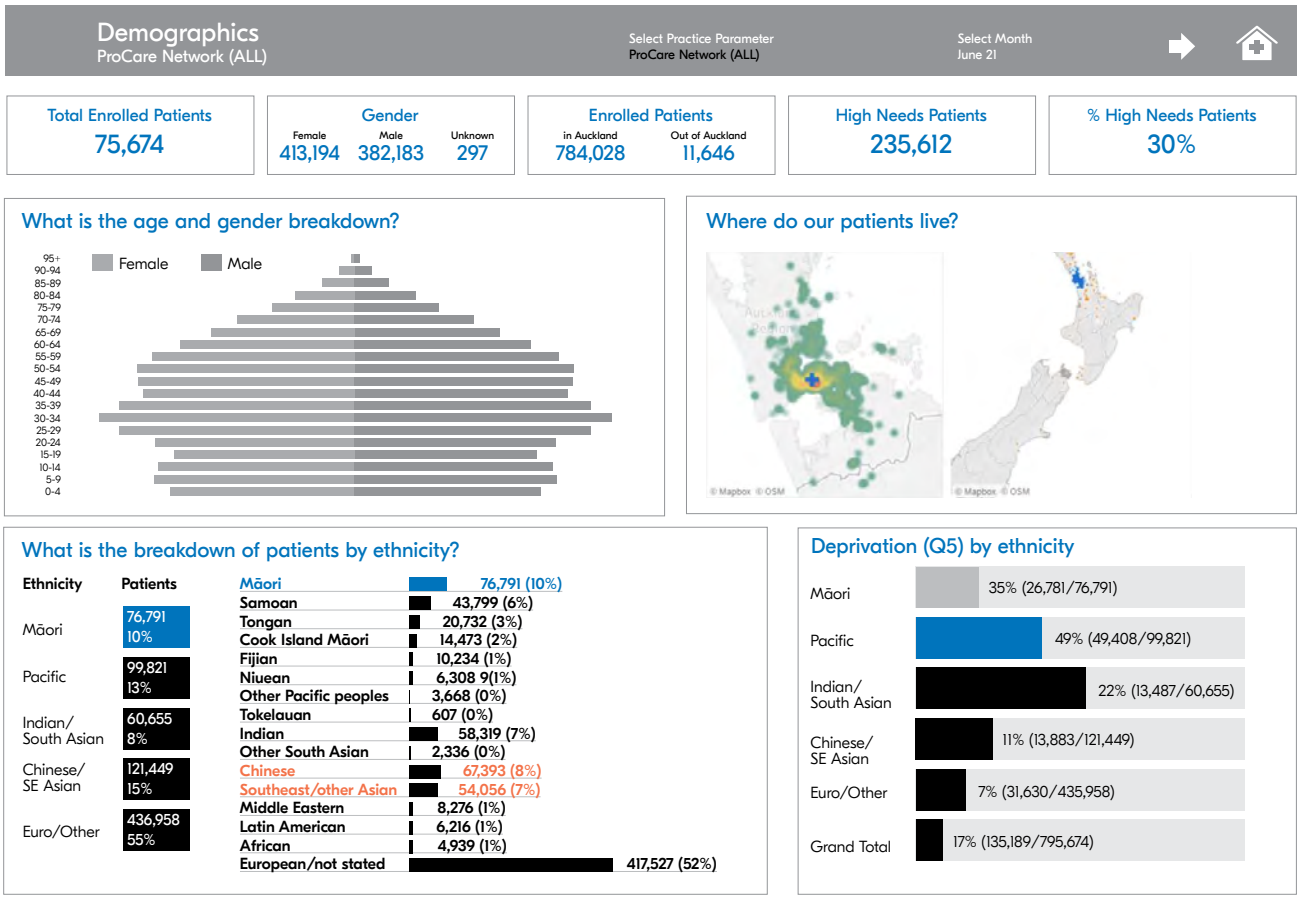


Table: shows a breakdown of the ProCare network population

Indian/Other South Asian - Indian including Fijian Indian, Sri Lankan, Afghani, Bangladeshi, Nepalese, Pakistani, Tibetan

Chinese/South East Asian Ethnicity Code 40, 41, 42, 44 (if not included in the Indian/Other South Asian)

Data Source: National Enrolment Service Register

Data driven dashboards identify whānau unmet needs and guides care

Information on health status is based on 19 indicators, including screening, long term conditions and frequency of visits. This is collated for individuals in each household, allowing practices to identify those whānau with the greatest unmet needs.

Dynamic electronic reports allow clinical teams to click on each household for detailed information about the individuals within it and their health status.

In addition, multiple indicators are aggregated by whānau — groups of people living at the same address — so that providers can consider the whole whānau and unmet needs at a glance and tailor care accordingly.

"Producing data reports which identify whānau with unmet needs allows practices to see the whole household, often multiple families living in one home, across three or four generations and allows practices to think differently about care — finding out what matters to them and how can we walk alongside to support their aspirations."

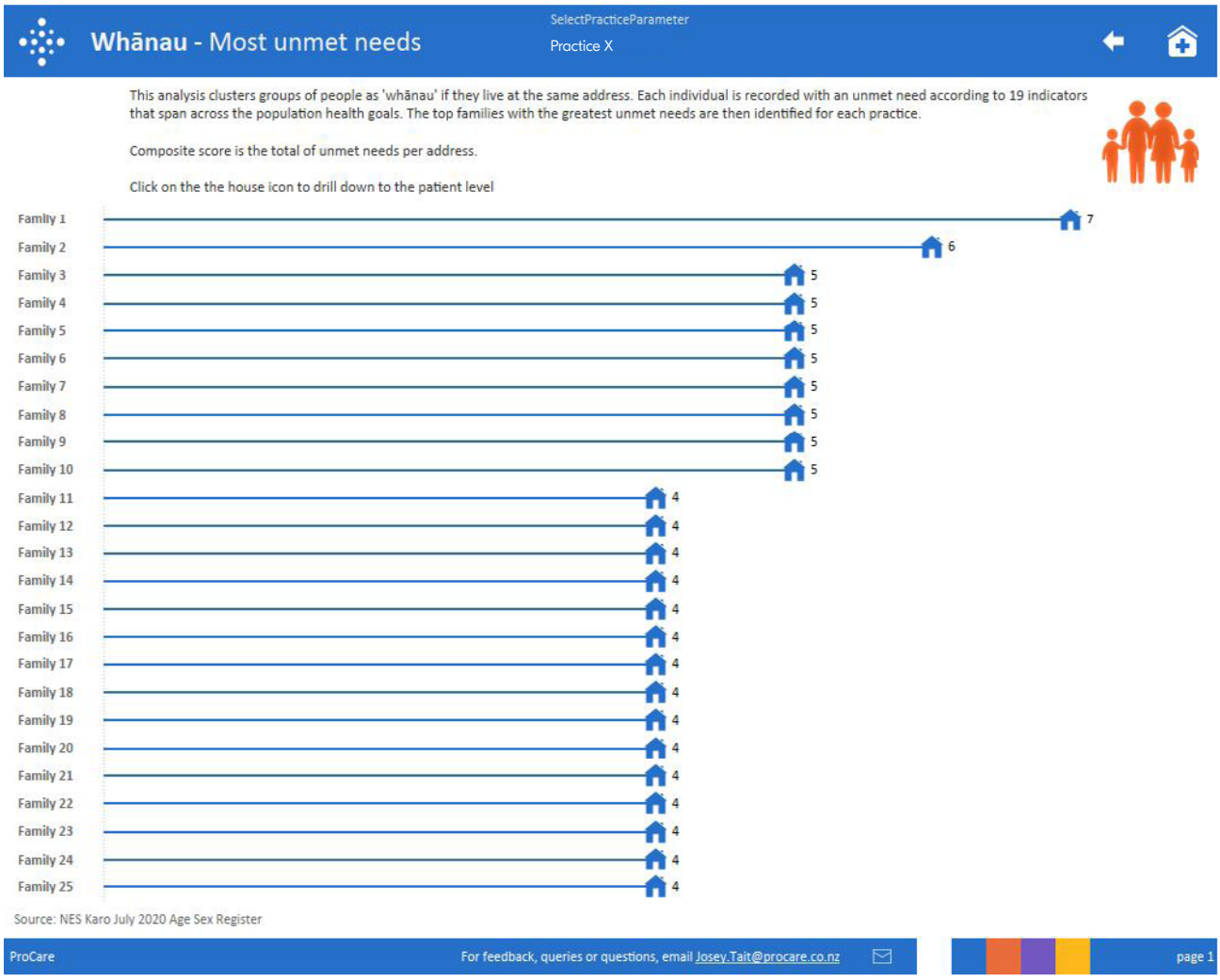
— Dr Sue Wells.

Table: whānau unmet need for a practice in the ProCare network. Indicating family 1 has 7 unmet needs.

Whanau -Most unmet needs (NHI list)
ProCare Network (ALL) As of 2021-06-01

Composite score is the total of unmet needs per address.

This is based on family members enrolled in your practice, other members may be enrolled elsewhere. Yhis is a snapshot of your patients with greatest unmet needs in 2021-06-01. Patients may have transferred out or a family member may have passed on.



Quality plans

The strategy gives a framework for the quality improvement activities across the ProCare network. Based on the picture of their population's health that the data shows, each ProCare practice is required to produce an annual quality plan.

Quality plans include a Māori health plan, an equity plan, a clinical gap analysis and identification of areas of care where the practice intends to focus improvements over for the next 12 months. The Māori health plan is based on Te Tiriti O Waitangi and the Te Whare Tapa Whā model of health.

The Whare Tapa Whā holistic model is an important foundation for each practice to be culturally safe. For optimal health, all four 'walls' of the whare/house, wairua/spiritual, hinengaro/mental, tinana/physical, and whānau/family must be robust and balanced. Equity recognises that different people have different levels of advantage and requires different approaches and resources in order to achieve equitable health outcomes. It also challenges practice teams to discuss implicit bias and power imbalances. The clinical gap analysis is based on each practice's population health report and enables practices to examine equity across their patient populations and to identify any gaps in health need or service delivery.

The quality plan also aligns with the work individual practices are required to undertake to achieve the RNZCGP Foundation and Cornerstone quality standards to avoid duplication. Flexible funding allows practices to develop tailored and targeted services based on real time information, to reach out to the people who need most support, engage with other community and social services and to focus on staff training and upskilling in relevant areas.

Plans are submitted to the network and practices get individual feedback and support from ProCare for activities they want to undertake.

"Every practice has a different demographic structure, with large populations of Māori, Pacific and people living in the most deprived areas in Auckland — some with predominantly young adults and children, others caring mainly for older patients. The data shows where efforts need to be targeted, the clinical need and the gaps are evident. This means every practice has the tools to proactively take steps to improve the health of the people they care for."

— Dr Sue Wells

Step 4: this is an excerpt from a general practice

Clinical gap analysis: review clinical targets							
Clinical target	Goal %	Māori %	Pacific %	Q5 Other %	Total pop. %	Equity gap	What do we want to do about it? (See ideas for change - page 14 of guidance document)
CVD risk assessment	90%	88%	92%	89%	91%	No	Keep up the good work! Assessments being done but equity gap is in getting on to treament for those at high risk, see below.
CVD secondary prevention	70%	60%	67%	86%	68%	Non stat-signif	Why are quantile 5 doing better? Cheaper visits? This is a 'reverse equity gap?'
CVD primary prevention	70%	50%	50%	70%	67%	Yes	Māori/Pacific equity gap? Due to health education/ infrequent attendance/cultural or language barriers? Need to target these peopel use flexible funding to offer free visit or phoen consultation re medication/ managment. Call all those with CVDR>10%
Diabetes management of micoalbuminuria and macroalbuminuria	90%	100%	80%	100%	88%	Yes - small signif	Pacific not doing as well? Check all diabetics with microalbuminuria on treatment - small total numbers though.
Diabetes HbA1c <64%	80%	67%	50%	80%	67%	Yes	Pracifica have poorer diabetic control. Ongoing area of effort.
Diabetes blood pressure	80%	67%	67%	73%	64%	No	
Brief advice to stop smoking	90%	94%	86%	85%	84%	No	Māori rates excellent, better than others
8 month immunisations	95%	100%	100%	100%	91%	No	Keep up the good work!
2 year immunisations	95%	100%	NA	91%	91%	No	Keep up the good work!
Flu 65+	75%	86%	73%	79%	79%	No	Keep up the good work!
Cervical screening	80%	85%	63%	80%	83%	Yes	Low Pacifica rates-equity gap of 20%. Use lists to phone targeting these women and ensure no financial barrier using flexi funding.

Healthy start

1

Children to have a healthy start to life

Clinical champion, Dr Justine Mesui, Peninsula Medical Centre

Dr Justine Mesui is enthusiastic about the potential for the work underway as part of the population health stategy to create a better future for all babies, but particularly those in high needs populations. She says that, while previously clinicians knew there were major equity issues, the strategy now provides a framework and a focus for being able to do something about them.

'These babies will be something amazing. The general practice is part of their lives before they're born and will see that child grow up, so it's really important we're able to engage with the whānau from the very beginning to ensure they have the most support to achieve their potential. Even the six-week check is too late. It takes a village, and we are that village.'

Use of the Best Start Kōwae early pregnancy assessment tool, developed as part of Gen2040, is a priority for improving wellbeing in the under-fours and a reflection that pēpī Māori are almost twice as likely to have potentially avoidable death compared to babies of Pākehā mothers. The tool involves a comprehensive assessment of the health and social status of wāhine in the early stages of pregnancy, covering issues such as smoking, alcohol and drug use, family violence and housing.

'The early pregnancy assessment tool is pioneering. It's a stake in the ground for our Māori mums, many of whom are young and vulnerable,' says Dr Mesui. 'It's a resource guide and an attempt to standardise our approach to pregnancy and early child care but it's also up to practices how they use it. Many practices had elements of the tool, but this pulls it all together, including formalising engagement with social services.' Dr Mesui says engagement with communities is key, forming those closer connections and promoting access in ways that work best for whānau. ProCare practices such as Turuki Healthcare and The Fono have been innovative with their Māori and Pacific communities, listening to what people want and

think and need. That includes, for example, offering antenatal classes by Zoom so that wāhine don't have to worry about the time and cost of transport.

Work is also ongoing to develop local maternity hubs, bringing together practices, social services and midwives so that women can access the range of services they need in an integrated way. For example ProCare is connecting practices wanting to work in this way to Kāhui Tū Kaha (Ngāti Whātua organisation) — a not-for-profit provider of housing and mental health services.

"We recognise the complexities, but this is making it about the whānau. There's real potential to build on this with future structures and funding models in locality networks. We want to keep evolving these ways of working as the health reforms progress."

— Dr Justine Mesui

CASE STUDY: Free nappies and PJ's at Health New Lynn support immunisation programme

Good immunisation cover is a vital tool in ensuring child wellbeing and increasing and maintaining immunisation uptake is a priority.

Immunisation rates for Māori tamariki have typically lagged behind those of European children, but a range of initiatives has ensured that immunisation rates for Māori babies and children has been consistently close to the 95% target.

Immunisation rates generally dropped in 2020 as a result of COVID-19 lockdowns, but some parents and caregivers, particularly Māori, remained hesitant to attend general practice when face to face consultations resumed. Decline rates also increased, fuelled by social media anti-vax misinformation.

To boost coverage and increase engagement with practices, ProCare, in collaboration with The Warehouse, provided 400 sets of pyjamas and tens of thousands of nappies to thank whānau who attend their practice for childhood immunisations.

This initiative proved successful for whānau and practices with immunisation rates improving by several percentage points. Programmes such as this also help foster trusted long term relationships with patients and this is the cornerstone of good general practice.

CASE STUDY: Pēpi packs

In collaboration with Ready Steady Quit Hapū Māmā initiative and Hapai Te Hauora, ProCare practices with the highest Māori and Pacific populations are providing expectant Māori and Pacific mums with a 'bounty pack' or 'pēpī pack' containing essential information about the stages of pregnancy and practical goodies for new mothers.

The packs consist of a woven flax sleeping basket with small packs of New Zealand products including lotion, nappy cream, nipple cream and stretch mark cream. They also include a directory with key information about the health system and the services wāhine are entitled to including two free doctors visits, advice about midwifery and obstetric support, antenatal groups and immunisations, and mental health as well as resources such as food banks and local NGOs.

The aim is to support a healthy pregnancy and positive start for their babies, help new mums navigate the often confusing and complex health services and improve engagement between wāhine hapū patients and their general practice.

The pack connects with the Best Start Kōwae tool and links into relevant support services such as Ready Steady Quit, a free 12 week programme to help pregnant women and anyone living in the same household become smokefree.

ProCare is exploring options for funding for packs to be made available for other high needs groups such as Pacific women.

Youth to increase engagement with primary care

2 Youth to increase their engagement with primary care

Clinical champion, Dr Janice Brown, University of Auckland Student Health and Counselling

The University of Auckland's student health service carried out a pilot with the aim of improving engagement with Māori and Pacific students by reaching out to those students enrolled in the practice and the university who hadn't been seen for two years.

Using flexible funding the practice offered students a free half-hour appointment with the nurse that covered basic observations, screening for alcohol and drugs and family health history, sexual health advice and discussion of any mental health issues. Students could also access point of care testing for sexually transmitted infections and HIV.

If any issues were identified an appointment was made with the GP, health improvement practitioner or health coach, or a referral made to a relevant agencies. Students were given a feedback form to complete on site and received a $20 supermarket voucher after completion. Feedback from students was extremely positive.

A review of the pilot programme found of the 347 students contacted it resulted in:

- 110 nurse appointments
- 41 DNA nurse appointments
- 23 declined appointments
- 124 no response
- 19 students indicated they were not longer at University so were transferred to another GP
- Total engagement percentage was 60%.

Reflections
75% of patients fed back that the appointments were helpful. The nurses really enjoyed seeing students with the 30 minute appointment time being invaluable as it provided time to build a professional relationship with the student.

Example outcome
An 18 year old Cook Island/Māori female mentioned during her appiontment with the nurse that she had been experiencing palpitations and revealed family history of hypertension. The nurse conducted a blood pressure check which was found to be elevated. An urgent review with a GP was organised and an ECG booked, along with three month GP reviews. Without proactive engagement, this would not have been picked up.

"Youth health is vital for the future of New Zealand and engaging students is a huge opportunity to improve population health. A lot of it is about education — these are our future leaders."

CASE STUDY: Supporting youth engagement in health service

ProCare is taking practical steps to encourage young people to connect with health services by giving them key information about what's available at a critical stage in their lives. A campaign to raise awareness about the range of primary care options will include social media information and video, with involvement from 'influencers' to promote the message.

It includes material to be distributed through Auckland schools, containing a range of basic information designed to help school leavers navigate the health system as they transition to a life away from home.

Included is information and practical advice such as how to choose or change GPs, what practice enrolment means and the range of charges; contacts for free services such as family planning, sexual health and Te Tumu Waiora mental health support; and tips for access to wider primary care services such as pharmacy and dentistry. It also promotes the Health and Disability Code of Rights and health privacy obligations.

The material will be available to all young people across Tāmaki Makarau, not just those enrolled in ProCare practices.

"There aren't enough hours in the day or clinicians in the world to do everything for everyone on an individual basis so we've got to think of the best ways to make a difference to those whose needs are greatest and do that in a safe and cost-effective way."

—Dr Janice Brown

All people and their whānau to be enabled to improve their wellbeing

3 All people and their whānau to be enabled to improve their wellbeing

Clinical champion, Gay Chapman, Nurse, Counties Medical Integrated Health

Social issues are a huge factor in everyone's wellbeing, and many people have multiple social factors impacting their health and wellbeing, practice nurse Gay Chapman points out. That might include living in poor and overcrowded housing, not eating well, and being on a low income that stops them attending their general practice because of cost.

Counties Medical Integrated Health is now using flexible funding to offer free 30-minute appointments for new patients and people identified by the team as potentially benefiting from more time or more support.

Good self-management for the practice's large number of people with diabetes or pre-diabetes is key and a weekly nurse-led diabetic clinic provides a range of support including dietary advice and insulin management.

"You can feel the relief people experience when they know they can have a free visit because that's money they can use for other essentials like food. One of the main things we can do is encourage better self management and basic health literacy, such as helping them to use the patient portal to understand their results."

She says that one of the most common factors impacting on wellbeing is alcohol, and screening and some brief education can make a positive difference.

"We have people who are drinking daily, using alcohol to sleep, and they haven't had a conversation before about their alcohol use, even what are safe levels and what makes a unit. We can get them thinking about the consequences of heavy drinking, including sometimes risky sexual behaviour, and about cutting down. If needed we can make an appointment with the GP or services like Community Alcohol and Drugs."

Advocating for changes to external factors which affect health is also key to our population health strategy and so we are partnering with other community organisations to advocate for changes in the environments that impact on population health such as smoking and the sale and supply of alcohol.

CASE STUDY: Promoting mental health wellbeing, Hayley Clare, Health Improvement Practitoner (HIP), Stoddard Rd Medical Centre

Hayley Clare moved from her previous role in secondary mental health services at the end of 2020 to join Stoddard Road as one of the first cohort of Health Improvement Practitioners in New Zealand general practices through the rollout of integrated primary mental health services www.tetumuwaiora.co.nz.

A registered mental health practitioner, the HIP works alongside a health coach and awhi ora support workers to provide free behavioural health and wellbeing support within the practice team.

A key feature of the service is 'warm handovers' so that anyone presenting to the practice who can benefit from Hayley's advice is seen in the practice on the same day or soon after.

"One of the biggest things is the easy access to the support we can offer. If a GP sees a patient who he or she thinks I can help — whether it be relationship or parenting issues, anxiety, sleep problems or chronic pain — then they can just walk down the corridor to see me. In the past, that patient may have had a referral to other services, or sometimes the issue would go unresolved because the GP didn't have the time."

Hayley says that having a HIP available encourages people to talk about issues related to their wellbeing that they wouldn't otherwise raise, helping to take away any shame or stigma people feel.

"One of the things that's really important to me is that we are seen as a mainstream service, that we're normalising conversations about mental wellbeing, physical health check. Somebody doesn't need to be crying in a GP's office to need help with their wellbeing."

Hayley sees a broad mix of people of all ages and cultures, but is keen to see more men, particularly Māori and Pacific men access the advice and tools that the HIP and health coach can offer, as well as engaging more widely with health services.

"One of the biggest challenges in practices is time, so it's fantastic to be able to help more people. Even if someone leaves my room and there hasn't been a definite plan or outcome, that person knows that there is somebody there that they can talk to in the future."

The ongoing COVID-19 pandemic has and is likely to continue affecting the mental health and wellbeing of people in our communities and it will be essential to there is provision to respond to this need. Having support available through general practices ensures 'physical health' and 'mental health' are not siloed. It also ensures that people can get early support and begin their wellbeing journey as soon as possible rather than languishing on a wait list.

CASE STUDY: Respectful kōrero key to increasing flu vaccination for Māori

A new model of care was piloted in 2020 to encourage flu vaccine uptake in Māori aged over 65 without expecting them to travel to their practice. With a focus on whakawhanaungatanga (connectedness and relating in a culturally appropriate way) this pilot was grounded in tikanga and that Te Ao Māori informed all hui, communications and resources to maximise buy-in from whānau.

Data was extracted from practice management systems and the national immunisation register to identify patients who were then phoned by ProCare's mobile flu team. The call team could speak te reo as well as English and kōrero with older people about their health and coping with Covid-19 and provide basic information about flu, as well as arranging a convenient time to be visited by the mobile van to have the vaccine.

The ProCare Māori mobile flu team developed a whānau koha (information pack) to send to whānau who accepted a referral for a flu vaccination, or who declined but wanted more information. The whānau koha included information on frequently asked questions about the flu and useful services in the area including Te Puna Manawa — HealthWest and Te Whānau o Waipareira — Waipareira Trust who operate immunisation outreach services. Also as an acknowledgement of their time on the phone, it included a reusable facemask and a voluntary option for whānau to send their feedback to the team, giving value to their experience and whakaaro (thoughts).

This model of care has shown promise for whānau, both in the flexibility of home visits and also with personalised, unhurried engagement that puts whanaungatanga first. Whānau were generally happy to receive the calls, and these were also an opportunity to increase health literacy by answering questions where appropriate.

"Thank you all who took the time to talk on the phone and the visits at home. You gave me hope. Very much appreciated."

— Kuia

Supporting people with long-term conditions

4

People living with long term conditions to have an improved quality of life

Clinical champion, Dr John Cameron, Westmere Medical Centre

Dr John Cameron believes that ProCare's population health approach is supporting moves to reconfigure wider general practice and primary care.

In the past, Dr Cameron says, it was often difficult to get high quality, relevant and integrated data into practices, rather than just adding more layers of information.

"The information we get through the ProCare network is actually meaningful at a practice level, it means we can target our population and then take it down to an individual level so we can use it to provide better care. We're the troops and we need that organising structure to enable us to be as effective as possible."

Dr Cameron describes the population health stategy approach as an opportunity to shift away from 'counting activity and widgets and focusing on disease processes to actually look at outcomes'.

"We can look at how we're actually going to make a difference to people living with long term conditions, not just ticking a box. We may have done all our retinal screening and our foot checks, yes, we've registered all our smokers - but then what? If I'm just recording that a patient's been seen, no change, and I'm not actually going to do anything, then it's a waste of their time and a waste of my time. We need to give them the best journey, the best information, ask them what they need."

What that means in Dr Cameron's practice is that members of the team use the information provided to bring patients to the clinical practice meeting who they think would benefit from more help.

"It may only be a handful of patients each month, but it's an opportunity to discuss how things could be improved. It's changing thinking and putting the clinicians in the patient's shoes. So that means, for example, supporting one patient who wasn't eating well and spending days in the local cafe by developing a health eating plan that includes the practice nurse visiting him at home and checking that he has decent food in the fridge."

"It's not just about understanding their health needs, but actually asking people about the sort of support they want and how they want to access it. We have to be practical because we can't provide everything, but we've still got to try to do the best possible. We need to be able to hear our patients more, not just assume that everything is fine because they stay enrolled with us."

"At the coalface we're often too busy doing what we do to just step back and look at what's going on, and ask how we could do better. But we need to make that time because that allows us to be more productive as well as helping our patients. It's a real shift in culture but practices need to use this information."

There are overseas examples Dr Cameron believes New Zealand could easily replicate, where chronic disease management and acute care are completely separated at practice level, with separate clinics for planned proactive care and urgent presentations.

"They're managed the same but it's a completely different paradigm and taking care of the acute stuff gets in the way of providing better care for long term conditions. Seeing the child with the sore ear and caring for the long term diabetic or asthmatic need a different approach to how services are delivered. Scheduled long term conditions appointments would involve all the necessary pre-work being done and allow time for conversations about progress and the whole range of needs to enable a person to stay as healthy as possible."

ProCare's Sam Partsch onsite at an HVAZ gardening programme.

Work that takes place in the primary care and general practice setting is complemented by ensuring patients are engaged with community activities which encourage healthier lifestyles such as the work ProCare does as part of the Healthy Village Action Zone (HVAZ). HVAZ operates in 14 churches across Auckland with programmes to encourage healthy eating, weight loss and also gardening.

Ageing well

Clinical champion, Dr Kawshi de Silva, Te Atatu South Medical Centre

5
Older people to have an improved quality of life

Dr Kawshi de Silva is passionate about doing more to improve the quality of life of older people and with a background in public health she says it's important that she 'walks the talk' when it comes to prevention and health improvement.

With more than half of the population in her Te Atatu practice aged over-65 and a small team she says its vital to make the best use of everyone in the team, all working in the same direction, using the data provided through ProCare to ensure a shared focus on quality improvement.

"ProCare understands that the framework needs to work for each practice and have the ability to prioritise and adapt their activities to suit their circumstances. You take a very small practice like ours and you wonder how it's possible to do everything. This gives us the opportunity to prioritise the stuff that matters."

"You need both a top and bottom approach,' Silva says. 'You need a combination of the right culture, values and leadership within the practice so you are focused on making a difference for your community, as well as the capacity, the information and the incentives to be able to do it well."

Her practice takes an opportunistic approach to identifying and supporting older people at risk of falls. That might include the GP including some screening questions as part of a consultation, the receptionist noting the gait and movement of a patient, or offering an extended appointment with the nurse for a detailed assessment, subsidised by flexible funding.

The practice is also working with the aged residential care settings it supports, discussing areas where they can improve falls assessment and prevention and cross pollinating learning.

"At our staff meetings we discuss together what we need to do for our community and how we can make it work. We are all stretched and it can be hard but it's vital the whole team is involved in implementing initatives that will benefit the enrolled population, the community and the practice itself. "

— Dr Kawshi De Silva

Better Together Collaboratives

All practices are encouraged to participate in Better Together Collaboratives, peer learning networks established by ProCare to support practical clinical change under each of the population health strategy's five goals.

Each collaborative includes teams from multiple practices coming together virtually to learn, apply and share improvement methods, ideas and data on service performance for a given healthcare topic. Topics are developed based on feedback from practices within the five overarching goals — from implementing the Best Start Kōwae tool, to creating youth friendly practices, to increasing the provision of alcohol screening and brief advice, to preventing falls and managing medication in older people.

Clinical collaboratives would typically involve face to face meetings, but COVID-19 circumstances required a rethink. Adapting the Institute for Healthcare Improvement methodology, a programme of three one-hour interactive Zoom sessions have been hosted for each collaborative topic, including the use of electronic post-it notes for brainstorming.

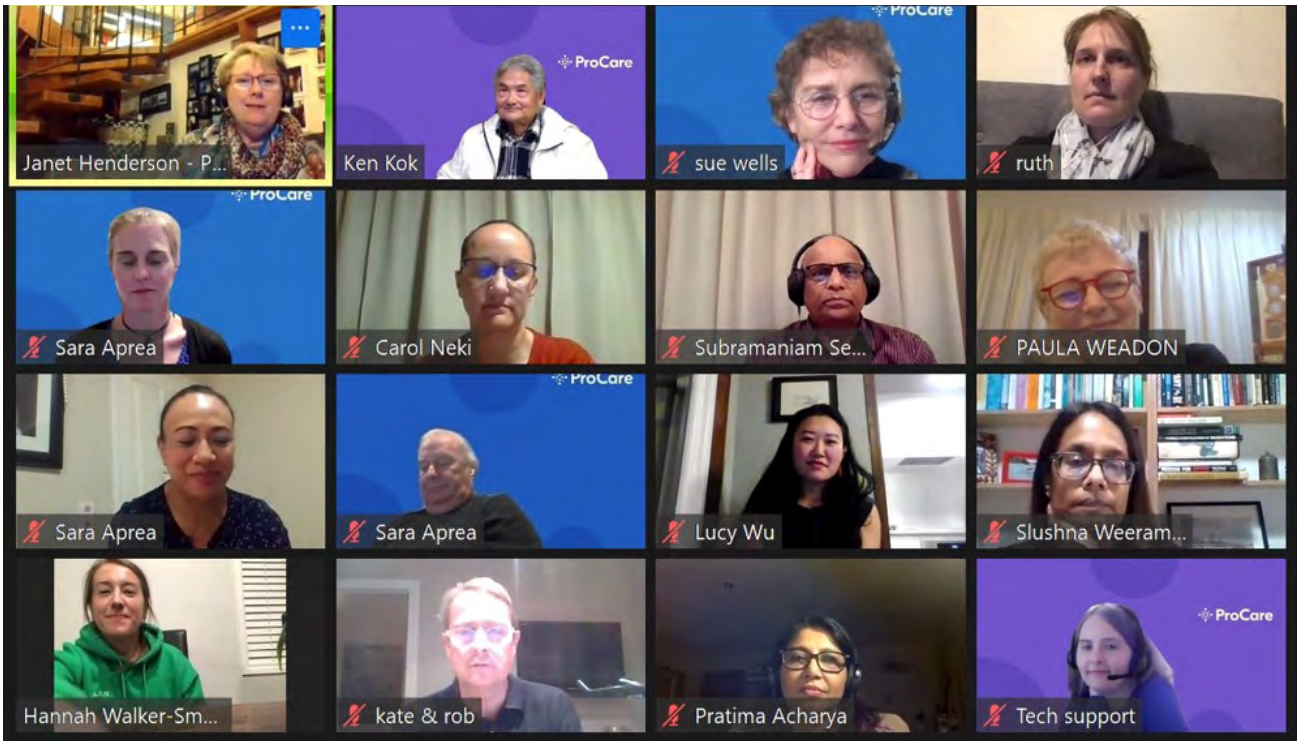
The collaboratives are driven by participants, using a proven quality improvement framework - the Model for Improvement which also includes 'Plan, Do, Study, Act (PDSA) methodology. Learning can also be used for professional continuing education credits, accreditation and audit purposes.

"The equity voice is essential. You have to take what works for each practice. The collaboratives have been variable in pace. The light goes on at different times. They start to look at the gaps and understand how it can work better for their population.

People have to understand the why. It's not about getting stuck in the mechanics of a process but ensuring that every intervention matters. With this they have their own data, in your face, they have their own choices and own flexibility and accountability about what they do with it."

Within the Collaborative, practice teams set a specific goal for making improvements to care and support for their own patient group and create a plan for how to achieve them. Groups of practices working on the same goal share ideas about how to improve and measure success, with consumer engagement in practice teams encouraged. Each practice is tasked to complete a storyboard to document their QI journey and track their results.

Three quarters of ProCare practices are participating in a Collaborative, with two thirds of participants finding the sessions very useful, one third moderately useful, and 86% of participants agreeing that they would recommend the methodology to other practices.



The journey continues

"Typically people would be turning up to us in a crisis. That lack of engagement with health has been how it has been through their whole lives. By getting them involved, we hope that it's not just them but their whole whānau who will improve their connection with health services, that a little drop in the ocean can become a much bigger ripple."

— Dr Sue Wells

This is a population health approach which can support ongoing improvements in whānau-centred primary care.

Whilst others have done health needs analysis, the approach of taking information and targeted clinical improvements down to an individual practice population is unique. It's a model to be scaled and spread. It could work across the whole country, combining aggregated population health information with the ability to target individuals and their whānau.

This is also a journey of community partnership and collaborations. We need to learn from our communities, other providers and organisations about their experiences, and expand general practice networks to truly become primary care and social services networks.

There is a real opportunity to move away from traditional, often reactive ways of doing things, and use data and community knowledge (tino rangitiratanga, tikanga) and relationships (whakawhanaungatanga) to meet the health needs and improve the wellbeing of local populations (kaitiakitanga, orietitanga).

This population health approach can and should underpin local health networks to support integration between providers and to drive innovation (whakamaramatanga) and improvement.

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