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PRACTICE VARIATION IN WAITEMATA PHO

An Evaluation of the Status Quo
A Quality Initiative in Primary Care

Report Number II
September 2012

Report prepared by

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Contents

Introduction

Dear Colleagues,

We are pleased to present to your practice the second comprehensive report on clinical outputs. Please use your unique practice code to identify your practice's performance, in each graph. This is supplied with your report (or ring Margot McDonald on 4480019). Your practice's relative position, compared with others in WPHO is easily seen. Please note that although some data may be out of date, the data acquisition and display methodology is consistent for each practice and the peer comparisons will also be consistent. We do hope that you will examine the report thoroughly and discuss the graphs and their significance with colleagues. The purpose of these reports is to review practice capability in a number of important clinical parameters. It is a primary care quality improvement endeavour, as we stated in the first report August 2011;

The overall goal of this kind of exercise is to reduce the number of patients missing out on preventive or curative services in each practice's population, and therefore in the PHO as a whole. General Practices provide acute and long term care and with the advent of Population Health initiatives, many funded via capitation and with specific targeted projects, preventive care has assumed an equal importance to reactive care. The operating margins between Public Health on one side and Personal Health on the other have been blurred by the introduction of Population Health in the middle. Practices are the entity ultimately responsible for personal health services, the care for individuals and families.

In this second report we emphasise the value of a PHO working with their practices to assume responsibility for the health of enrolled populations and communities. The DHBs and Ministry of Health have developed various incentives and targets to promote clinical outputs. These are expected to improve health gain as the evidence based algorithms ensure that clinical outputs become beneficial, and measurable health outcomes for patients and the community. In the early days of population screening we tended to report on what practices had accomplished, for example from 2004 on we looked at CVD risk assessments done; today we look at and report on the **patients not done**, we highlight those missing out. In the CVD example there are, as on now, in WPHO 22,000 plus patients not screened in last 5 years.

Sources of data and their limitations are discussed in each section; we realise that there are imperfections in any collected data. We have attempted to minimise these. Clearly the major limitation is when a practice activity has been performed yet not recorded. Those practices who record well show more capability (and may earn more PPP remuneration), however we have no option but to preserve the mantra, "not recorded, is not done". You may like to know that WPHO compared with many other practices is doing very well, (for example, we have seen elsewhere 5 year CVD/R rates below 20%!). If WPHO practices on the low side (about 1/3 of all) do however significantly improve, we will be exceptional! PPP income will be maximised and more importantly, patient care (only considering non-acute cases) will be optimised. Very few individuals or families will be missing an accepted level of preventative or curative care.

Again, we do realise the limitations of the data to accurately reflect the adequacy of clinical care, but this is all we have to evaluate performance by this year. By next year, we hope to be able to access laboratory and pharmaceutical data directly and thus check the achievement in actual clinical care, rather than the achievement in just the recording of the activity.

We believe that Government is very interested in seeing results from their health funding; a good way to show this is by demonstrating target (or above) levels of (evidence-based) clinical output activity. In primary care, practices provide both preventative and acute reactive services; in the younger age we tend to look for risk/disease (screening), in older patients we are often managing secondary prevention and in the very old we may with some conditions tend to wait for illness to progress and then deal with the problems.

Acute care (both primary and secondary) is interwoven with preventive care, in some practices (especially rural) acute care may dominate. However, GP Teams are responsible for both. We are interested to know what makes different practices tick – what is the role of nurse led clinics, how and why is it that some practices consistently reach target and others have difficulty? What realistically can the PHO do about this, more CME or CNE, other academic detailing?

How can the delivery of primary heath care be measured and improved? There seems to be three ways:

1. Measure how well practices are functioning (looking at variations and a gap analysis for example, identifying patients who have missed out)
2. By measuring heath gain in the community (looking at morbidity, mortality and hospital utilisations, the usual DHB Health Needs Analysis for example)
3. By developing new evidence-based tools that promote good health (like our electronic decision support tools)

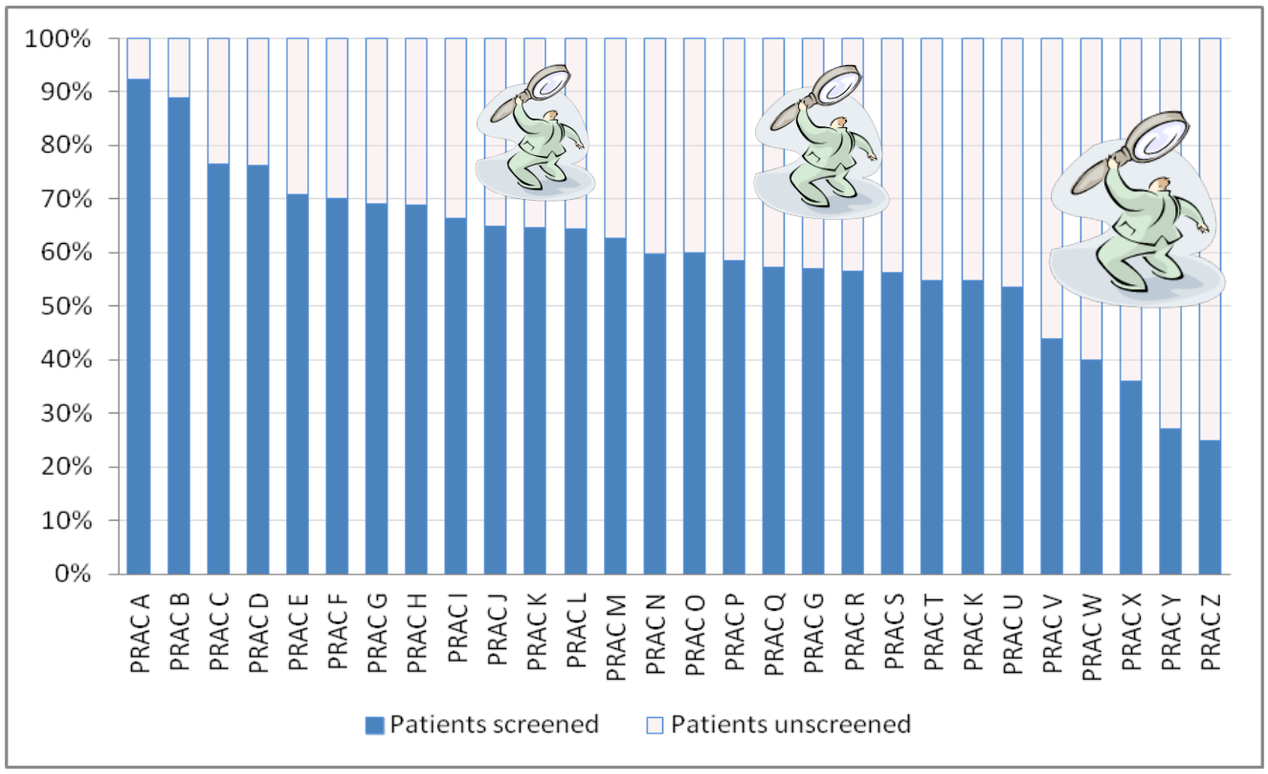
In future PHOs may be required to investigate and reduce inequalities (gender, ethnic and socio-economic) and pay more attention to the hospital utilisation by their patients. In the US and UK considerable work is published on secondary care output variations; the term "unwarranted variations" means variation not explained by clinical factors. In NZ it is timely to look at primary care variations; perhaps here the variations, in clinical outputs, have greater impact on more patients, than in secondary care.

When we look at the graphs, or talk in percentages, the impact is intellectual and remote from our daily work. When we look at the numbers, either PHO aggregated (as the very large numbers with our 22,000 with no CVD/RA recorded) or per practice, the impact is more significant. When we give practices the names, gender and ages of their patients missing out, the impact has meaning on an emotional and ethical level.

The following graph depicts this: the work, on significance and measurement of those "patients missing out", has derived from the wider work, the Health Needs Analysis (yet to be published). Why have we analysed practice (not provider) based data? Well, simply because only practices can make a difference; the corporate entity the practice and who owns it, can provide interventions to change the statistics, improve quality measures and improve practice remuneration. Encouraging practices to do this is the "small bites" of the elephant!

Figure 1

Depicting "patients missing out" – accumulated numbers are huge. We will assist practices to identify these patients on a case by case confidential basis.



The PHO has developed RNZCGP approved Continuous Quality Improvement (CQI) clinical audits that GPs may like to undertake (see Appendix 1).There is one for each of the PPP indicators as well as one for less than optimally controlled diabetics and women who are recorded as never having had a cervical smear (See Appendix 1). Please feel free to suggest any further CQIs that you may wish to undertake and PHO staff will arrange to facilitate this. Contact details are in Appendix 1.

We would value your feedback and have enclosed forms at the end of the report. Please fax back or email comments. If you consider that your practice "performance" has been incorrectly reported in a particular area, please contact us regarding the issue. We are aware that the availability and completeness of data varies between practices and, to a certain extent, it depends on the information system used by each practice. So whilst for instance we are able to access specific Dr Info data for some practices, we are unable to do so for My Practice users or where Dr Info is not operational (in 6 practices).

These limitations are documented where relevant. However, data that is provided directly by the MoH (for instance, cervical screening, childhood immunization and other PPP indicators) should be of equally accurate quality for all practices. We are of course, keen to discuss with you any data issue that you feedback to us and amend the situation if needed in order to provide a realistic picture of your practice achievements. It is always possible to do an SQL – but only logistically possible on specific items in the odd practice.

Source of data and implications

The performance of primary health care can be evaluated by reviewing hospital admissions for certain chronic conditions or for Ambulatory Sensitive Hospitalizations (ASH). Whilst we recognize that ASH rates may be a valid measurement and useful MoH national indicator, they do not tell the full story of primary health care on a day to day basis. Primary health care delivers an array of population based services which are beyond indicators measurable at the hospital level. Screening programmes are a good example of this. An analysis of hospital records fails to help individual practices in meeting their nationally, or regionally established, health targets.

As a PHO we aim to assist practices to perform at optimum levels and significant practice variations in important clinical work are of concern and lead us to consider what support interventions the PHO can implement.

Standardisation of Populations:

We are aware that differences in the make-up (demography) of the population of each practice occur as well as in the health status of each practice population. We minimize this variation whenever possible by standardizing the population (when relevant and possible) by age, sex, ethnicity and quintile (NZ Deprivation). This is most relevant with hospital utilisation data and does not apply when a percentage of targets are examined, for example, percent of over 65 YO receiving flu vaccination. We cannot account for the existing differences in health status of the population. But this is what primary health care is precisely meant to address; to reduce existing inequalities. Nevertheless, in an effort to minimize these differences extreme events were eliminated from some analyses. For example, accidents and births and very high cost admissions, were eliminated from hospital data; these situations are beyond the reach of primary health care services.

Data Sources:

In this second report we have utilised and merged a number of data sources. Whilst in the previous report we only used data from PHO Performance Programme and Practice Management Claim System (PMS), this report also includes data coming from Dr. Info as well as national registers; the National Immunization register (NIR) and National Cervical Screening Programme (NCSP) register. This data is collected at the central level of the MoH and it is less dependent on accuracy of practice reporting. This has allowed us to highlight some important data issues both relevant to the national registry (such as the gap analysis finding that 12% of our patients eligible for screening are not on the NCSP register) as well as inconsistencies between PPP data and Dr. Info data at practice level.

We strive to represent true practice clinical achievements in each programme. We have therefore endeavoured, for example, to accurately calculate coverage of breast screening in each practice, by merging data from national registers (on publicly funded screening) with PMS data where private screening is also recorded. We hope you will find this type of data representation useful. You will note in this example, that including the private screening data promotes many practice to achieving target! We have where possible compared later data with last year, showing in most cases significant improvement. We will be pointing this out to the MOH where relevant in all PPP calculations.

We acknowledge that some of the differences in practice variation might be due to an incomplete reporting from the practice to the PHO. This is particularly the case for CVD or diabetes management. Practices that have joined us recently might only have data that reflect part of their work under these indicators. However, as said previously, within the clinical programs we have to assume, "not recorded is not done". In some situations, laboratory data (e.g. HbA1c) can be obtained from the data warehouse. We therefore would encourage you to, regularly and thoroughly report data back to us, or ask for help, so that your performance on basic indicators can be a true reflection of the service delivery you are undertaking. The practice Hobsonville Gardens Rest Home has been excluded from this report as this practice looks after a very select group of elderly patients for whom population health programmes would not be relevant.

Thank you for your attention to this report and we do hope that all of your practice team will have the opportunity to describe, discuss and dissect the various practice output measures here. I would be grateful for any feedback on this exercise.

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Screening Programmes

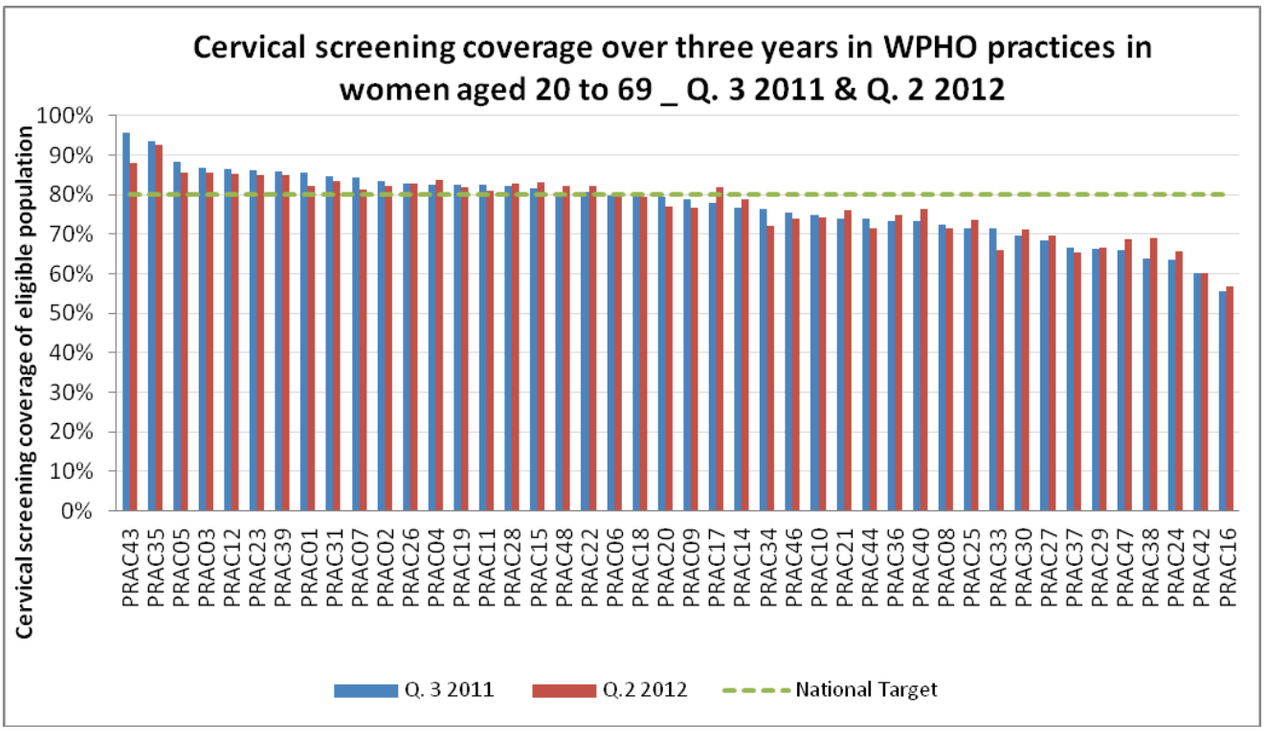
1. Cervical Cancer Screening

Cervical cancer screening is an important, long established national screening programme to which WPHO practices fully adhere. This is a vertical programme managed by the National Screening Unit but smears are taken in general practice. A fee for service is paid by the patient unless specific funding is available. It has been reported to us that sometimes patients who have been screened in the practice are not on the NSU register. This means that the laboratory (LTA) has not sent the report. We will look into this.

Towards the end of last year WPHO undertook a systematic review of the achievements of the cervical cancer screening programme amongst its enrolled population. This was only possible thanks to collaboration with the National Cervical Screening Unit who agreed to provide us with data on the status of our patients on the National Cervical Screening Programme (NCSP) register. Interesting findings have emerged from this review, possibly the most important of which is the fact that 12% of our enrolled patients who are eligible for cervical screening were not on the NCSP register and therefore these patients have (theoretically) never been screened in NZ.

The following graph shows coverage of the target population (women aged 20 to 69) in WPHO practices in two quarters: Q. 3 2011 and Q. 2 2012. These data sets span performance coverage in the previous three years period.

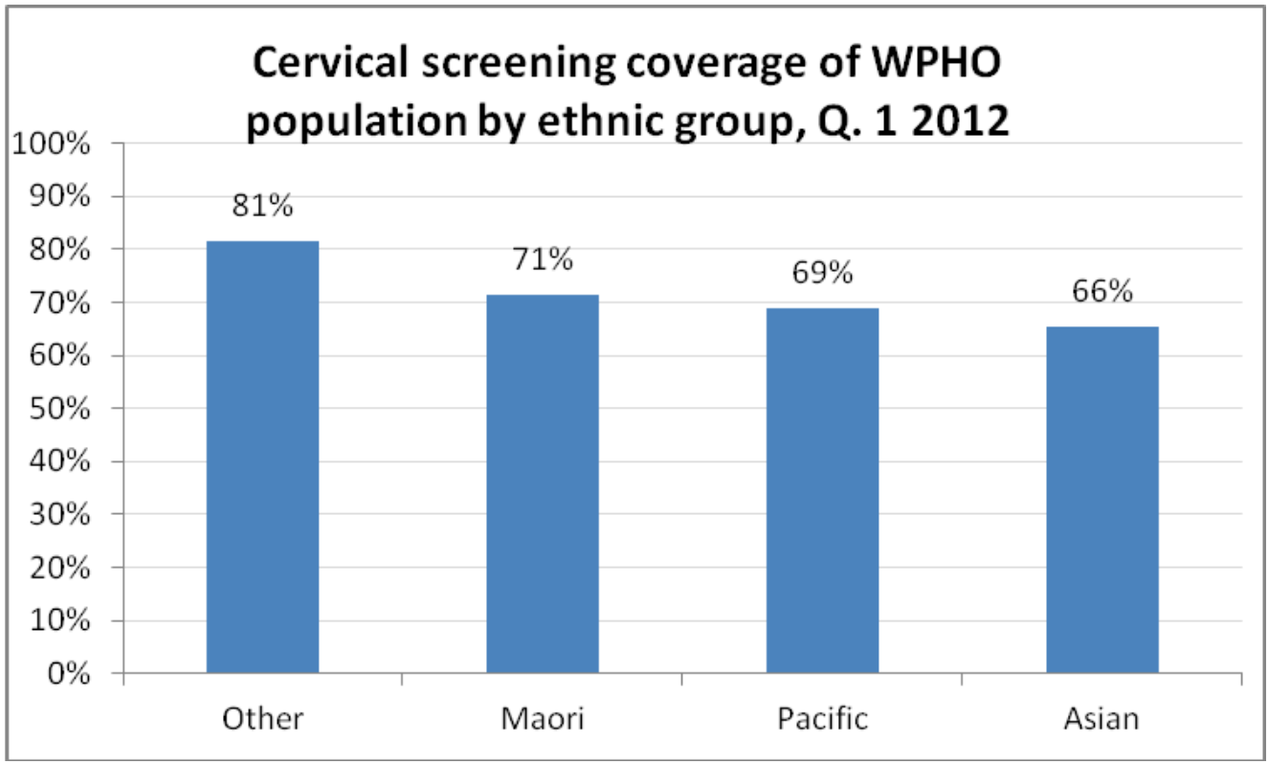
Figure 2



Source: PPP programme Q. 3 2011 compared to Q. 2 2012.

Cervical cancer screening coverage for the women under the WPHO has consistently reached 78% since Q. 3 2011, placing our overall coverage very close to the 2011 MoH target of 80%. However, half of the practices actually have not reached the 80% target set by the MoH and 2 of these have coverage below 60%. Because coverage here is calculated over three years, one would not expect to see significant improvement in a time period of six months. It is thus encouraging to see there has indeed been improvement in coverage in the lower performing practices on the right hand side of the graph.

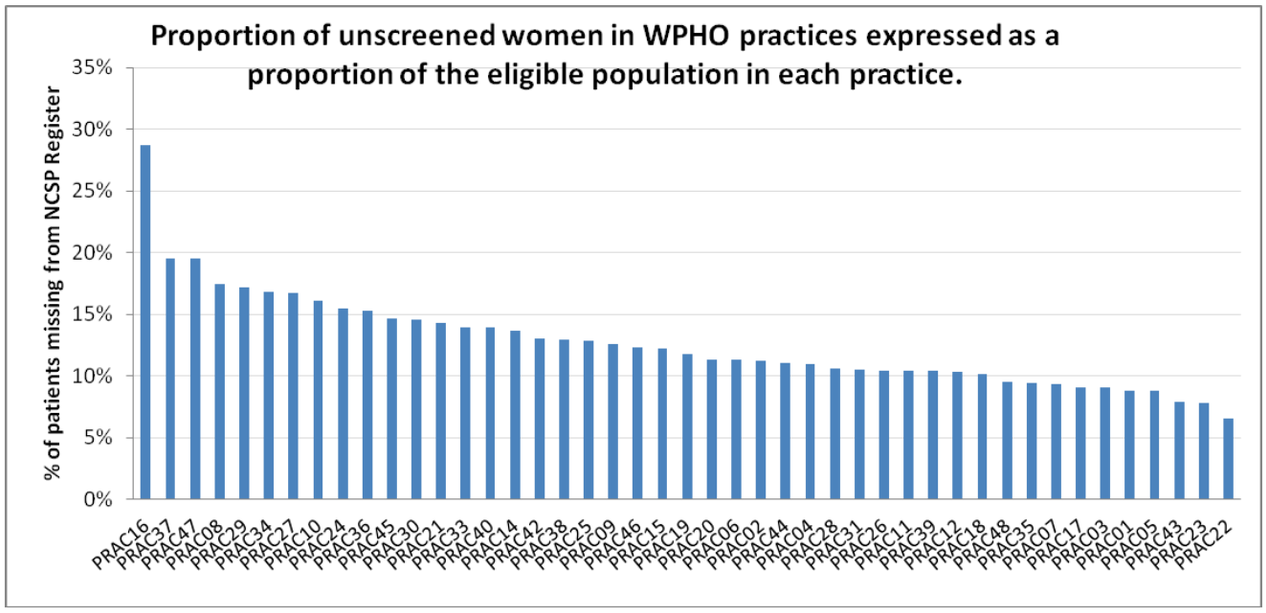
Below we present the coverage of cervical screening by ethnicity in our population. Coverage for women of Asian origin remains the lowest, followed by Pacific and Maori people. Given that people of Asian origin make up 10% of our enrolled population, efforts should be made towards improving coverage in this ethnic group.



Source: PPP Q. 1 2012

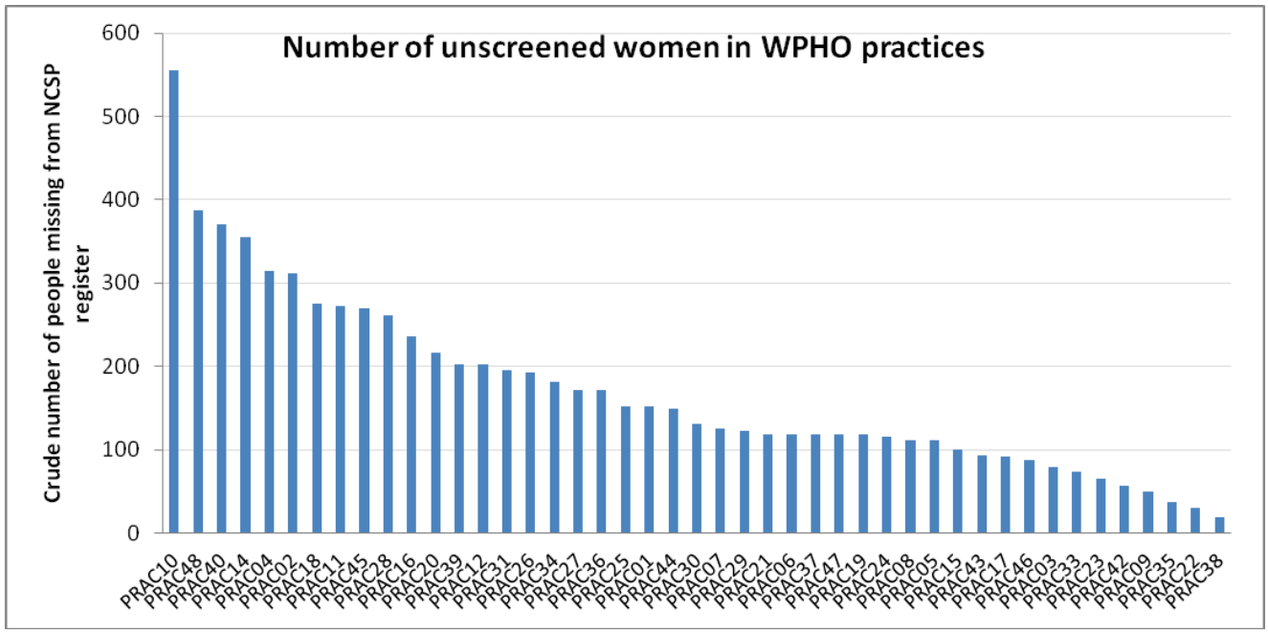
As previously mentioned, one of the worrying finding that emerged from the review carried out in collaboration with the National Screening was that 12% of our eligible (enrolled) population were not recorded on the National Cervical Screening Register. Because results from any test carried out under the cervical screening programme (smear result, HPV testing, histology, colposcopy) has to be reported to the National Screening Unit register, we can conclude that these women have never been screened in this country. The following two graphs attempt to break down the number of women never screened (7,704) between the practices.

Figure 3



Source: National Cervical Screening Register (nominator) and WPHO enrolled population Q. 3 2011 (denominator).

Figure 4

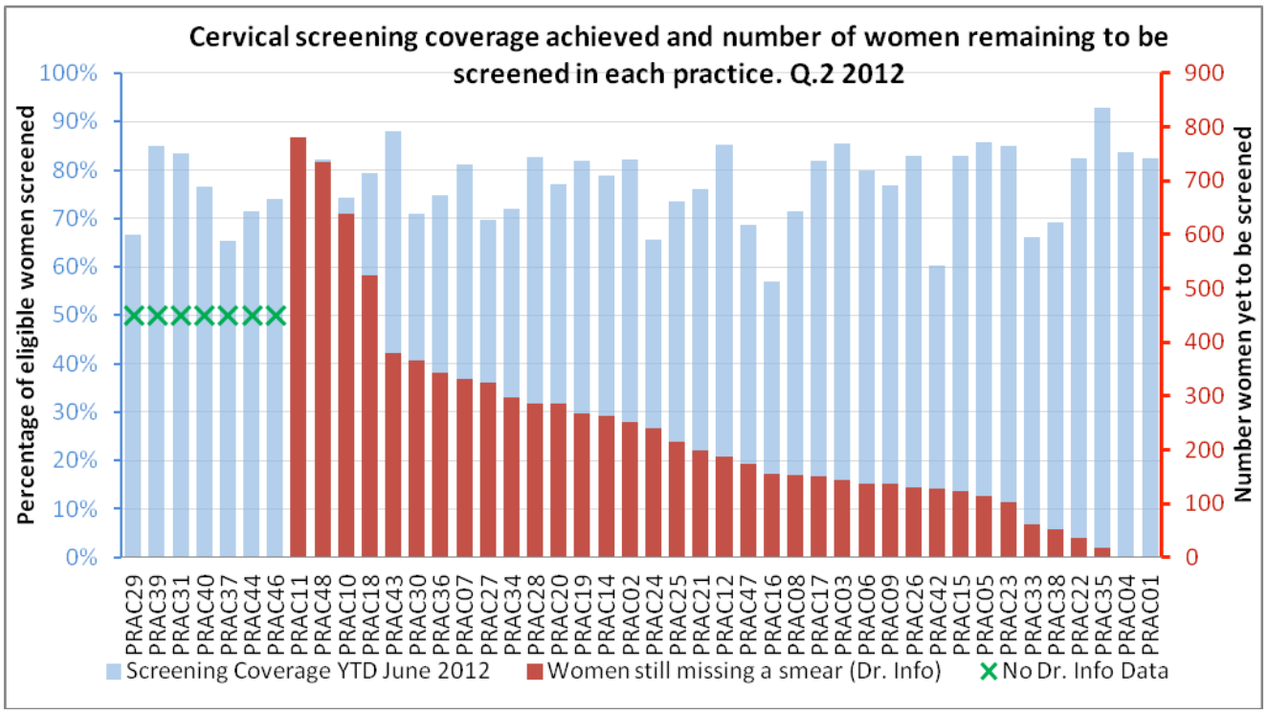


Source: National Cervical Screening Unit Register (nominator) and WPHO enrolled population Q. 3 2011 (denominator).

Although some of the patients in the list of women missing from the NCSR will have had a hysterectomy and would therefore (may) no longer require cervical screening, it was only a small proportion of the patients missing from the register who were in the older age groups. Unfortunately, as it was highlighted in a recent pilot voucher programme, the National Cervical Screening Register does not accurately reflect hysterectomies (total or partial). Only individual practices hold this information. The mismatch between the NCSP register and the practices' records is partly responsible for this high number of women which appears to be "never screened". What would really be useful for the PHO is to be able to precisely quantify the number of patients who have undergone a hysterectomy per practice and therefore be able to safely exclude them from the number of women eligible for cervical screening. The PPP programme, in fact, bases its coverage figures over an estimation of the eligible population, adjusting for possible hysterectomies. But quantifying the hysterectomies accurately, and having these reflected in the NCSP, would allow for the calculation of a more realistic coverage of the population under this PHO.

The following graph compiles data from two different data sources: PHO Performance Programme and Dr. Info. It illustrates the most recent data available for cervical screening coverage as well as the crude number of women who remain to be screened (amongst the eligible population as calculated by Dr. Info). Unfortunately, there is no information available for practices that are not Dr. Info users.

Figure 5



Source: Screening coverage data from PPP Q. 2012. Screening coverage is calculated amongst eligible women over the past three years. Crude number of patients remaining to be screened was drawn from Dr. Info and refers to July 2012.

Practices such as PRAC11, PRAC48, PRAC10 and PRAC18 stand out as, although they have all achieved over 70% coverage of their eligible population, they all have over 500 patients who remain to be screened. PRAC48 and PRAC10, as indicated previously, also have a high crude number of patients missing from the NCSP register and therefore apparently never screened in New Zealand. Dr.Info would presumably count these patients as women who are still missing a smear.

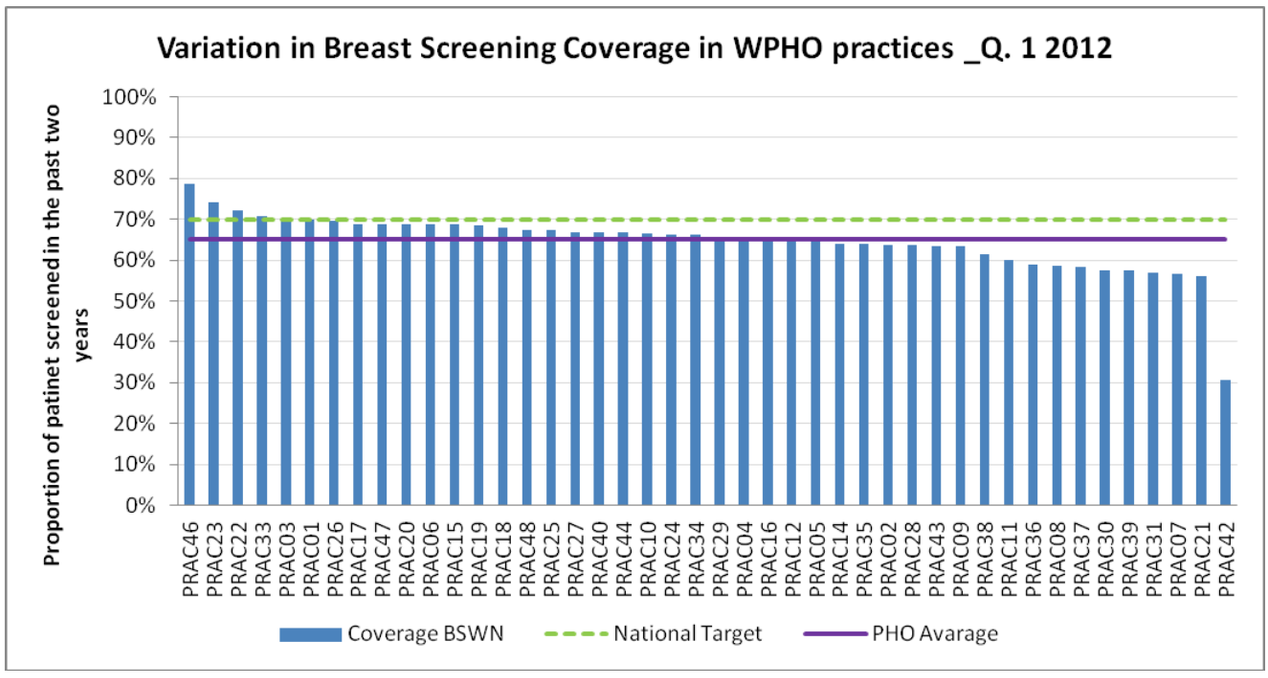
Another interesting element emerging from this graph is illustrated by PRAC01 and PRAC04. Both these practices have achieved high cervical coverage screening (over 80%) but according to Dr. Info there is no woman (zero women) who still requires a cervical smear in the eligible age group in the past 3 years. However, according to the PPP data 20% of these practice eligible population remains to be screened. It is unclear where this discrepancy in the data between the two information systems arises. One suspicion is that, as highlighted above, the hysterectomy adjustment made by PPP when calculating eligible population for screening is not accurate and it is therefore disfavouring practices such as these two. Another explanation is that there is some problem with Dr. Info. Although this data is likely to illustrate broadly true practice performance, some caution needs to exercised when interpreting the figures.

2. Breast Cancer Screening

Breast Screening is another long established programme to which all of our practices adhere. The controversy with the measurements in the programme is that a number of patients elect to have breast screening privately, as opposed to under the free national scheme. This is well known to both general practitioners, the PHO and Breast Screen Waitemata Northland. Breast Screen Aotearoa has declined to acknowledge that private mammograms can be counted as screening. Although the practices have access to information on private mammograms, the PPP programme will not allow the use of this data towards achieving the PPP targets. This affects the numerator in the programme.

We checked practices with a lower than average uptake of mammograms and counted patients who opted for private screening. The following graph illustrates breast screening coverage of eligible population under the Breast Screen Aotearoa programme only. Data refers to the 24 months period ending in March 2012 and was drawn from PPP.

Figure 6

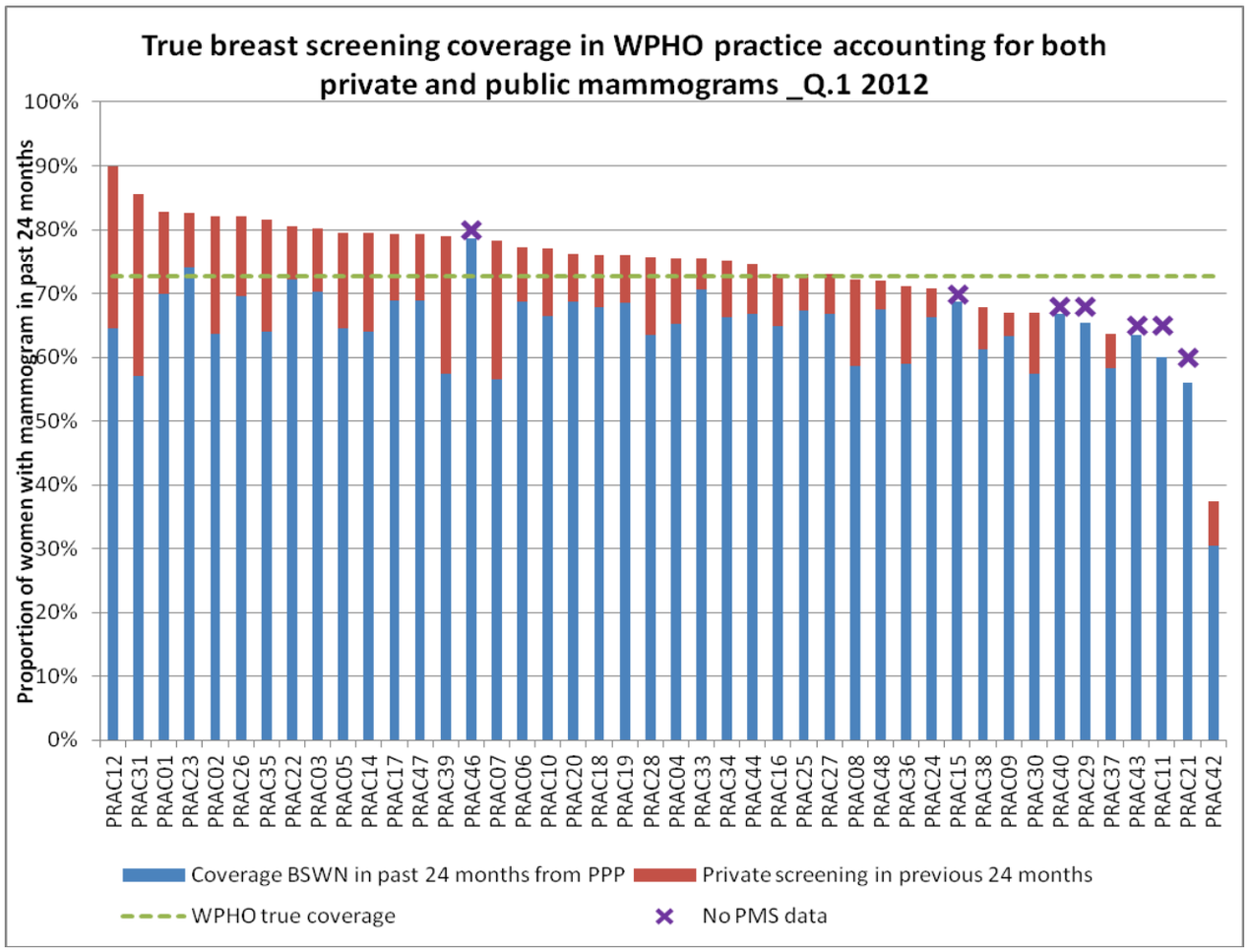


Source: PPP Q.1 2012. Data reports Year to Date coverage which for breast screening spans two years.

The PHO average performance in this programme is 64% overall coverage. Only 7 practices have achieved the 70% target set by the national programme.

Below we present the same PPP data but we have added the proportion of private mammograms that are undertaken in each practice. Unfortunately, it was impossible to find any reliable data in PMS for breast screening for the six practices identified with the symbol ×. These practices use a different information system from all other practices in the WPHO and the data does not translate with enough level of details to the MPS. So it was impossible to quantify private screening in these six practices.

Figure 7



Source: PPP March 2012 for Breast Screen Waitemata Northland (BSWN) and PMS data matched to BSWN register for gap analysis in order to identify private screening. Data for private screening is missing for six practices. These practices are My Practice users and we cannot accurately access breast screening information in PMS (this year).

The amount of private screening per practice varies from practices that apparently have no private screening (0%) to practices where nearly a third of its eligible population (29%) opts for private. So practices such as PRAC31 in the above graph would appear not to reach the national target of 70% of the eligible population screened (PRAC 31 only has 54% of its population screened under BSWN). However, as 29% of its population is currently opting for private screening, this practice has actually an overall coverage of 82%, well above the 70% national target. According to this data, the overall breast screening coverage in WPHO is of 73%, with 29 practices having achieved the national target. This is over 4 times as many practices as public screening alone (PPP data) indicates. In fact breast screening coverage for the PHO is probably higher than the demonstrated 73% and this figure is likely to underestimate the true extent of breast screening: this would be true under the assumption that a proportion of patients in six My Practice users also opt for private as opposed to public mammograms.

We are aware that Breast Screen Aotearoa does not recognize any mammograms carried out privately as 'screening". However, this methodology of looking at data per practice is very valuable for the PHO as from a population health perspective it would surely be more important to concentrate efforts on practices on the right hand side of the above graph rather than focusing on practices such as PRAC 31 where indeed 82% of the patients have in fact had a mammogram in the past two years. What is clinically important is that the screening is done, not who does it.

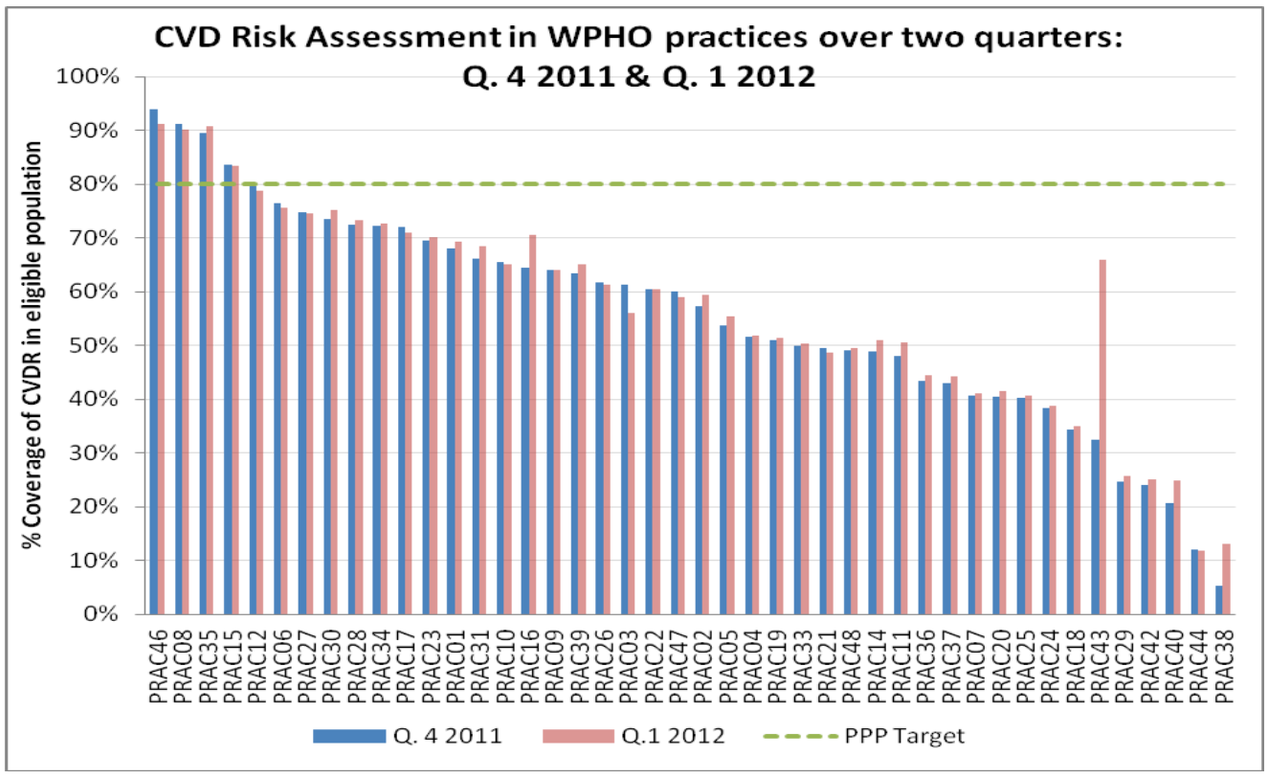
The demography of practices such as PRAC 41 and PRAC 42 is such that general practice is not their main stream of activity. These practices have been included for the sake of completion because their performance counts towards the calculation of breast screening coverage as worked out by PPP.

3. Cardio Vascular Risk Assessment

CVD screening is one of the Ministry of Health targets which measure the delivery of comprehensive cardiovascular services. This target is defined as the number of enrolled eligible people who have undergone a CVD risk assessment in the past 5 years. The following graph represents CVD screening for the two most recent quarters in WPHO practices.

Explanation on targets: the present national target is 60% and 2013 will be 75% and 2014 90%. The present WDHB target is 75% this year. However we have chosen 80% for this PHO audit – just to stimulate thinking of how we as a PHO can reach this!

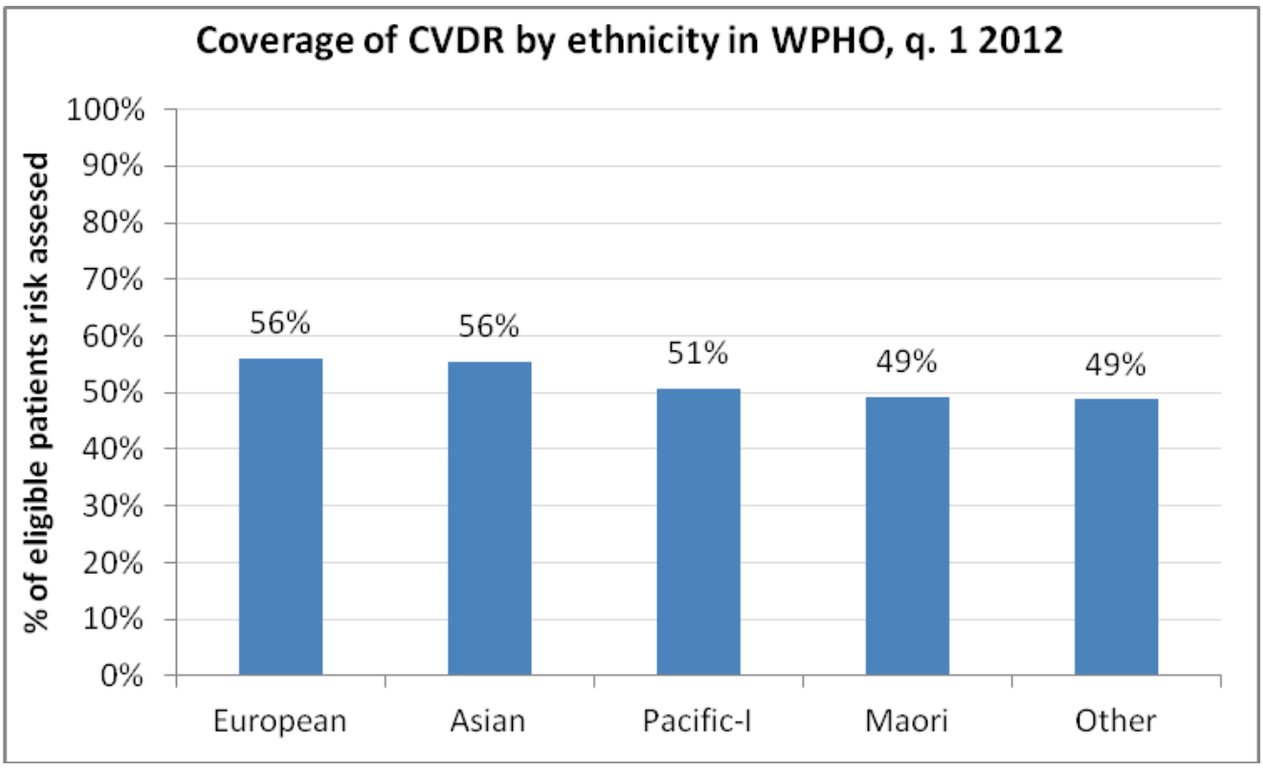
Figure 8



Source: PPP Q.4 2011 & Q.1 2012. Eligible population for CVD screening as defined per PHO performance.

Difficulties with data measurement

In this analysis (especially) a number of practices (e.g. Prac 40,44) have recently joined WPHO. Their previous PMS was Profile for Mac and we cannot easily transfer the CVD data (risk assessment and management) data across. This will be corrected practice by practice, by Query Analysis, or a Clinical Audit approach. As a last resort we may need to manage a SQL with MedTech. Practices that performed their CVD/RA with Predict have similar issues in transferring data. We are discussion with Enigma the possibility of merging data with the Edge. Very new practices as with Prac 38, have not yet been able to build up their numbers.



Source: PPP Q.4 2011 & Q.1 2012. Eligible population for CVD screening as defined per PHO performance programme.

Number of CVD screenings required per practice in order to meet a target of 80% coverage of the eligible population. The same ordering of practices as per previous graph has been maintained. Data was drawn from PPP Q. 4 2011.

Practice	Checks to target		Practice	Checks to target
PRAC46	-68		PRAC47	113
PRAC35	-56		PRAC47	113
PRAC08	-79		PRAC03	141
PRAC15	-27		PRAC05	299
PRAC12	19		PRAC04	947
PRAC06	36		PRAC19	189
PRAC30	41		PRAC14	662
PRAC27	51		PRAC11	704
PRAC28	147		PRAC33	159
PRAC34	67		PRAC48	1389
PRAC17	98		PRAC21	356
PRAC16	89		PRAC36	261
PRAC23	61		PRAC37	25
PRAC01	143		PRAC20	436
PRAC31	225		PRAC07	501
PRAC43	91		PRAC25	352
PRAC39	285		PRAC24	244
PRAC10	315		PRAC18	701
PRAC09	88		PRAC29	403
PRAC26	224		PRAC42	171
PRAC22	48		PRAC40	1647
PRAC02	440		PRAC44	989
			PRAC38	93

In this data analysis we have set a target of 80% - as an aim for WPHO. The new practices joining will have difficulty – some are well below 50% CVDRA now. We will have some work to do.

PPP National Target

The variation in CVD (recorded) screening is large and practices range from having achieved coverage of 10% of their eligible population to having achieved screening of well over 90% of their eligible population. The expected target for CVD screening as established in the PPP is set at 75% of the eligible population. As of the time of analysis, only 6 of our practices have reached this target and the number of checks required, per practice, in order to reach this target vary widely, as indicated in Table 1: from 19 to 1647. It is necessary to speculate as to the wide variation in screening coverage in such an important programme. Remember, for every death from prostate or breast cancer, there are 10 that die of CVD.

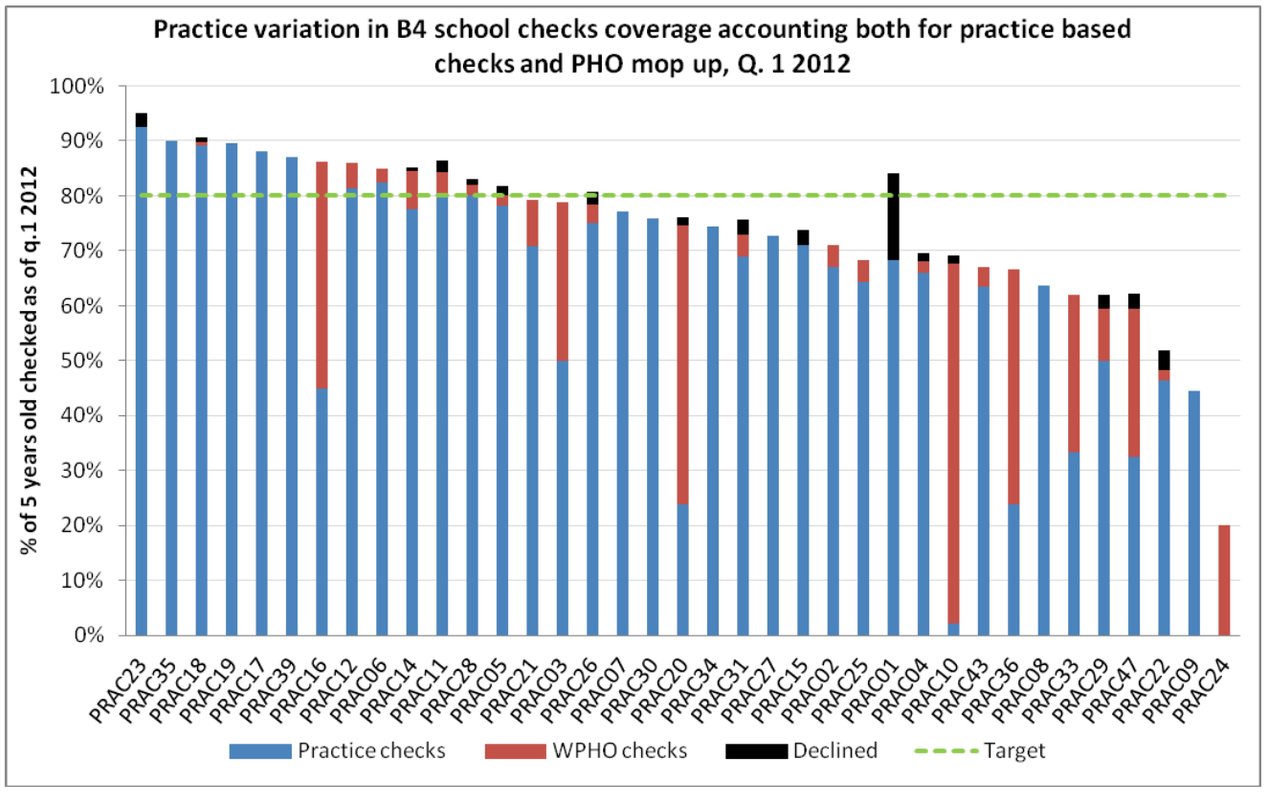
Note, in practices that have exceeded target their numbers are indicated as negative (additional checks carried out over and above the 80% target). Low levels of recording CVD Risk do not necessarily mean patients have missed out on essential care, however cardiovascular disease is so important; we (and the Minister, the DHBs and PHOs) deem that recording the risk and the management of the high risk, also important. How else can primary care "prove" it is doing a good job! Please note the disturbing findings when we look later in the document at recording of CVD Management in the very high risk patients (Previous CVD event).

4. Before School Checks

The B4 School Check is a free health check for pre-school children who turn four after 1 June every year to ensure they are healthy and able to learn well at school. These checks are undertaken by registered nurses in the practices. Occasionally, some practices are unable or unwilling to carry out these checks and a group of dedicated nurses at the PHO works towards targeting eligible children from such practices.

The graph below illustrates, for each practice, the proportion of children currently 5 years of age who have received a B4 school check, whether it was done by the practice nurse herself (in blue) or whether it was carried out by our outreach nurse team (in red). The overall coverage of this program at PHO level for this cohort of children is 66%. However, we have incomplete data for the 6 practices that have joined this PHO with the PHO merge in July last year and who are still currently with us. These practices have therefore been excluded from the following graph. The new coverage for the PHO, considering the cohort of children who were 5 by the end of Q. 1 2012 and excluding practices with incomplete data, is therefore 73%. In the following graph we have also accounted for decliners, which are not many PHO wide but who can make a significant difference for a practice with a small number of 5 years old.

Figure 9



Source: MPS Q. 1 2012. The denominator here is all children aged 5 by the end of Q. 1 2012, who therefore should have therefore had a B4 school check. Six practices were excluded from this analysis because of incomplete data.

Given that the target for the b4 school checks programme is currently set at 80%, 13 of our practices have achieved this target whilst the remaining practices have not achieved it for this cohort of children. Some practices being a long way away from it at end Q1 2012.

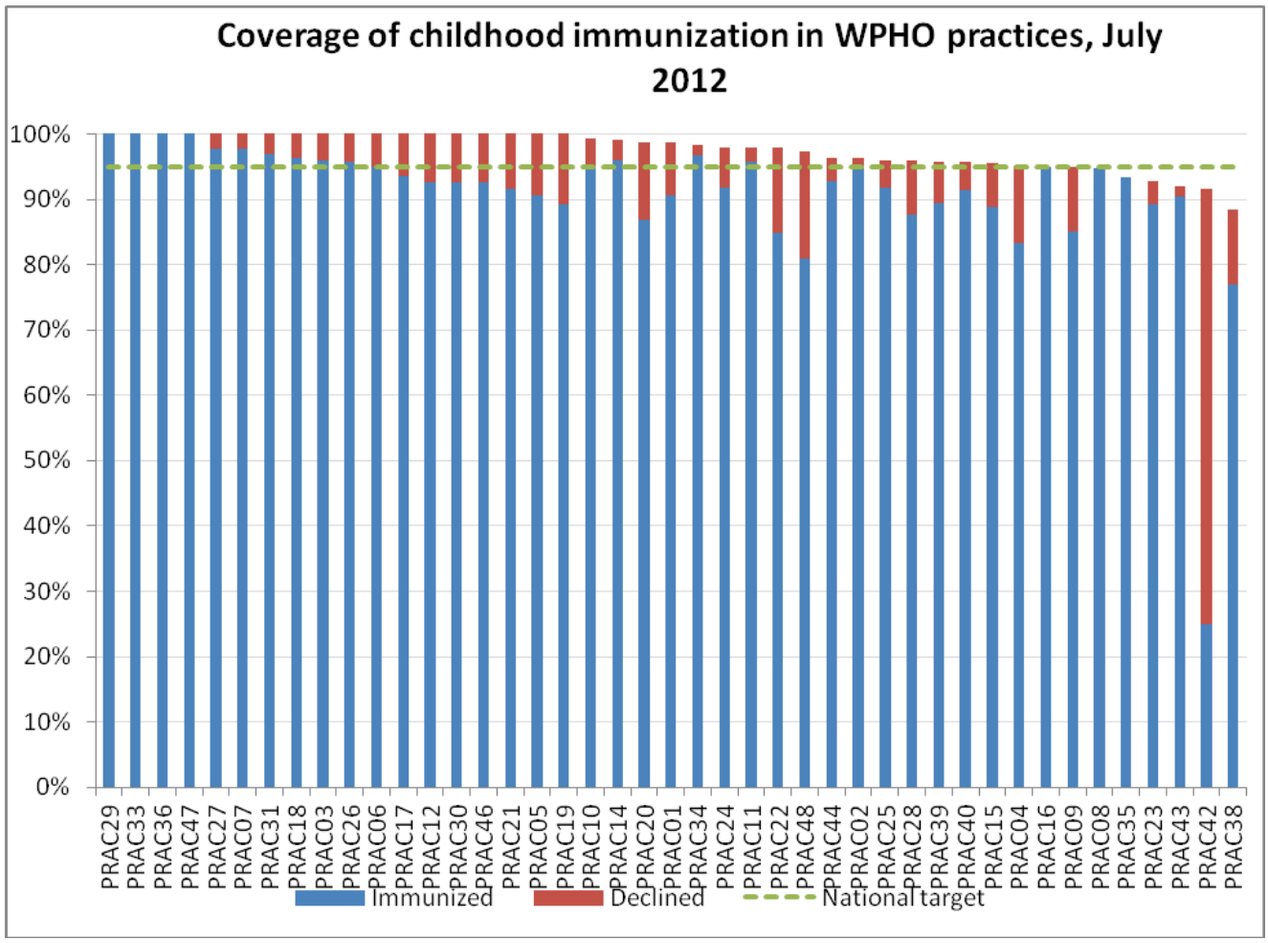
Public Health

1. Childhood Immunisation

Improving coverage of childhood vaccination is another of the Ministry of Health targets and the Ministry has set a series of progressive immunization targets: 85% of 24 months old children immunized by 2010; 90% of 24 months old children immunized by 2011 and 95% 24 months old children immunized by 2012.

The following graph reports on coverage of immunization amongst 24 months old children registered with our PHO. By this age toddlers should have completed the 15 months age specific vaccination schedule presented. Prac 42 has a large number of West Auckland families that decline immunization of behalf of their children. It is difficult to know what to do about this enrolled group, clearly it is a public health issue, but unlikely to affect herd immunity in that area. We will discuss the issue with the practice.

Figure 10



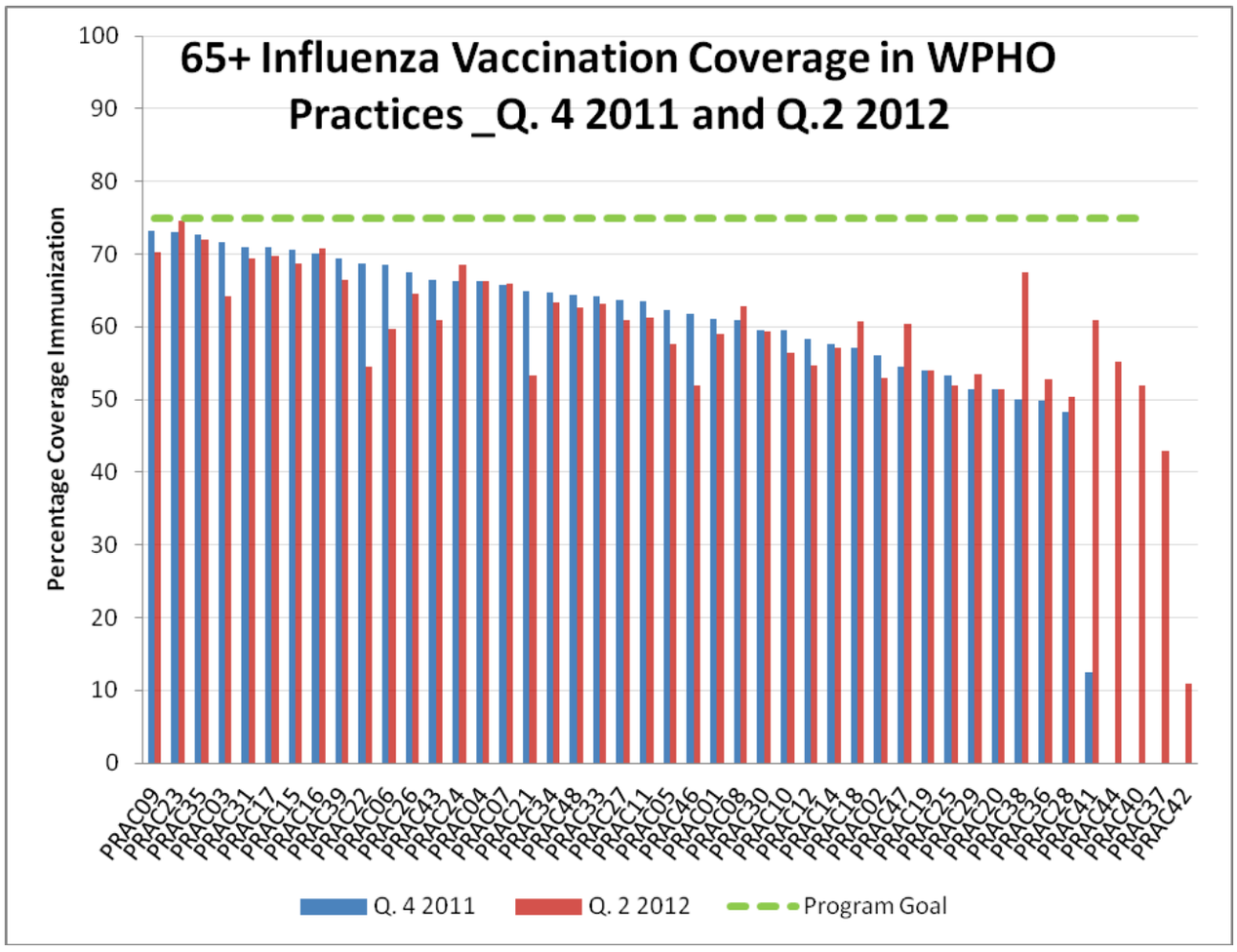
Source: National Immunization Register. Data spans the calendar year ending in July 2012 and refers to 24 months old children.

2. Seasonal Influenza Vaccination

Vaccination coverage for seasonal influenza, or flu vaccine, is offered gratuitously to anyone aged 65 or over, all pregnant women and anyone under 65 years with specific medical conditions. However, it appears that only information regarding vaccination of people aged 65 and over is reliably feedback to the PHO. Thus the following analysis includes only people aged 65+ in each practice (as the denominator) and only vaccinations administered to this group of patients (as the numerator).

Note: Data for two different PPP reports was used. However, since this year the deadline for flu vaccination has repeatedly been postponed, it is likely that the data referring to Q. 2 2012 does not fully capture the extent of the work carried out by the practice and some flu jabs might have been administered after the 30th of June 2012. It is interesting to note though, that practices that achieved high coverage last year also achieved highly in this year, albeit up to June 2012. Thus practice commitment towards vaccination of the elderly seems to be consistent over time. It is therefore a worry that some practices on the right of the graph, compared with those on the left, do not seem to value the opportunity to help prevent serious illness (pneumonia mainly) in their older population. No data for 2011 was available for PRAC44, PRAC40, PRAC37 and PRAC42.

Figure 12



Source: PPP December 2011 and June 2012.

The overall coverage achieved by the PHO in the last quarter for which data is available is 60.16%, thus there is wide room for improvement on this indicator.

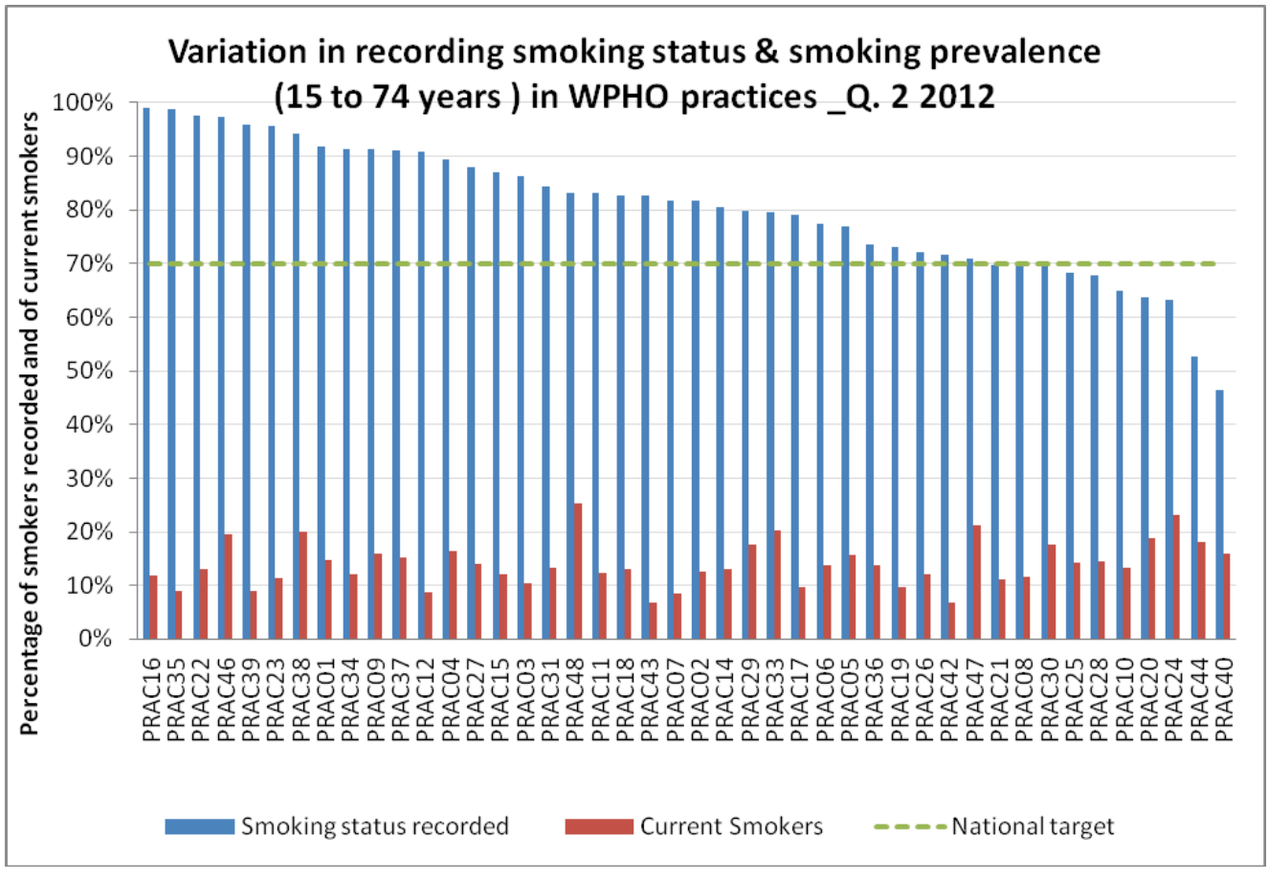
3. Smoking Cessation Programme

Monitoring behaviours relating to tobacco use in is vital for the development and evaluation of effective tobacco control policies, programs and services. Whilst data on smoking prevalence is routinely collected at hospital level, not all practices have traditionally recorded this data consistently. This PHO has made great progress towards a more diligent recording of smoking status and it has now achieved and surpassed the 70% national target for recording smoking status of the eligible population. Waitemata PHO has in fact recorded the smoking status of 80% of its eligible population. However, as for other indicators, performance varies across practices. The current smoking prevalence in WPHO is 14% of the population for whom smoking has been recorded.

Following on from the initial ABC of Smoking Cessation and ATM training sessions in August 2011 WPHO switched to providing in-house training at the affiliated practices to reach those GPs and Nurses who found it hard to attend the formal training sessions, or who were from new practices, or were new staff.

The following graph shows variation amongst smoking-recording status in practices and smoking prevalence. Smoking prevalence here is calculated as the number of smokers over the number of people whose smoking status has been recorded.

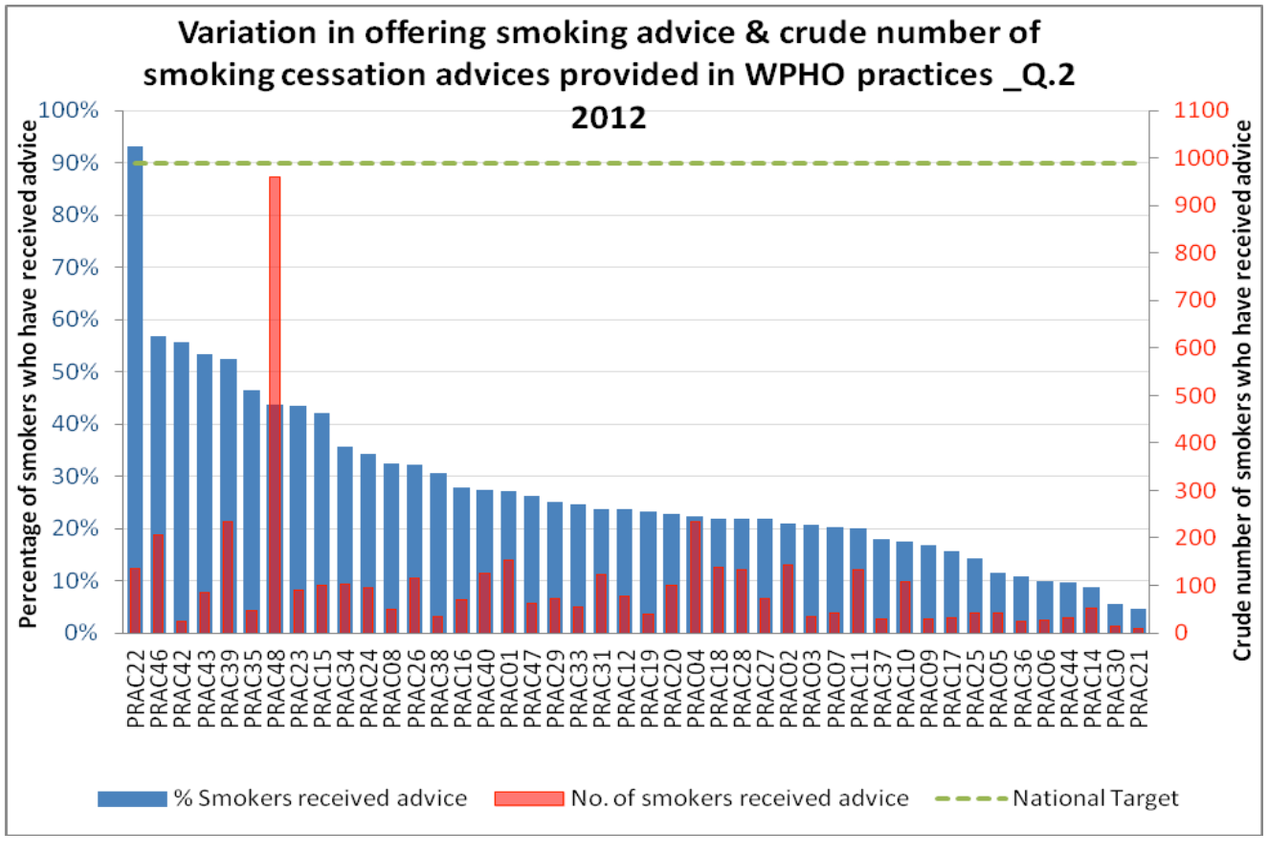
Figure 13



Source: PMS Q.2 2012. Percentage of current smokers is based on number of people for whom smoking status is recorded.

The following graph compares the proportion of smokers who have received advice in each practice with the crude number of smoking cessation interventions. So practices such as PRAC22 that have achieved well in terms of providing smoking cessation advice to its patients (93% of smokers have received advice) however only had to carry out a relatively small number of interventions (135) due to the fact that there are few smokers in this practice. We know this with a certain amount of security because this practice has coded nearly 100% of their patients as smokers or non- smokers (see previous graph). Conversely, PRAC 48, which has provided advice to 44% of their patients, in real numbers this practice, has provided advice to 961 smokers. Of course the ultimate aim is to record the number of smokers who become ex-smokers!

Figure 14



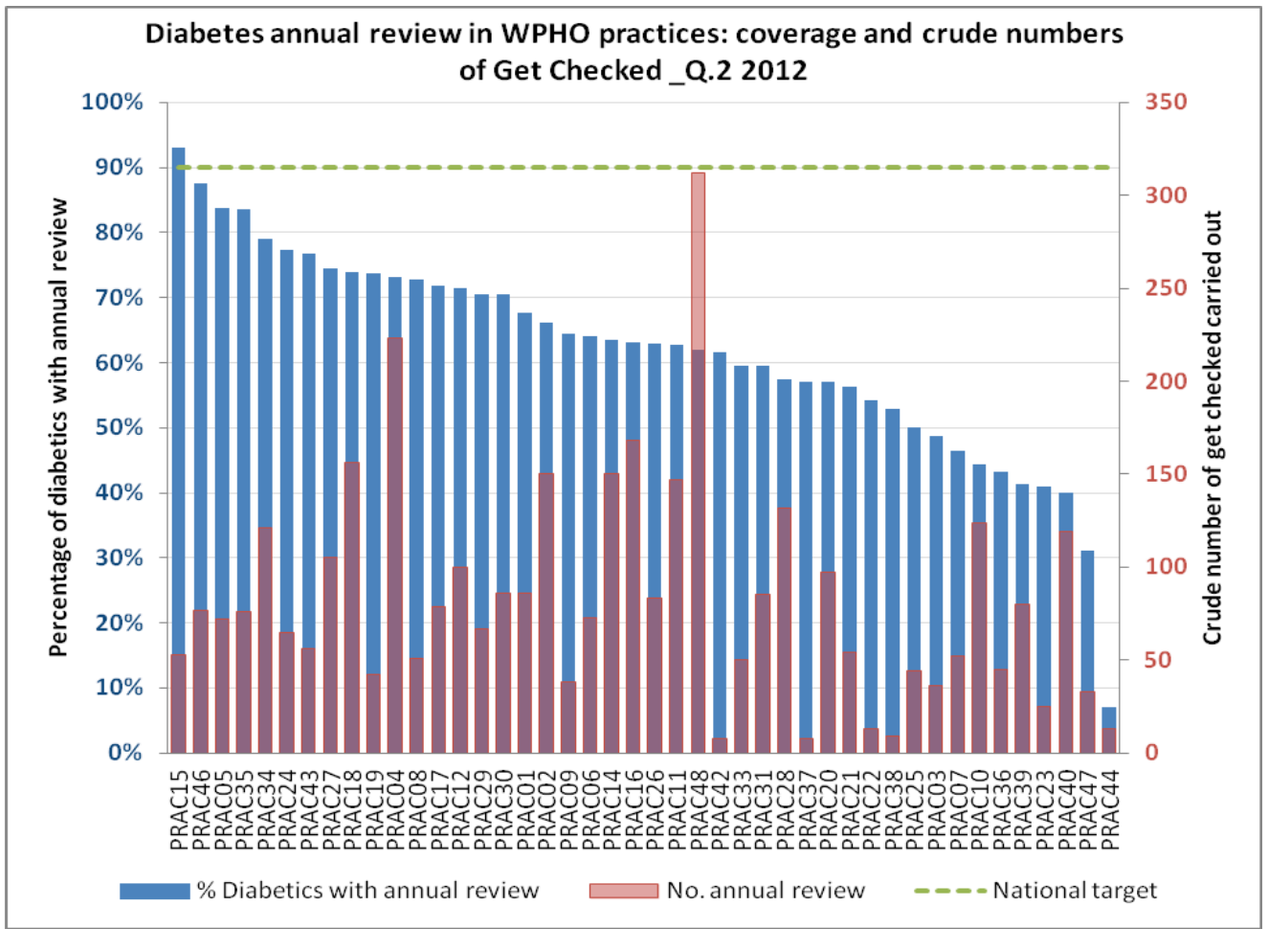
Source: PMS Q.2 2012. Dotted green line represents the national target for smoking cessation advice.

Population Health (Health Targets and Quality Measures)

Diabetes Get Checked

The following data refers to the Diabetes Get Checked programme and it expresses the proportion of diabetes annual review each practices carries out over the number of diabetics in each practice. That is as a percentage. So to a certain extent this data relies on practices to accurately identifying and recording diabetics. The graph also illustrates crude numbers of checks carried out in each practice (red).

Figure 15



Source: PPP Q. 2 2012. Annual review was based on number of diabetics aged 15-79 in each practice. PRAC44 has recently changed computer system and it is possible that the full extent of their data is not translated correctly in our PMS.

Only one of the practices has reached the 90% national target of regularly checking its diabetics according to PPP or claims data. We realise there are discrepancies: for example we know that PRAC46 has carried out Get Checked on 100% of eligible population. However this is not reflected in the data picked up by PPP. We suspect this is an IT problem with audit tool. We are currently investigating which is the best audit tool for our needs. The PHO average of diabetic annual review is 60%. National data report that only 50% of diabetics receive an annual review, this is why a new approach to quality measures in diabetes control has to be adopted. You will have received notice of the Diabetes Care Improvement Package (DCIP) to be implemented at the end of this year.

Below we also present a list of the get checked numbers that each practice needs to do in order to meet the 90% national target for diabetes review.

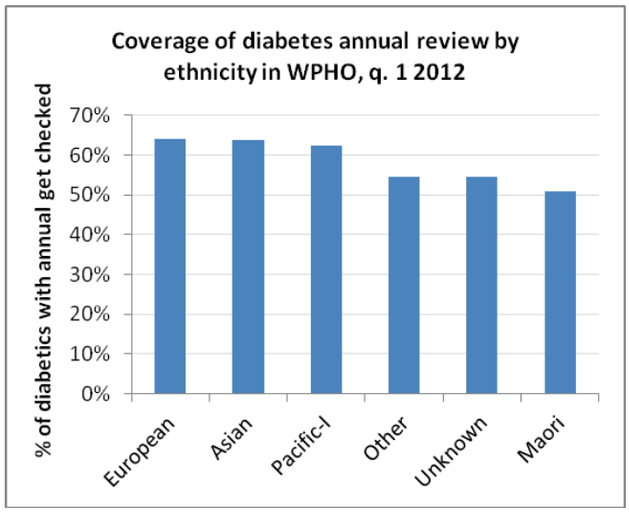
Figure 16

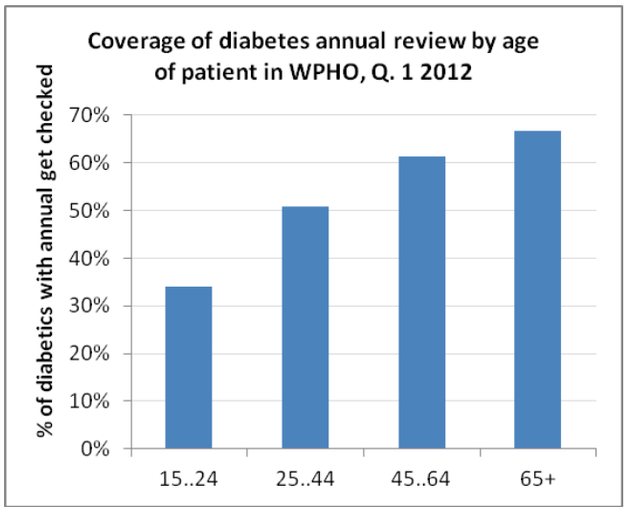
Number of diabetes annual review required per practice in order to meet the target of 90% national target. The same ordering of practices as per previous graph has been maintained. Data Source: PPP Q. 2 2012.

Practice	Checks to target		Practice	Checks to target
PRAC15	-2		PRAC26	36
PRAC46	2		PRAC11	64
PRAC05	5		PRAC48	141
PRAC35	6		PRAC42	4
PRAC34	17		PRAC33	26
PRAC24	11		PRAC31	44
PRAC43	10		PRAC28	75
PRAC27	22		PRAC37	5
PRAC18	34		PRAC20	56
PRAC19	9		PRAC21	32
PRAC04	52		PRAC22	9
PRAC08	12		PRAC38	6
PRAC17	20		PRAC25	35
PRAC12	26		PRAC03	31
PRAC29	19		PRAC07	49
PRAC30	24		PRAC10	127
PRAC01	28		PRAC36	49
PRAC02	54		PRAC39	95
PRAC09	15		PRAC23	30
PRAC06	30		PRAC40	148
PRAC14	62		PRAC47	62
PRAC16	71		PRAC44	154

The following is a brief overview of diabetes review coverage of the entire population under this PHO in terms of ethnicity and age bands. It seems that the younger diabetics are not having, or having recorded, the same frequency of checks as the older diabetics.

Figure 17



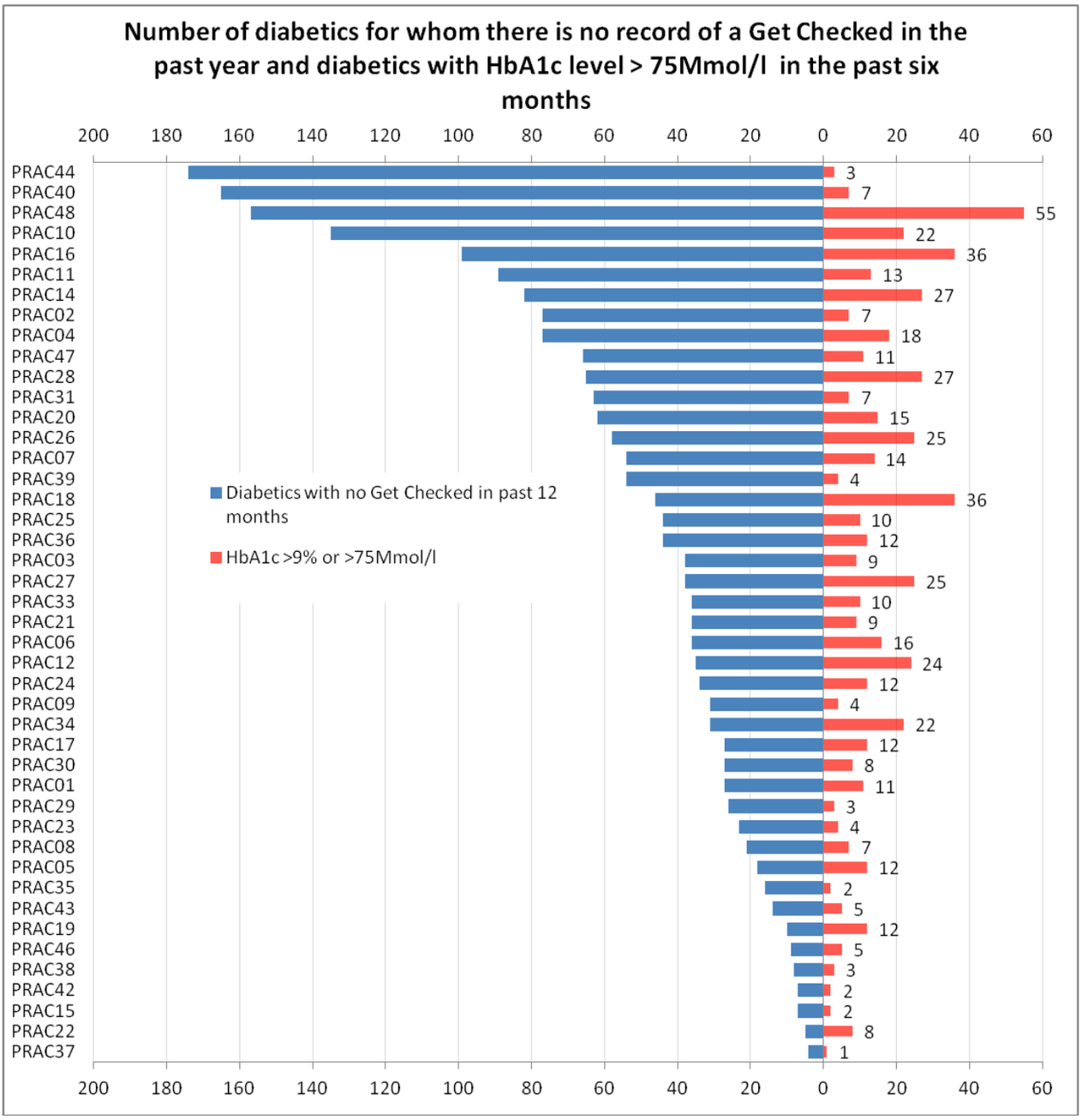


Source: Practice PMS Q. 1 2012. Recording of get checked was done based on diabetic people aged 15-79 in each practice

2. Diabetes Management

The following graph presents the number of patients who have yet to receive their annual screening (blue). This graph also provides a snapshot in time of number of people (red) with uncontrolled or poorly controlled, diabetes (measured as the number of people in each practice with glycosylated haemoglobin level higher than 75Mmol/l). Please note that the time frame of these measurements is different: whilst the number of diabetics without a Get Checked in measured over a period of time of 12 months, the number of diabetics with elevated blood glucose level is taken as a snapshot in time and looks at patients records over six months. However, given that HbA1c offers an indication of longer-term blood glucose control, this is a very valuable indicator of diabetes management. Practices with a large number of "high HbA1c patients" may like to conduct an audit and formulate a care improvement plan; that is a CQI that generates MOPS points (See Appendix 1).

Figure 18



Source: Number of diabetics without a record of get checked was derived from PPP as recorded in Practice PMS Q. 1 2012 and reflects a year of data. Recording of get checked was done based on diabetic people aged 15-79 in each practice. Number of patients with elevated blood glucose levels was drawn from DrInfo as of July 2012 report and reflects reading in the previous six months. There was no data available in DrInfo for PRAC37, PRAC46, PRAC29, PRAC39, PRAC31, PRAC40, PRAC44. The HbA1c reading of their patients was therefore extracted from the Claim system, looking at the same time period.

We acknowledge that glycosylated haemoglobin level only provides a partial picture of how diabetics are being managed in our practices: diabetes is a complex disorder and requires a systematic approach to care. Blood glucose level is a very crude indicator of effective patients' management. There is in fact mounting evidence that mean blood glucose level during the preceding 6 to 8 weeks has only limited validity if being used as gold standard for the management of diabetics. The quality of

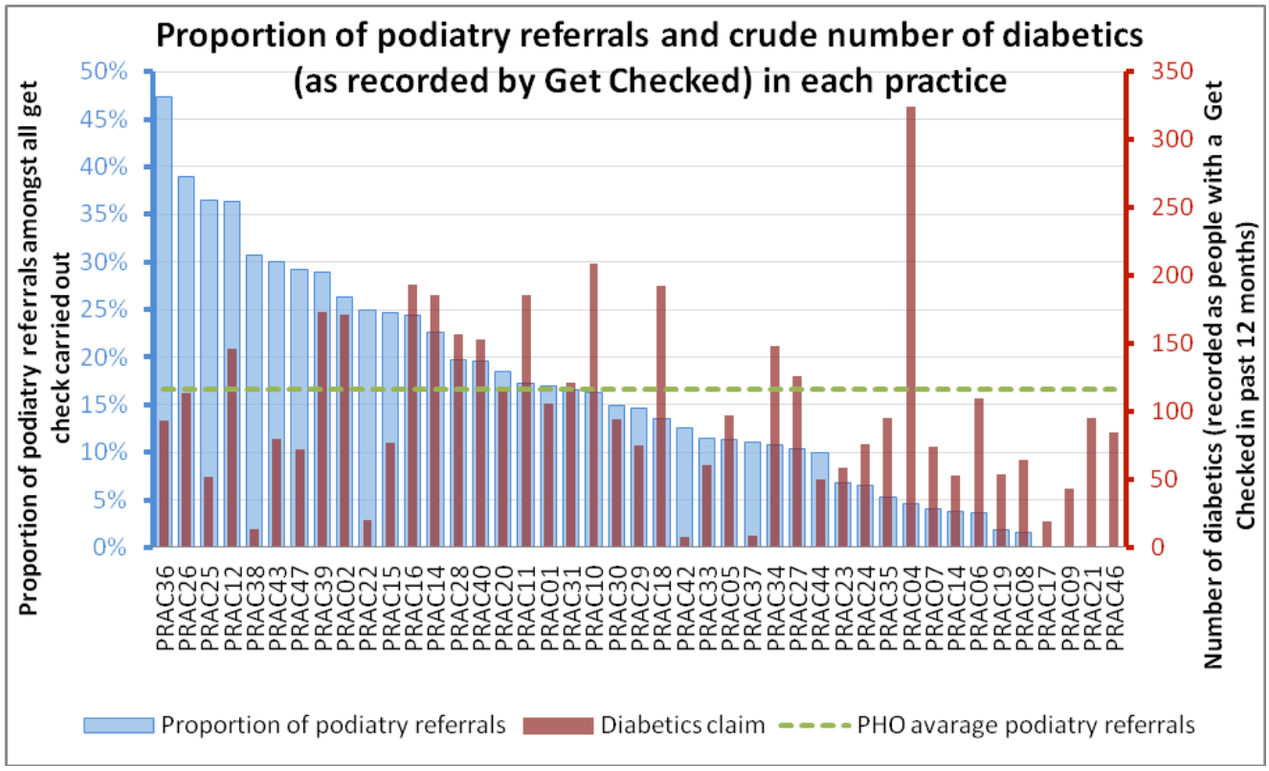
metabolic control should be determined entirely within the therapeutic target worked out together with the patient. Having said this, HbA1c levels are one indicator readily available to the PHO from MPS whilst searching through individual patient' files in order to assess adherence to agreed plan would take so long that it is beyond the scope of this exercise.

Next year, with the Diabetes Care Improvement Package (DCIP), agreed with WPHO and WDHB, over 10 indicators (including blood pressure, renal function and other measures of micro or macro vascular damage in diabetics) will be examined to access adequacy of diabetic management. We anticipate these indicators will be measured and presented "automatically" without requiring administrative effort from practices.

Another measurement of diabetes management that we decided to have a look as a one off was the proportion of podiatry referrals carried out in each practice. This information is represented by the blue bars in the following graph whilst the red bars represent the number of diabetic patient in each practice.

3. Podiatry referral frequency for diabetic patients

Figure 19



Source: Claim data from WPHO register Q. 2 2012.

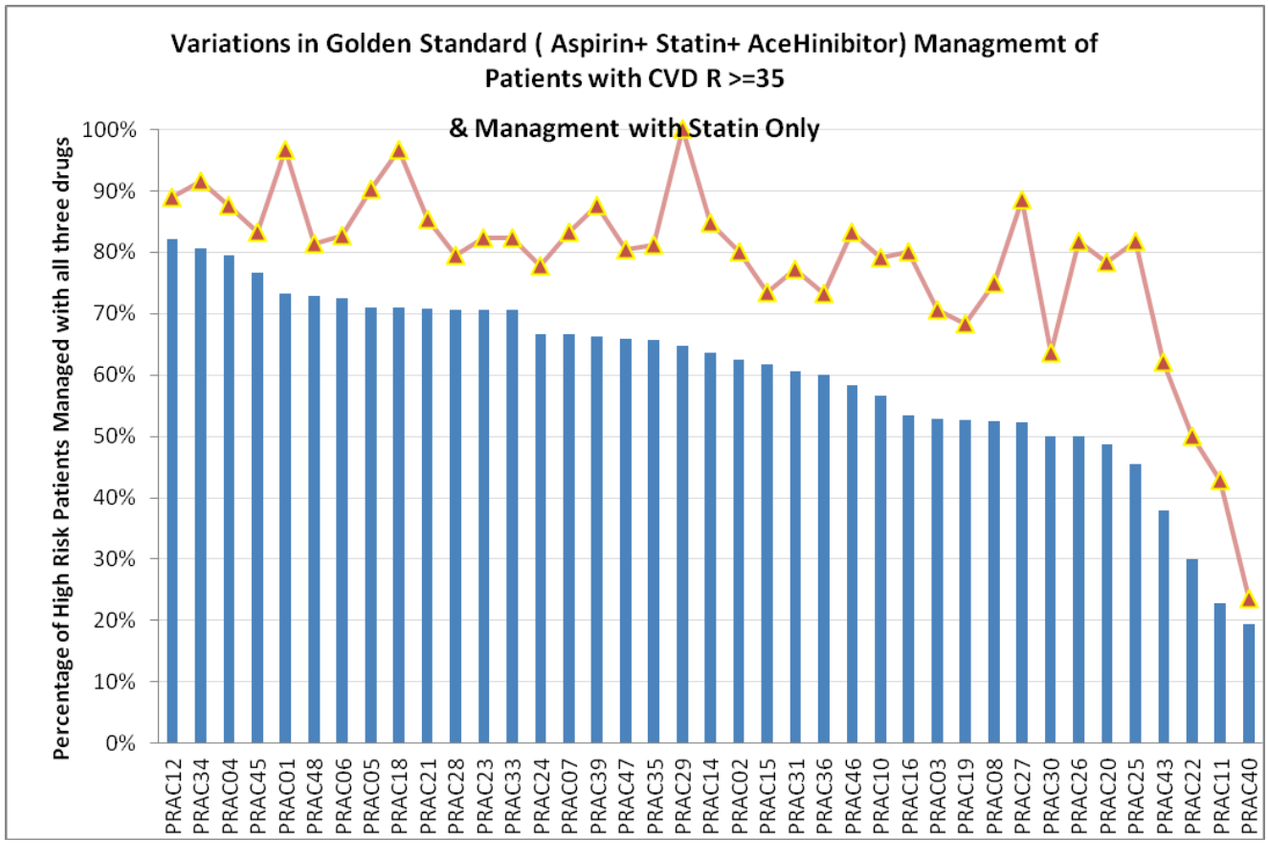
PRAC04 stands out here because it has a high number of diabetics (324) yet it has only referred 15 of them (4%) for podiatry referrals. PRAC21 and PRAC46 have nearly 100 diabetics each and they appear to have made no referrals for podiatry.

Podiatry referrals are of course age dependent and we have not yet analysed against age bands, but we thought practices might find this information interesting.

4. CVD Management

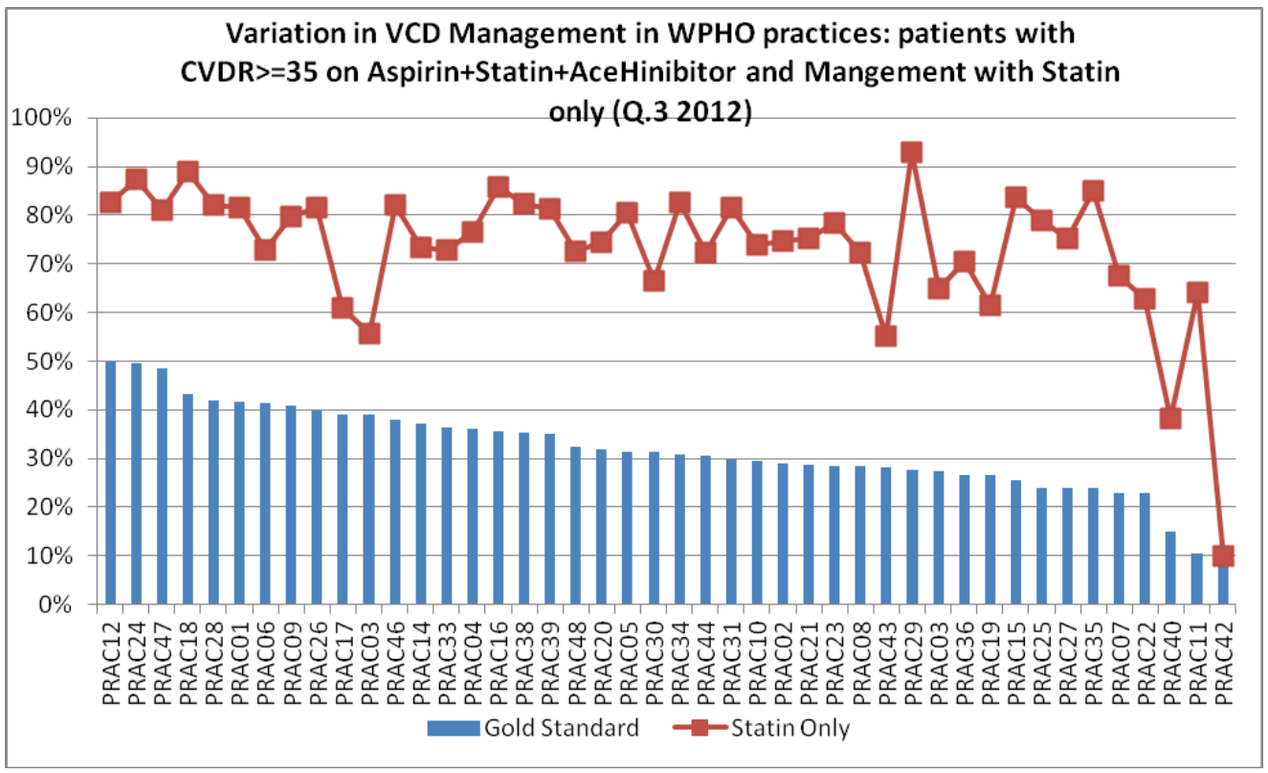
The following graph illustrates the achievements of individual practices in managing patients with known very high CVD risk by adopting the Gold Standards (patients on the three drugs: Aspirin, Statin and ACE inhibitor- or BP lowering) as well as high risk patients managed with Statin only. Patients on two drugs are not in the analysis (see below re aspirin) and we realise that some of the very high risk may in fact be normotensive without BP lowering, but not very many! The 35% risk chosen means a past history of a previous CVD event – these patients must be managed well as without the three drugs they are bound to have another MI or CVA. The next two graphs span a 9 months period. Please note the decline in CVD/M recording in the later graph. This no doubt represents the lack of funding for CVD/M based on recording, (more below on this). We would welcome your opinion.

Figure 20



Source: PMS Q.4 2011, Practices with less than 10 patients with CVD risk >+35 were eliminated from this analysis.

Figure 21



Source: Claim Database. Q. 3 2012. Practices with less than 10 patients with CVD risk >+35 were eliminated from this analysis.

Although the information presented in these graphs is valuable for the PHO and should also be noted by practices, there are a number of serious limitations with the data source and collection:

1. We have a concern that the indicator in the claim database chosen to select patients on the goal (gold?) standard treatment, only picks up a partial picture of what it is happening in the practices. For example, patients could be purchasing Aspirin without a prescription and the practice does not have this recorded in the PMS. Thus a practice such as number 25 in this first graph, with a relatively low proportion of its high risk patients on the combinations drugs (45%) has actually over 80% of its patients on Statin (or equivalent), one would think also on aspirin. Conversely, a practice such as PRAC40 in the first graph has both a very small proportion of its high risk patients on either the combination drugs or Statin alone. We are hoping that in the near future we can have access to Pharmaceutical data so that we can more comprehensively and reliably assess the management of patients with high CVR based on their prescriptions.
2. Analysing at Claims data alone is likely to obscure some information. For instance claims under CarePlus would not be reflected in this data. Although CarePlus only can only be allocated to 5% of all the patients under this PHO, it is indeed likely that some practices have high enrolment in Care Plus, particularly for the very high risk CVD patients, i.e. those with previous events. Unfortunately, our current audit tools are unable to gather this information, thus we are unable reflect the true performance in this indicator per practice.
3. Looking at Claim data reflects, to a certain extent, the availability of funding from the DHB for this specific intervention (CVD Management). CVD management has in fact decreased substantially between the two time periods shown above and this has to be a reflection of the fact that we ceased funding this intervention. Doctors might well still be managing their high risk CVD patients but because they are unable to charge for this, we are not picking up this information from the PHO end. Monitoring of good performance in primary health care cannot be related to availability of funding for specific conditions and this has helped the PHO realize that we need to re-evaluate the audit tool.
4. Finally, some practices had a small numbers of patients with CVD R >35, thus any one patient who is not managed adequately might disproportionately skew the statistics against this practice. For this reason, any practice with 10 or less than 10 high CVD risk patients was eliminated from this analysis.

Pattern of Hospital Services Utilisation

The following graph presents the result of a large piece of work currently being undertaken with the collaboration with WDHB. Co-investigators of this study are: Dr. Peter Sandiford, Epidemiologist and Public Health physician; Dr. Lifeng Zhou, Epidemiologist; Dr. Lannes Johnson, Clinical Director, WPHO and Ms. Micol Salvetto, Population Health Analyst, WPHO.

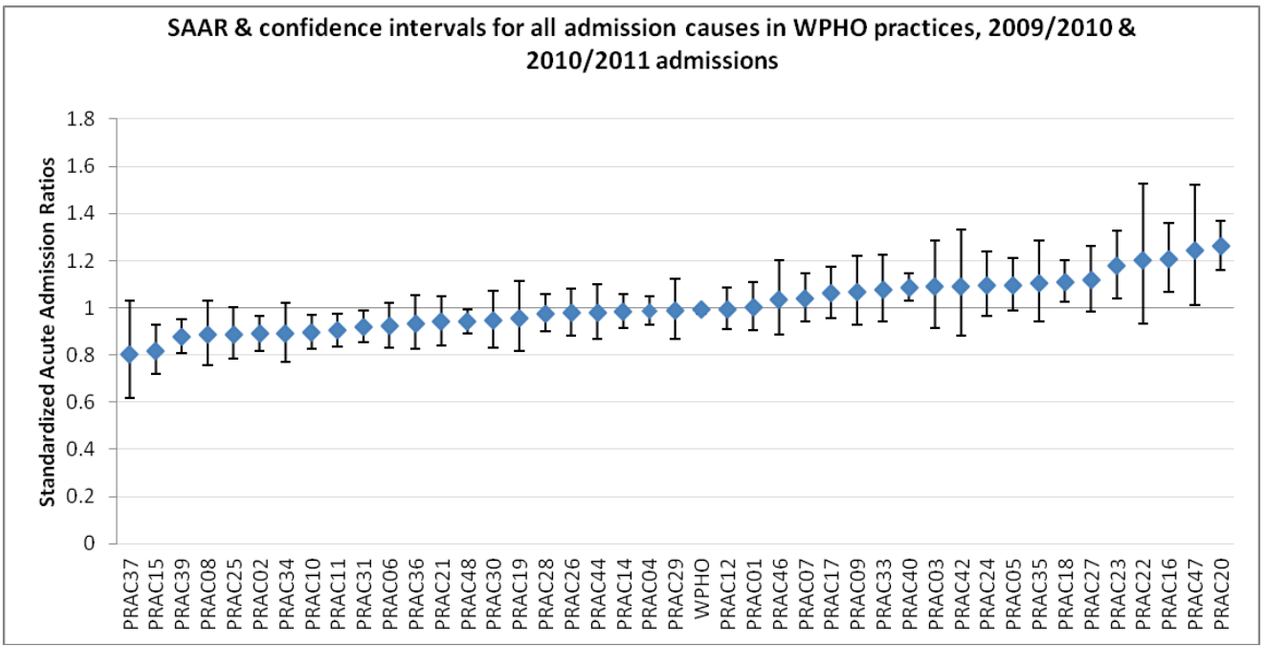
This small study aimed at establishing practice based, PHOs and DHB's performances in terms of Standardized Acute Admissions Ratios (SAAR). The first part of the research is intended to create a ranking of the practices' population admission rates. The second part of the analysis is intending to establish which practice specific characteristics would be good predictors for higher than average hospital admissions.

The data refers to admission over two years (2009/10 and 2010/11) and looks at admission for all practices under the Auckland and Northern DHB. Each practice population was standardized for age, ethnicity, gender and NZDep to the population of the Northern PHOs. In the following graph 1.0 corresponds to the Acute Hospital Admission Ratio of all practices in Auckland and Northland, so practices above 1-0 have higher admission ratio than the combined Auckland and Northland practices whilst practices below 1.0 have lower acute admission ratios than this group.

The admissions counted were true overnight admissions and excluded any hospital transfers or long ED stays. GP initiated admissions were included however the **majority (70 – 80% of admissions) were apparently self-referred.** That is, nearly all admissions were patients that either bypassed their practice, or were not recorded as arranged by the GP. Data from Starship hospital was not included, only admissions of people 15 and over were counted.

Data for two consecutive years of admissions is presented below. The two years yielded consistent data.

Figure 22



Source: Population data enrolment Northern PHOs 2010 for 2009/2010 NMDS data and Northern PHOs 2011 for 2010/2011 NMDS data. Hospital Admission data: NMDS 2009/2010 and 2010/2011. Population standardized to Northern region and SAAR of 1.0 corresponds to the admission rates of Northern DHBs combined.

Some caution needs to be exercised when interpreting practice specific admission ratios. In order to interpret a practice's population admission rate, in terms of Acute Hospitalizations, the position of the practices on the graph, in respect to 1.0 should be noted. The vertical bars denote the Confidence Intervals. If the Confidence Intervals of the practice happen to touch the horizontal line at 1.0, then their performance is not significantly different from the performance of all other practices in the Northern region. Smaller practices have larger confidence intervals. So for instance PRAC 20, 16, 23, 18, 40 and PRAC 47 have a significantly higher admission ratio than all other practices in the Northern region. The same logic applies to practices below the line (1.0), 15, 39, 25, 02, 10, 11, 13, 48, have significantly lower SAARs.

A separate analysis was performed (results not shown here) to establish whether practice variation on admission ratios changes over the two year period. In other words we aimed at establishing whether fluctuations in admission over time are random, with some practices having 'bad years', or rather, whether SAARs are consistently high or low. The analysis demonstrated quiet conclusively that SAARs for All Causes of admissions (as shown above), and disease specific admissions, Cellulitis, CHF, COPD and Diabetes are consistent from one year to the next. However, admissions for Constipation and Secondary Cancers are not consistent over the two year period analysed.

Also, further analysis (not reported here as results have yet to be published) demonstrated that it is the practice management of acute cases that determined its rate of SAAR and not the disease load in each practice. We hypothesized that practices with high SAARs might in fact have a higher proportion of complex patients requiring hospitalizations. The results of the analysis demonstrated the opposite: practices with high SAARs have less complex case patients admitted. This demonstrates either that certain high SAARs practices have limited accessibility and patients are opting for ED instead, or that practices with higher SAARs may be less effective at

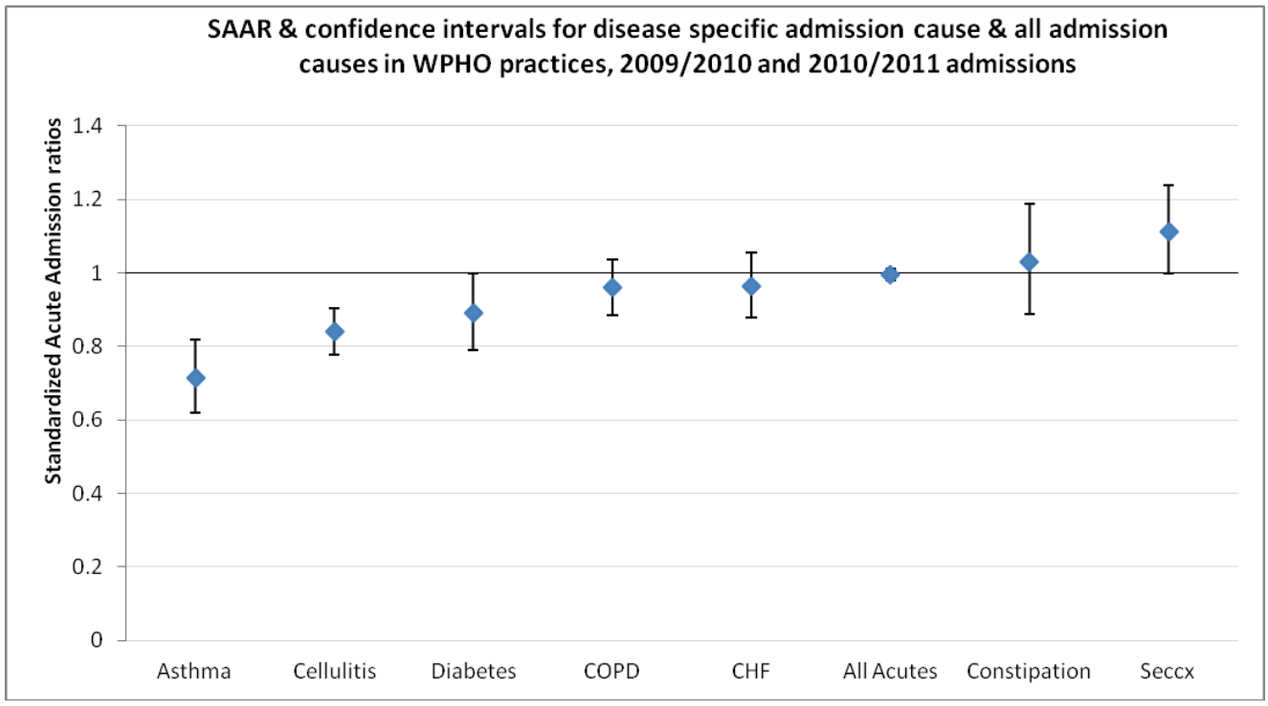
resolving their patients medical problems (for any reason, for example barriers to access or availability from hours of opening) and the patients are thus admitted more often.

As a whole, our overall PHO Acute Admission Ratios are consistent (around the 1.0) over the two years. This indicates that we have similar admission ratios as the combined SAARs for Auckland and Northland practices.

Disease specific SAAR

The following graph shows admissions for current WPHO practices for a number of conditions that are believed to be amenable to primary care interventions. These are: Asthma, Cellulitis, Diabetes, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure and Constipation. Data for admissions for Secondary Cancers (Seccx) are also presented here.

Figure 23



Source: Population data enrolment Northern PHO 2011, Hospital Admission data: NMDS 2009/2010. Population standardized to Northern region and SAAR of 1 corresponds to the admission rates of Northern DHBs combined.

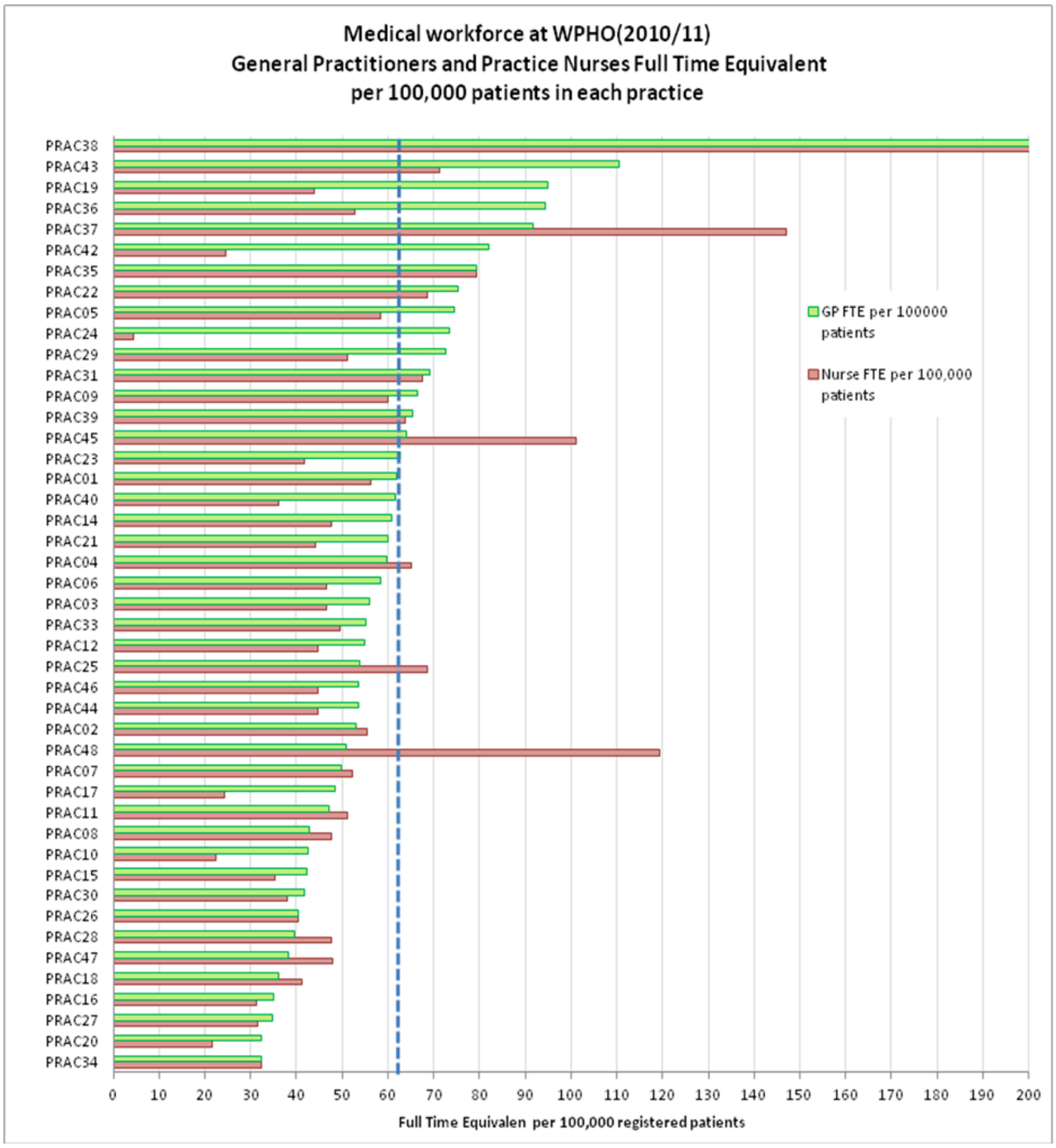
The practices under t WPHO appear to have lower admissions ratios than all practices in the Northern region for Asthma and Cellulitis, whilst for the other conditions the SAARs are not significantly different from 1.0.

Unfortunately, disease specific SAARs per practice cannot be shown due to the fact that the disease specific numbers are too small and the Confidence Intervals so wide that these figures would only be significantly different from 1.0 for very few practices.

Medical Workforce of WPHO Practices

Full Time Equivalents (FTE) for doctors and nurses were drawn from a survey of all our practices carried out in 2010 and then repeated in 2011 for the new practices that have joined the PHO after the merge.

Figure 24



Source: Practice surveys conducted in 2010 and 2011. Both the A&E practices were excluded from this graph as their staff-to-patient ratio is skewed towards overstaffing: both these practices need a higher number of GP and nurses' time as they serve a population which is considerably larger than the population of their enrolled patients. The dotted line represents the WDHB GP full time equivalent per 100,000 patients (which is 62) and was drawn from NZ Medical Workforce Survey 2011.

Continuous Quality Improvement (CQI) Audits for MOPS

Integral to the practice variation analysis and reporting is the RNZCGP Continuous Quality Improvement (CQI) initiatives as part of Maintenance of Professional Standards (MOPS). In 2010 CQI's that align with the PHO Performance Management Programme (PMP) were developed and have been approved by the RNZCGP through until 2015 (See Appendix). These PMP oriented CQI are population based screening-oriented activities including the likes of breast cancer screening, cervical screening, childhood immunization, smoking status, CVD risk assessment, identification of diabetics and so forth. All WPHO generated CQIs are available on the RNZCGP MOPS website. Summary sheets for reporting purposes are available from WPHO.

In 2012 two CQI's were developed and approved as extensions of the PMP indicators of diabetes and cervical screening. Having identified patients who have diabetes as part of the PMP programme indicator, the new diabetes CQI looks to improve the management of the cohort who demonstrate poor control (HBA1c). The CQI is flexible in terms that the GP can select the cohort of patients he/she is most interested in (i.e. less than optimally controlled through to those who have significantly elevated HBA1c warranting intensive treatment). The second CQI approved in 2012 targets the management of those women eligible for a cervical screen who are recorded as never having had a cervical screen. The dominator for this CQI is dependent on determining those patients who may not be eligible or not require a cervical screen and that process is built into the first stage of the CQI. These CQI's are included for your perusal.

As at October 2012 two other CQIs are being developed. A skin cancer surveillance CQI is expected to assist GPs in better understanding how those patients with Basal Cell Carcinoma (BCC), Squamous Cell Carcinoma (SCC) and/or melanoma are being managed in both primary and secondary care post diagnosis and how they are being followed into the future. There is little international work to draw on. The other CQI in current development is the off-license use of atypical antipsychotics in those folk who do not have a diagnosis of schizophrenia or are on Risperidone as part of their behavioural management for dementia.

If you have an idea about a CQI (they needn't align with this practice variation report) that you would like developed or a query about a currently approved CQI, then please don't hesitate to contact the WPHO Clinical Facilitator Dr. Shane Scahill on 021 0277 1583 or clinfotech.pharma@gmail

Appendix 1
Examples of Continuous Quality Improvement Initiatives (CQI)

The Royal New Zealand College of General Practitioners

Endorsement of CQI Activities for MOPS Credits

Name:
Shane Scahill and Dr. Lannes Johnson for Comprehensive Care and Waitemata PHO

Date:
9/08/2012

Title of Activity:
Improving suboptimal glycaemc control in type 2 diabetics

Expiry:
9/08/2017

General Practitioners involved in activity:
Doctor members of comprehensive CARE and Waitemata PHO

1. Topic:

Type 2 diabetes is a significant public health issue in New Zealand and CQI activities of this nature are expected to contribute to improving health need. It is estimated that up to 40% of diabetics remain unaware of their condition. The risks associated with suboptimal control of diabetes are significant, particularly with respect to microvascular and macrovascular complications. The PHO performance programme (PMP) includes an indicator for the identification of diabetic patients and there is a RNZCGP approved CQI activity titled diabetes detection. This helps to address the detection of diabetics but this CQI specifically extends the detection activity with the aim of identifying and subsequently managing those diabetic patients who demonstrate suboptimal or poor control.

2.Plan

This section should be based on the best evidence available, e.g. evidence-based guidelines.

Indicators

1. The identification of patients with less than optimal or poor control of their diabetes based on the BPAC guidelines of HBA1c 64 to > 100mmol/mol
2. Development of a management plan
3. Improvement in HBA1C levels in this cohort

Criteria (How will you measure if you are meeting the indicator?)

The data which identifies poorly controlled diabetics will be extracted from the Patient Management System. Following implementation of the CQI activity this data can again be extracted and levels of improvement (or otherwise) determined.

Standards (What standards of performance do you want to achieve?)

Diabetes management at the PHO level

All people enrolled with the practice who have been coded as diabetic

Numerator	The number of enrolled people in the practice with a record of a diabetes annual review during the period of the audit
Denominator	The number of enrolled people in the practice who are coded in the patient management system as diabetic

The current national goal is 80% and the following targets of improvement have been set as part of the PMP Programme and provide guidance for where practices could set their goals for improvement

Baseline	Expected % annual improvement
0% to <40%	10%
40% to <50%	7.5%
50% to <60%	5.0%
60% to <70%	2.5%
70% to <80%	1.0%
>80%	No change

Diabetes management of less than optimal/poorly controlled diabetics at the GP level

Numerator	The number of enrolled people in the practice with an HBA1c 64 to 79mmol/mol
Denominator	The number of enrolled people in the practice who are coded in the patient management system as diabetic

The BPAC guidelines (BPJ Issue 42) state the following definitions for level of diabetic control:

< 50 mmol/mol	Exceptional control
50-54	Very good control
55-64	Acceptable in many individuals but higher than recommended
65-79	Suboptimal glycaemic control
80-99	Poor glycaemic control
> 100	Extremely poor glycaemic control

Each GP will have different patient case mix when it comes to diabetes and baseline levels of performance also differ. There is flexibility in this CQI to select either the full range of patients with HBA1c from 64 to > 100 mmol/mol or a subset based on the BPAC definitions outlined above. The cohort selected needs to be outlined in the management plan.

GP variation in performance is significant and therefore targets set for improvement will need to align with baseline performance. Target outcomes could be reported in terms of the percentage of GPs patients who move from one HBA1C level to another. Expected performance could be set by the individual GP or through peer review or a practice based meeting.

Second cycle outcomes – targets could be set will be set by individual practices dependent on the proportion of poorly controlled diabetics they have relative to their known population of diabetics. An example includes:

1. The improvements in absolute numbers and proportions of patients that have HBA1C between 64-79 mmol/mol
2. The improvements in absolute numbers and proportions of patients that have HBA1C > 79 mmol/mol

Equally a more descriptive case based approach could be taken outlining the baseline HBA1c, interventions undertaken and outcomes achieved. The approach taken will depend on GP preference, case-mix and to some extent the practice size. Either way the management plan will need to describe the approach taken and the performance expectations.

Describe the process used to develop the indicators and criteria above:

List guidelines and other resources used.

The PHO Performance Programme (PMP) indicator definitions have been used

The BPAC guidelines on the use of HBA1C for screening and diagnosis (2011).

3. Data

Describe data (to be) collected.

The data will be extracted from the Patient Management System with the HBA1C ranges outlined below as one example.

1. Absolute number and proportion of known diabetics in the practice that have less than optimal glycaemic control (HBA1C) 64-79 mmol/mol
2. Absolute number and proportion of known diabetics in the practice that have less than optimal glycaemic control (HBA1C) > 79 mmol/mol
3. The management strategy/plan
4. The types of interventions made

When is a second cycle planned? (This includes repeating data, check, act and monitor stages.)

Quarterly, six monthly or annually as deemed most appropriate for the GPs in respect of their patient populations.

Comments

This CQI extends the diabetes detection indicator within the PMP programme.

The Royal New Zealand College of General Practitioners

Reporting of a CQI Activity - Diabetes

Doctor's Name: _____

Title of activity:
Improving suboptimal glycaemic control in type 2 diabetics

First Cycle (10 Credits)

Topic
Describe why and how you chose this topic (relevance, needs assessment) etc.

1. Data:
Information Collected.
Date of data collection: _____

2. Check:
Describe any areas targeted for improvement as a result of analysing the data collected.

3. Action:

Describe how these improvements will be implemented.

4. Monitor:

Describe how well the change process is working. When will you undertake a second cycle?

Second Cycle (10 Credits)

1. Data:

Information Collected.

Date of data collection: _____

2. Check:

Describe any areas targeted for improvement as a result of analysing the data collected.

3. Action:

Describe how these improvements will be implemented.

4. Monitor:

Describe how well the change process is working. When will you undertake a second cycle?

Comments:

The Royal New Zealand College of General Practitioners

Endorsement of CQI Activities for MOPS Credits

Name:
Shane Scahill and Dr Lannes Johnson for Comprehensive Care and Waitemata PHO

Date:
22/08/2012

Title of Activity:
Women having never received a cervical cancer screen

Expiry:
22/08/2017

General Practitioners involved in activity:
Doctor members of Comprehensive Care and/or Waitemata PHO

1. Topic:

Cervical cancer is a significant public health issue for New Zealand women and the health system as a whole. Early detection and treatment of cervical cancer leads to a reduction in premature death for women in specific age bands. The available international evidence suggests that women between the ages of 20 and 69 years should be screened for cervical cancer once every three years. This is a recommendation outlined in the Ministry of Health Guidelines for Cervical Screening in New Zealand (2008). However, the coverage rate is now measured 25-69 even though eligible population remains at 20-69. As such, women aged 25 to 69 years who have never been screened for cervical cancer are the target population for this CQI.

Cervical screening coverage is one of the indicators within the PHO performance programme (PMP). This is a nationally developed initiative supported by District Health Boards NZ (DHBNZ) and administered by Primary Health Organisations (PHOs). The PHO Performance Programme aims to improve the health of enrolled populations and reduce disparities in health outcomes through supporting clinical governance and continuous quality improvement processes within PHOs and their respective practices. Performance with respect to membership of the Programme is measured via an agreed indicator set that is selected through a robust process and is focused on achieving desired health outcomes. This indicator set may draw upon indicators from other quality improvement programmes where that is appropriately agreed by stakeholders working through the Programme's engagement and decision making processes.

The purpose of this CQI is to extend the previously approved CQI for patients identified as not having a screen in the previous 3 years to those patients who have NEVER had a cervical screen. The aim is to determine the cervical cancer screening coverage rates these patients and to improve upon this through strategies outlined in a cervical screening management plan.

2. Plan:

This section should be based on the best evidence available, e.g. evidence-based guidelines.

Indicators

The PMP indicator measures cervical cancer screening rates over the previous 3 years for all women enrolled in the practice aged between 25 to 69 years. The focus of this CQI is more specific in that it aims to detect and manage those women who have never had a cervical screen.

1. Identification of those women (25-69 years) who are recorded as never having had a cervical smear
2. Understanding the reasons why this cohort of woman have not had a smear undertaken
3. A management plan including strategies for screening these women based on this understanding
4. Improvement in screening rates of these "never before" screened women

Criteria (How will you measure if you are meeting the indicator?)

The data which identifies those women never screened will be extracted from the Patient Management System. Following implementation of the CQI activity this data can again be extracted and levels of improvement (or otherwise) determined.

Standards (What standards of performance do you want to achieve?)

The PMP indicators outline the expected standards of performance at a PHO level and previous practice variation analyses suggest that there is a significant range of performance across Waitemata PHO practices with regards these indicators. Therefore, the targets for improvement will vary by doctor/practice dependent on current performance with respect to those women whom have never had a cervical screen. The management plan will outline the rationale for and selection of levels of improvement for this indicator. The performance standards outlined in the management plan will be available for peer review as part of the development process of the plan.

Total population and high needs

Performance formula at PHO level

Numerator	Count of women enrolled in the practice between the ages of 25 and 69 years who have received a cervical screen in the last 3 years
Denominator	Count of women aged 25 to 69 years enrolled in the practice and adjusted for the expected number of women who have had a hysterectomy

The national goal is >75% and the aim of this audit is for practices to improve their screening rates in the second cycle. The PMP programme provides the following guidance for target setting for improvement at the practice level:

Baseline	Expected % incr
<35%	10%
>35% to <60%	3% to maximum of 60%
>60% to <70%	1.5% to maximum of 70%
>70% to <75%	1.0% to maximum of 75%
>75%	No change

The PMP indicators do not take into consideration decline rates but this CQI will do so, outlining decline rates and the reasons why as part of the audit process/outcomes.

The performance at a practice level for never screened patients

Numerator	Count of women enrolled in the practice between the ages of 25 and 69 years who have never received a cervical screen
Denominator	Count of women aged 25 to 69 years enrolled in the practice and adjusted for the expected number of women who have had a hysterectomy

Describe the process used to develop the indicators and criteria above:

List guidelines and other resources used.

The management plan will outline the rationale for levels of expected improvement. The following programmes and guidelines were used to develop this CQI:

PHO Performance Programme (PMP) indicator definitions

The MOH Guidelines for Cervical Screening in NZ

3. Data:

Describe data (to be) collected.

1. Absolute number and proportion of women who are eligible but have never had a cervical screen
2. The management plan to improve uptake rates in these never before screened patients
3. The types of interventions made
4. The rates of completed screening as the primary CQI outcome

When is a second cycle planned? (This includes repeating data, check, act and monitor stages.)

Quarterly, six monthly or annually as deemed most appropriate for the GPs in respect of their patient populations and processes within individual practices. This will be outlined in the management plan.

Second cycle outcomes – targets will be set by individual practices dependent on the proportion of women who have never had a cervical screen and reassessed as part of the second cycle.

Comments:

The PMP is a standardized, nationally monitored programme and this CQI has been adapted to suit the needs of Waitemata PHO doctors by focussing on those women who are recorded as never having had a cervical screen.

The Royal New Zealand College of General Practitioners

Reporting of a CQI Activity - Cervical Screening

Doctor's Name: _____

Title of activity:

Women having never received a cervical cancer screen

First Cycle (10 Credits)

Topic

Describe why and how you chose this topic (relevance, needs assessment) etc.

1. Data:

Information Collected.

Date of data collection: _____

2. Check:

Describe any areas targeted for improvement as a result of analysing the data collected.

3. Action:

Describe how these improvements will be implemented.

4. Monitor:

Describe how well the change process is working. When will you undertake a second cycle?

Second Cycle (10 Credits)

1. Data:

Information Collected.

Date of data collection: _____

2. Check:

Describe any areas targeted for improvement as a result of analysing the data collected.

3. Action:

Describe how these improvements will be implemented.

4. Monitor:

Describe how well the change process is working. When will you undertake a second cycle?

Comments:

The Royal New Zealand College of General Practitioners

An Example of a PHO Performance Framework Based CQI Activity

Name:

Shane Scahill and Rachel Lloyd for Comprehensive Health, Harbour Health, Waitemata PHO

Date:
17/02/2011

Title of Activity:
Breast cancer screening coverage (PHO Performance Programme)

Expiry:
01/03/2016

General Practitioners involved in activity:

Doctor members of Comprehensive Health Services, Harbour Health Limited and the newly established Waitemata PHO (currently in a transition phase).

1. Topic:

The PHO performance programme (PMP) is a nationally developed initiative supported by District Health Boards NZ (DHBNZ) and administered by Primary Health Organisations (PHOs). The PHO Performance Programme aims to improve the health of enrolled populations and reduce disparities in health outcomes through supporting clinical governance and continuous quality improvement processes within PHOs. Performance with respect to membership of the Programme is measured via an agreed indicator set that is selected through a robust process and is focused on achieving desired health outcomes. This indicator set may draw upon indicators from other quality improvement programmes where that is appropriately agreed by stakeholders working through the Programme's engagement and decision making processes.

The current indicators include the list below that are deemed to be significant health issues for the New Zealand population. The Primary Health Care Strategy and Better Sooner More Convenient are two pieces of health care policy which calls for improvement in the health of the nation through a population health focus and improved access to and provision of quality care by health professionals working as teams. Team based activity is influenced not only by the performance of individuals but also by the way they work as a team. The PMP programme aligns with these policies and requires individuals within a team to perform for the benefit of the patient and the population at large. The GP is a significant part of this team but rely on the skills of others to be able to successfully deliver care or to improve on what is currently being delivered.

Each of these indicator groupings has been formulated into a CQI activity:

- Breast cancer screening coverage
- Cervical cancer screening coverage
- CVD assessment and management
- Diabetes detection and follow-up
- 65+ year old influenza vaccination coverage
- Age appropriate 2 year old vaccination
- Smoking cessation

The purpose of this CQI is to determine the high needs breast cancer screening rates in the practice and to improve upon them in the following cycle. Early detection and treatment of breast cancer lowers the rate of premature mortality among women. The available international evidence suggests that women within a particular age band should be screened for breast cancer every two years.

2. Plan:

This section should be based on the best evidence available, e.g. evidence-based guidelines.

Indicators

This indicator measures breast cancer screening rates for those high need women (Maori, Pacific, or Decile 5) between the ages of 50 and 64 years

Criteria (How will you measure if you are meeting the indicator?)

The data will be extracted from Patient Management System (PMS). Individual GP level patient data can be extracted from the PMS to assess the baseline status and the performance outcomes for patients registered to that lead GP. This data can also be audited across all GPs in the practice to compare providers and to encourage continuous quality improvement across the practice team. In this case the GP will be doing a service to the practice by auditing all patients and providing feedback to individual GPs.

Standards (What standards of performance do you want to achieve?)

High needs population – Maori, Pacific and Decile 5

Performance formula

Numerator Count of high need women enrolled in the practice between the ages of 50 and 64 years who have received a Breast Screen Aotearoa screening mammogram in the past two years

Denominator Count of high needs women aged 50 to 64 years enrolled in the practice

The national goal is >70% and the aim of this audit is for practices to improve their screening rates in the second cycle. The PMP programme outlines the following targets for improvement which could be used as guidance for practices in setting their own goals:

Baseline	Expected % incr
<20%	10%
>20% to <60%	4% to maximum of 60%
>60% to <70%	2% to maximum of 70%
>70%	No change

Data:

Describe data (to be) collected.

Proportion of patients falling into the above mentioned demographic who have had a BSA screen in the past 2 years

When is a second cycle planned? (This includes repeating data, check, act and monitor stages.)

Likely to be annual

Comments:

This is a standardized nationally monitored programme.

Appendix 2 - Feedback on this Document

Please fill in and either FAX (09 415 1092) or send to WPHO PO Box 302-163, North Harbour 0751 Attention Micol.

Feedback on Practice Variation Report II

1. Which Practice to do you work for?

- ☐ Albany Basin Accident & Medical
- ☐ Albany Family Medical Centre
- ☐ Archers Medical Centre
- ☐ Beachhaven Medical
- ☐ Belmont Medical Centre
- ☐ Birkdale Family Doctors Ltd
- ☐ Birkenhead Medical Centre
- ☐ Browns Bay Family Doctors
- ☐ Browns Bay Medical Centre
- ☐ Byron Medical Centre
- ☐ Coastcare A&M Red Beach
- ☐ Coastcare Birkenhead
- ☐ Coast to Coast Healthcare
- ☐ Devonport Medical Centre
- ☐ Dodson Medical Centre
- ☐ Family Medicine Birkenhead
- ☐ Fenwick Medical Centre
- ☐ Glenfield Doctors on Chartwell
- ☐ Glenfield Medical Centre
- ☐ Hauraki Medical Centre
- ☐ Health & Counselling Massey Uni
- ☐ HealthZone
- ☐ Hibiscus Coast Medical Centre
- ☐ Integrated Medical Centre
- ☐ Kitchener Road Medical Centre
- ☐ Kawau Bay Health
- ☐ Kowhai Clinic (Glenfield)
- ☐ Kowhai Surgery
- ☐ Medplus Lake Road
- ☐ North Harbour Medical Centre
- ☐ Northcote Point Doctors
- ☐ Onewa Road Doctors Surgery
- ☐ Red Beach Family Medical Practice
- ☐ Shakespeare Medical Centre
- ☐ Silver Fern Medical Centre
- ☐ Silverdale Medical Centre
- ☐ Snells Beach Medical Centre
- ☐ Sunnynook Medical Centre
- ☐ Sunset Road Family Doctors
- ☐ Takapuna Healthcare
- ☐ Third Age Health Services Ltd
- ☐ Torbay Community Doctor
- ☐ Torbay Medical Centre
- ☐ Waiake Medical Centre
- ☐ West Harbour Medical Centre
- ☐ White Cross Glenfield GP

2. What is your role at the practice?

☐ GP Owner ☐ GP Locum/Employee ☐ Practice Nurse ☐ Management

3. Was the practice variation document and the information it contains valuable to you in order to better understand the strengths and weaknesses of your practice's accomplishments in the population health programs analysed?

☐ Extremely Valuable ☐ Moderately Valuable ☐ Slightly Valuable ☐ Not at all Valuable

4. Do you find the data regarding your practice to reflect the actual measure of your practice technical output in the programs analysed?

- ☐ Yes, it is accurate in all programs
- ☐ It is only accurate in some programs/areas
- ☐ No, it is not accurate in any of the programs

Feedback on Practice Variation Report II

5. If you thought there was a problem with data representing the measure/assessment of your practice work, in which specific area is this happening?

- ☐ This is not happening, data is accurate
- ☐ Cervical Screening Coverage
- ☐ Breast Screening Coverage
- ☐ CVD R
- ☐ CVD Management
- ☐ B4 School Checks
- ☐ Child Immunization
- ☐ 65+ Flue Immunization
- ☐ Recording Smoking Status
- ☐ Diabetes Annual Review
- ☐ Diabetes Management

Please write any relevant comment. Also feel free to contact Dr. Johnson re. further discussion re. data inaccuracy.

6. If you think your practice is struggling to meet targets in any particular area, what would be the main reason behind this?

- ☐ Data is inaccurate, my practice has in fact reached appropriate targets
- ☐ The demographic of my practice makes achieving targets very difficult
- ☐ There are some PMS or IT related problems that make achieving targets very difficult
- ☐ Other (please specify)

7. Would you like someone from the PHO to visit your practice in order to discuss further support to meet targets?

- ☐ NO, thank you
- ☐ YES, please

8. Is there any other clinical parameter where you would be interested to see your practice outputs? Subject to data availability to PHO.