Quality Programmes **Case Studies**

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

Foundation™

Cornerstone™

Contents

PMAANZ

The Quality Programmes team at the 2023 conference

The Quality Programmes team travelled to Ōtautahi Christchurch last year to present and exhibit at the PMAANZ (Practice Managers and Administrators Association of New Zealand) Conference 2023.

The theme of the conference was Operation Transition – from Reactive to Proactive. Topical presentations included discussions on innovative approaches to Māori and Pacific health engagement, debt collection for medical centres in a cost-of-living crisis, and cyber security in the health industry.

The workshop

A highlight for the team was the workshop they held on the final day. They led a group of almost 50 participants through an activity on 'creating your persona', as well as discussions on how the Quality team could further serve their customers, and on current pain points within practices' quality journeys.

The team presented on the College's current quality framework given that a lot of the changes were introduced in 2020, in particular to communicate the changed requirements for Cornerstone accreditation which is now much simpler and not as onerous as previous requirements.

The feedback

The team also interacted with the 370 attendees, many of whom visited the College stand over the three days. They noticed that there were more practices enquiring about moving towards Cornerstone accreditation and expressing positivity in the programmes than in previous years. They also took note of improvements in the website suggested and sought feedback on the experiences of practices who had recently completed the Cornerstone Equity and CQI modules. Feedback on the modules was largely positive and the team is excited to help guide through more practices in the process in the months ahead.

The conference came to a close with Heidi Bubendorfer, the team's Principal Advisor, receiving recognition from her PMAANZ colleagues for the conclusion of her role as secretary. Heidi received well deserved praise for her five years of service.

The stand of the Quality Programmes team at PMAANZ in Christchurch

The Quality Programmes team: Carrie Hetherington (left), Lucy Wass (middle) and Sandhaya (Sandy) Bhawan (right), Missing from the photo is Heidi Bubendorfer

Lucy Wass leading the activity on 'creating your persona'

Foundation Standard **Facilitator training courses**

The College supports more than 1000 general practices across Aotearoa to provide safe, equitable and high-quality health care for people through its two Quality programmes – Foundation Standard and Cornerstone.

The College's Quality Programmes team observed high levels of staff turnover in general practices post-COVID. As a result of this movement, large numbers of new practice managers and other staff members required training around how to gain Foundation Standard certification and a general understanding of our Quality programmes.

Supporting practices post-COVID

We needed to offer detailed support on a larger scale, which resulted in the idea of running a Foundation Standard Facilitator training course.

College staff Heidi Bubendorfer, Principal Quality Programmes Advisor and Carrie Hetherington, Quality Programmes Advisor – Training and Education Design developed two Foundation Standard Facilitator training courses:

1. For general practice staff, mainly practice managers
2. For Quality leads and coordinators working in Primary Health Organisations (PHOs)

Recognising that both general practice and PHO staff are time-poor, the two courses are eLearning packages, designed with flexibility in mind. The courses are complete with resources, recorded webinars, interactive quizzes and activities.

To ensure maximum flexibility, the self-directed learning portion of the course is emailed directly to participants to work through over four weeks. Individuals then attend an online question and answer session led by Heidi and Carrie. One of the general practice participants expressed that, '*it felt like I was getting one-on-one support*'.

A game changer

The two courses have been a game changer for general practice and PHO staff alike. A participant from the general practice course expressed that, '*the fear of the unknown is very real*' and the training course helped to '*take the fear out of the Foundation [Standard] process*'.

With overwhelming demand for the general practice staff course, 10 training sessions were conducted between October 2023 and February 2024. Over this period, 120 individuals were trained as Foundation Standard Facilitators. There is still a large waiting list for the course, so it has been implemented as an ongoing support tool that will be run regularly, ensuring that general practice staff can continue to receive assistance in a more interactive setting.

The future

Building on the success of the general practice course, the focus has now shifted towards training PHO staff, with the first three sessions being held in April. A participant from the first PHO training course we held shared that staff from their own practices had taken our course and are now recommending that staff at their PHO take the version designed for them.

There is a waitlist for the PHO course with further sessions to be scheduled throughout the year. The Quality Programmes team hope to train up to 90 PHO staff members by the end of 2024.

Carrie Hetherington

Quality Programmes Advisor – Training and Education Design

Heidi Bubendorfer

Principal Quality Programmes Advisor


HDC HEALTH & DISABILITY COMMISSIONER
TE TOIHAU HAUORA, HAUĀTANGA
Your Rights when receiving a Health or Disability Service
Respect
Fair Treatment
Dignity and Independence
Proper Standards
Communication
Information
It's Your Decision
Support
Teaching and Rese
Complaints
Important Information
Please report immediately to reception if you have:-
difficulty breathing
chest pain
excessive bleeding
Manage Your Own Health on Line
By
Problem with Privacy?
CHAPERONES
Wanting to make suggestion?
Kindly make sure you check our schedule of charges on the waiting room wall so there are no surprises
Cervical Smear Tests
AVOID FLU
Safer health care for YOU
Immunise against HPV
Meningococcal Disease
Hopper Home

CQI module at **Gate Pa Medical Centre**

Gate Pa Medical is a family-orientated medical centre that has been offering general practice services to around 3,000 patients for approximately 30 years. Situated in a lower socioeconomic area of Gate Pa in Tauranga, it has a high-needs population of close to 50 percent.

Its long-standing mission statement has been to 'provide quality accessible whānau care', and it has tried to foster and maintain strong links with our community through Focus Groups and our kaiāwhina.

We consider ourselves to be an innovative practice and because of our size we're very adaptable. There are strong lines of communication within the practice team made up of four GPs (two FTE), two practice nurses, a receptionist, a practice manager who has a strong relationship with a large number of patients, a part-time health improvement practitioner, clinical pharmacist and kaiāwhina.

Continuous Quality Improvement (CQI) is something we do all the time, but projects are not always documented. The CQI module is something we undertook to maintain our teaching practice status.

We were aware of the very poor statistics in uptake of Faecal Immunochemical Testing (FIT) in Māori and Pasifika populations in other areas of the country, as the Bay of Plenty was one of the last regions to roll out the National Bowel Screening Programme.

We built a project around personalising the programme and by using our relationships or whānaungatanga with patients to see if we could achieve higher uptake rates over a six-month period.

This involved change methodology across the entire project, with adaptation using CQI principles to address several factors, including postage issues, health literacy issues and cultural concerns. CQI was used also to ensure that input was completed in a cost-efficient way.

The results at the end of the six-month project showed markedly improved statistics with:

- 75 percent of Pasifika patients (39% national) participating in the programme
- 74.5 percent of our Māori patients (49% national) participating in the programme.

These results have continued to improve following completion of the module.

We found that although there was a cost to the practice, it was moderate, and we concluded the learnings could be implemented more widely if funding for general practice was obtained, with the likely result of a much more equitable and cost-efficient system for National Bowel screening.

This project reinforced the importance of whānaungatanga to our team, with many of our patients who had already tossed the kit into the rubbish after it had arrived unsolicited and unexplained in the post going on to complete the testing.

We achieved far better results after we had our first positive result who went on to have a colonoscopy. They had two adenomas removed within 10 days of the result being received. Being able to share a patient's positive story with others acted as a huge spur.

Through our project we outlined the immense power of the relationship a general practice team has with their patients and began reconsidering other areas where with adequate reimbursement a GP practice could improve efficiencies in the wider health system through their relationships; for example, decreasing the high rate of failed hospital appointments for our high-needs patients, and improving screening and immunisation rates.

> "We achieved far better results after we had our first positive result who went on to have a colonoscopy. They had two adenomas removed within 10 days of the result being received.

CQI module at **Amuri Community Health Centre**

Amuri Community Health Centre is the only general practice in Rotherham – a town nested by the bank of Waiau Uwha River in Canterbury, in the northernmost part of the Amuri Plain. Originally it was a business operated by an individual GP, but it evolved into a general practice owned and managed by an NGO called the Amuri Community Trust. Its charitable status opens access to funding which would not be available otherwise. Community ownership is also an attractive alternative to provide best care in the everchanging environment, and to attract the finest health professionals.

In 2011, the centre moved into its premises built in accordance with the Government's Primary Health Care Strategy of an integrated Health Centre, which focuses on prevention rather than cure. In addition, a locum cottage was set up as a Red Zone to allow care of patients with COVID-19 symptoms. It is an example of the practice's commitment to manage safety of patients and the staff.

Currently, Amuri Community Health Centre proudly employs two GPs, Dr Margriet Dijkstra and Dr Sarah Ballam, one paramedic practitioner, one clinical lead nurse, four PRIME trained nurses and two healthcare assistants, as well as admins, receptionists and cleaning crew. The centre is run by a community appointed board of directors, and maintains a close relationship with eight District Nurses who work throughout the wider Hurunui District.

Forward thinking

Purchasing the CQI module was a result of a strategic meeting attended by the board, the entire staff and District Nurses. The goal of the meeting was to review procedures and processes, and to exchange ideas for what the future of the practice should look like. Monitoring care outcomes and reflecting on health needs of the community allows the centre to establish and maintain high-quality responsive healthcare which is both innovative and lifelong.

For a Fellowship assessment visit to take place, a practice must hold current Foundation certification and Cornerstone accreditation. Purchasing the modules also opens up a pathway to future teaching. As discussed during the meeting, going forward the centre is interested in hosting registrars, increasing the number of staff and promoting rural health care.

Lessons learnt

The centre's CQI project involved a review of the HbA1c in their current population and implementation of changes to improve management of Type 2 Diabetes with respect to glycaemic control. Their small-sample study revealed that the staff performs well in addressing diet and lifestyle factors, which was demonstrated by the fact that 85% of patients received documented advice.

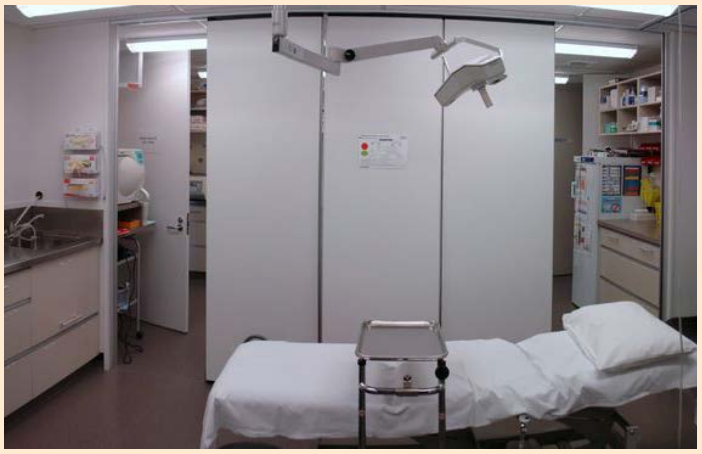
Two of the patients, however, whose HbA1c went up, required further referrals to a dietician. As a rural practice, the centre doesn't employ dieticians and therefore needed to consider other options, such as health coaching.

Under the new medication guidelines, the study showed an average reduction of 15.5% in HbA1c, which didn't reach the target level of 20%. Nevertheless, 40% of patients met the target, and 20% of patients received new agents for Type 2 Diabetes to try. Since the module incorporates elements of the New Zealand Triple Aim framework, the staff was pleased to learn that the centre is up-to-date with the latest medications, as recommended by the Diabetes Foundation Aotearoa.

Looking back

Doing the module was a useful experience. It revealed vulnerable areas requiring closer attention in terms of improving health outcomes. For example, the staff realised that diabetic patients are not well-managed and could benefit from a more functional type of medicine, such as health coaching. The 15-min model of attending to patients' needs makes it difficult to thoroughly address diabetes, particularly regarding the implementation of lifestyle changes. For this reason, the centre is considering either hiring a health coach or training one of the existing staff members to meet the demands. Overall, the process of comparing past and present treatments was a valuable experience which generated reflections on all aspects of providing high-quality health care.

General practice is challenging and sometimes what the staff would like to do is different from what they are able to do. Nevertheless, certain initiatives are already taking place. Rotherham has a large Filipino community, and the clinical-lead nurse started a discussion on their health needs and how the centre can address them better. It just so happens that one of the healthcare assistants is Filipino and can assist with English-Filipino translations during their visits. Rotherham has also a Māori community which the centre wishes to connect with in the next step. These initiatives show a systematic change and a patient-centred approach to holistic care of communities, taking into consideration their individual and cultural needs.



CQI module at **Aspiring Medical Centre**

Aspiring Medical Centre is a privately owned rural general practice in Wānaka. We are a team of experienced health professionals who offer a wide range of health services, from general medical care to specialised services.

With the nearest hospital over an hour away, we're well-equipped to manage the challenges of a rural health setting, including providing quality acute and emergency care. We pride ourselves on providing excellent healthcare to the Wānaka community and our regions visitors.

Wānaka is a tourist destination, and our population dramatically increases over the peak summer and winter periods. Winter brings the ski season and summer the holiday makers, international and New Zealand tourists.

The practice continues to grow with the increase in population to the Wānaka region across all age brackets.

What motivated your practice to complete the Cornerstone CQI module?

Aspiring Medical is a College teaching practice. We teach new upcoming GPs and it's a requirement that we hold Cornerstone CQI. We also felt that completing this module gave the practice an opportunity to continuously improve the quality of services we provide.

Tell us about your CQI initiative

Our aim and CQI project overview was to identify those at risk of developing Type 2 diabetes including Māori and Pasifika people who already have pre-diabetes and are below the age of 70 years, to try and reduce or delay their risk by:

- Involving the whole team within the practice (including the wellbeing team), the patient (and their families/whānau/carers) that may have associated cardiovascular risk factors, for example: smoking, elevated blood pressure and or elevated cholesterol. We empower this target group and their family or whānau with lifestyle interventions, continuity of care and ongoing support if required.
- Encourage the person to nominate their provider of choice, so that continuity of care can be achieved in partnership with both the doctor and the person.
- Offer either evidence-based lifestyle medicine support sessions either in a group or private setting at an agreed interval (for example, weekly or fortnightly) and review process or individual sessions with a nurse and or their Doctor and or involving the wellbeing team (wellbeing team at no cost to the patient). Lifestyle medicine can assist the prevention, management and reversal of chronic and lifestyle related diseases. It is centred around optimal nutrition, increased physical activity, improved sleep, reducing smoking/alcohol and improving wellbeing and connectedness. The evidence shows making changes in these areas dramatically improves health and can treat, prevent or reduce disease and ill health. Lifestyle medicine plays a key role in conditions such as pre-diabetes.
- Offer the right service to meet the needs of the person, if they decline lifestyle medicine intervention, enable them to access alternative support. For example, fully funded sessions with the wellbeing team for education and ongoing follow up.
- Ensuring that our CQI project is reflective of Health New Zealand Te Whatu Ora's Pre-diabetes and self-management advice.
- Ensuring all clinicians follow the HealthPathways: Prediabetes pathway for best practice and continuity of care (see report definitions and references for the pathway).
- Improve routine screening for diabetes for all our registered patients, using the dashboard to highlight if they aren't up to date with screening and to be able then to identify those at risk, providing equitable care to all patients. To assist these patients to learn more about pre –diabetes and prevent the progression to diabetes and the associated long term side effects.
- To empower these patients to be self-responsible for their own healthcare and checking their symptoms and recalls.

What did you have to do or think about differently as you worked through the CQI modules?

Our initial observation highlighted a large number of patients that had a classification of pre-diabetes did not have a nominated health care provider. To improve continuity of patient care, the patient should have a

nominated provider of their choice to be involved with their care. We explored why continuity of care benefits the patient.

Our CQI nurse team systematically went through the list of 180 patients (not just our target group) and contacted each person, discussed the benefits of having a nominated provider and in partnership with the patient a nominated GP was confirmed on their patient file.

Seven were unable to be contacted by a GP and they have an alert on their patient file to address at their next consultation.

Classification of pre-diabetes was checked that it was entered on the patients file correctly and that the associated recalls for monitoring were accurate and up to date. Recall for one year to check HbA1c unless otherwise specified by GP or plan of care (Initial HbA1c should be repeated after three months of lifestyle change and thereafter at six-to-twelve-month intervals).

What is different for your team after completing this work?

By creating and sustaining a process that becomes 'business as usual,' our clinicians are more involved with their patients working towards improved outcomes.

We've implemented the following changes:

- Complete three-monthly audits of our registered patients with prediabetes as a classification (from Thalamus) is being completed by our nurses. The audit:
  - Ensures the patient has nominated GP. If they don't, we check our patient portal and offer it.
  - Review blood test recall for HbA1c. If the yearly GP appointment is due, we co-ordinate that.
  - Review any deterioration of HbA1c levels and offer lifestyle support sessions.
  - Ensuring all clinicians are following Healthpathways for guidance for the patients shared management plan.
- Have a three-monthly meeting with [the College's] CQI team, continue using the PDSA cycle for quality improvement and update clinical team on data results.
- The new patient enrolment process has been updated- for any patient enrolling into the practice with a prediabetes classification, administration staff to create a task for the LTC nurse who will (as per Healthpathways):
  - arrange GP and nurse appointments working towards nominating a GP for continuity of care within partnership with the person, lifestyle education etc.
  - ensure correct classification is entered on patient management system.
  - manage any identified complications and risk factors.
  - check last HbA1c result and organise repeat if required.
  - set up blood test monitoring and annual GP recalls.
  - manage my health (our patient portal) is offered and encouraged for everyone that enrols, so that they can access their open record files and test results.

What is different for the patient?

- Improvement that majority of patients now have a nominated provider
- Reduced patient pre-diabetes blood test results to normal values by 7%
- Reduced patient blood glucose levels in the prediabetic range by 8%
- Overall improvement in patient engagement
- Updated diabetes screening recalls achieving 100%

Overall, the feedback from patients involved in the CQI module was extremely positive and they appreciated the level of care and their involvement with their health journey.

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CQI module at **Botany Junction Medical Centre**

Botany Junction Medical Centre is part of a group made up of two other practices (Highbrook Medical and Ormiston Medical) in Auckland. Across the three clinics, there are approximately 60 employees made up of GPs, nurses, MCAs, paramedics, pharmacists and customer service colleagues.

Building on their Foundation Standard

Last year, Botany Junction Medical Centre completed the Cornerstone CQI module. General manager of the practice Lucy Hall said there were a few things that motivated their practice to complete the module.

"We'd already completed Foundation Standard in 2022 across our three sites, so we wanted to continue our quality improvement activities and become accredited as a GPEP teaching practice.

"We had also identified a pain point for our rainbow community patients…most notably the systems and processes for accurate gender identification."

CQI initiative

The aim of their CQI initiative was to develop a comprehensive and inclusive patient gender identification system to ensure the accurate and respectful recognition of individuals within the rainbow community in general practice settings.

The practice implemented a new gender identification system and equipped staff with tools and resources to create a safe, supportive and culturally sensitive environment for all patients, regardless of their sexual orientation, gender identity or gender expression.

"Through cleansing our data and reviewing our processes, staff training and technology integration, our project delivered equitable and patient-centred care within the rainbow community.

"Completing this process has given us an enhanced understanding and awareness of how we can best support our rainbow community," Lucy said.

Patient feedback

The practice implemented a new system and signs around the practice. Here are some comments from their patients:

"*It took a while for the clinic to get my son's gender right, but we did notice an improvement and the doctor was extremely helpful and always on board with the gender journey.*"

"*It was great to see some signage around to show that it's a safe place to be authentic and open with staff.*"

"*I am now able to update my name and my gender in the clinic systems.*"

> "We had identified a pain point for our rainbow community patients... most notably the systems and processes for accurate gender identification.

Equity module at Fifth Avenue

He Waka Eke Noa Rōpū from left: Dr Tania Stokes, Julia Perry NP, Dr Todd Hulbert, Debbie Irving (Assistant Manager) and Janae Toner (Reception Lead)

Absent: Tawharangi Nuku (Kaumātua), Kiri Pieta (Director, Māori Health and Well Being, PHO), Michaela Kamo (Equity Programme Lead, PHO), Rebecca Lovett (HIP) and Mollie Cimmins (Health Coach)

Fifth Avenue Family Practice in Tauranga started our Equity journey four years ago. It began with the formation of our Māori health rōpū – He Waka Eke Noa ('We are all in this together'). This core group includes representatives from across the practice team, namely: Dr Todd Hulbert (Partner GP) Dr Tania Stokes (GP) Julia Perry (Nurse Practitioner) Debbie Irving (Assistant Practice Manager) and Tawharangi Nuku (our kaumātua).

We also had a lot of support from Kiri Peita and Michaela Kamo from the Western Bay of Plenty Primary Health Organisation. The first six months were spent really delving into equity and understanding the inequities that do exist for our patients. We held a Christmas lunch hui where we invited our Māori patients aged 65+ (our kaumātua). We listened to their past experiences and future concerns for themselves and their whānau. This gave He Waka Eke Noa the confidence to move forward with support and guidance from our Māori patients. And so our journey started, and we have gone from strength to strength due to our genuine understanding of why we have chosen an Equity pathway as a practice. We have not just ticked boxes to achieve our CQI and Equity Modules. Our teams have embraced Equity within the practice with respect and aroha; we're extremely proud of this.

Our journey so far...

- We started with bilingual signage following the best practice guide to ensure we were respectful in our translations
- We fully trained our staff in the pronunciation of our signage and an understanding of WHY we transitioned to bilingual signage
- Team members gradually started to greet all patients with kia ora
- We commissioned a Māori artist to create a weave that represents Te Whare Tapa Whā which sits front and centre in our waiting room
- We reviewed our enrolment policy to ensure no patients were sent away if they did not have standard ID to enrol.

For example, a patient that had not been enrolled at a practice for 40 years came to reception after trying seven other practices. We immediately enrolled her with a CSC and DL and she saw a GP that day. Consequently, three generations of her whānau are now enrolled and engaged with the practice, breaking down the barriers they faced previously

- We created a Priority Patient scheme that identifies priority patients and ensures they are seen by their GP when required
- We hold a Saturday Māori flu clinic every year where we contact each eligible patient to extend an invitation personally
- We commissioned a new website with an equity focus
- We wrote our Māori Health Policy, and we continue to grow and develop within the equity arena
- More recently we proudly completed our CQI and Equity module

While the process seemed very daunting at first, our approach was always to fully understand equity and what it means to our Māori patients. This has been our strength as a practice, and the benefits to our entire community have been wonderful to witness.

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Te Mauri (The Lifeforce), 2022

The colours incorporated in this porohita represent the holistic wellbeing of Te Mauri.

Te Wairua, the spirit – natural colour
Te Hingengaro, the mind – red
Te Tinana, the body – black

All of these elements make up who we are, and are interconnected. Whānau connections are an integral part of our wellbeing, which is signified by the outer fringe.

Artist: Rangi Ranui
Porohita Weave

5th Ave
FAMILY PRACTICE

Equity module at **Cook Street Health Centre**

About the centre

Cook Street Health Centre is a purpose-built, well-established general practice situated in Palmerston North that has been serving the community for 36 years, with an enrolled population of approximately 6000 people.

Our dedicated team consists of receptionists, nurses, health care assistant, nurse practitioners, general practitioners and a director of quality and culture, working alongside each other. The THINK Hauora (PHO)-employed Health Improvement Practitioner and LTC Nurse have scheduled clinics on-site and are an integral part of the Cook Street team.

The team strives to be early adopters and leaders in the region. Our centre is an active member of Ora Connect – a collective impact initiative that brings community organisations and resources together to activate 'A connected health community within the 4412' (meaning south-western suburbs of Palmerston North).

The equity team

Our equity journey began in November 2021 when we wanted to formalise what we had always done. This aligns with and provides evidence for the requirements of the Foundation Standard and the equity module. We are also a teaching practice and would like to continue teaching, advocating and promoting primary care to medical and nursing students, GP registrars and Nurse Practitioner interns.

We established an equity team to lead the staff on this journey. The team includes: Jane Ayling, Dr Alice Tait-Jamieson (Ngāti Tukorehe), Rachel Puts (Ngāti Hauiti) and Krystal Carrington (Ngāti Maniapoto). We gained feedback from our Māori population via email, phone calls and face to face interactions regarding what we were doing well and how could we improve experience of access and care. From this hui Wiremu & Trieste Te Awe Awe became Kaumātua & Kuia for the health centre providing guidance, support and advice.

The health centre closed for a day to enable the team to visit the marae of our kaumātua and kuia. Te Rangimarie marae at Rangiotu was built in 1858 to commemorate peace between the Ngāti Raukawa and Rangitane peoples. We listened to their story and others bearing in the Māori history of the Manawatū. This was the first visit for some team members and one team member gave her first pepeha in Te Reo Māori. Team building and learning and discussing the Meihana model has further enabled the team to be empowered to continue to grow their cultural awareness and for it to become their norm.

The feedback

Recently, there has been an increase of positive feedback from patients, both Māori and non- Māori, about how Cook Street Health Centre has become warmer and more welcoming to them. People have noticed the greetings, signage, accessibility, small attitude shifts and the language we use. Following our first Māori and Pasifika Hauora day, during which we offered free services, we received positive and encouraging feedback that has guided and enabled us:

- to have Te Whare Tapa Whā model posters in each consulting room,
- to greet people in their Pacific language,
- to provide resources in an appropriate language,
- and to hold the event annually.

Two general practitioners and a primary health care nurse provided free health checks to tāne as part of the community driven Ha Tāne Hauora Men's Health.

Below is an example of feedback received.

Kia ora Cook St Health Centre.

I would like to express my appreciation to the Health checkup I received at the Haa Rollathon.

The Nurses were fantastic and bubbly and made me feel safe and comfortable. The Doctor was great, he understood as an elder man what and where some of my concerns were and helped me understand what my body is doing and going through.

Bonus: I received a phone call when my blood results came through to advise me that they will be sent to my GP, and gave my results which was a pass on all accounts.

Great work team.

Ngā mihi koutou mo to tautoko me manakitanga.

In summary: From having visible Māori staff, normalising greetings in Te Reo Māori, signage that aligns with Te Ao Māori around the practice, clear leadership, documented plans, policies and processes, to facilitating protected time for all team members to attend noho marae and participate in education, the team is now more confident and competent in their ability to deliver high quality care within a culturally safe framework and be proud of the changes and new goals for the future. He maurea kai whiria - let's keep directing our efforts towards what is important!

The staff of Cook Street Health Centre during their visit to Te Rangimarie marae

> "People have noticed the greetings, the signage, the accessibility, the small attitude shifts and the language we use.

CQI and Equity modules at Ōtorohanga Medical Centre

Ōtorohanga Medical Centre (Ōtomed Ltd) has been serving the local community of the rural King Country area (Ōtorohanga, Waikato) for over 50 years. The current premises were purpose built and have been operating since 2019. The building is a result of a community fundraising, which eventually reached over $3 million, including two incredibly generous donations of $1 million each from two local farming families. The modern and functional workplace has allowed expansion of services to the Ōtorohanga community. The practice's rent goes back to the community via the Ōtorohanga Community Trust and is distributed by sponsorship of things such as school sporting uniforms, re-sealing the local netball courts, and even the purchase of a horse for the local Riding for the Disabled organisation.

The new building is more than just a medical centre. It includes an onsite Pathlab, pharmacy, theatre, x-ray room, ultrasound rooms, and a four-bay casualty. The practice is proud of its artwork carved and painted by local artists, specifically for the space. The artwork captures the significance of community and Ōtorohanga's strong connection to Māori history.

Ōtorohanga Medical Centre has 30 staff members (both permanent and casual), including GPs, nurses, administration, and MCA teams. Apart from five regular GPs, they also regularly host registrars, junior doctors and medical students. It is both a rural and teaching practice, which takes pride in giving registrars, students and junior doctors a comprehensive experience during their placements.

CQI module

The practice purchased the College's Cornerstone® CQI and Equity modules as these are required for them to be a teaching practice. The community had become isolated by the need to work virtually due to the COVID-19 pandemic and the following lockdowns, and many of their routine services, such as childhood immunisations, cervical screening, etc. had to be deferred during that time. For this reason, their CQI project focused on whakawhānaungatanga: reconnecting with the community, and creating a chance for the community to also reconnect with each other. The goal was to make it family-focussed, fun and interactive.

Te Whatu Ora provided Bowel Screening education and promotion with FIT kits available to take home for eligible visitors, and the Mobile Dental Nurse Service was well attended by kids from 1 to 18 years old. Whānau Ora Healthy Homes set up a stall providing on the spot assessments and applications, and St John Ambulance

staff provided a sausage sizzle and showcased their free Health Shuttle. Whare Āwhina promoted their local health and social services ranging from helping with transport to health appointments and counselling to family violence support and budgeting services.

We have built on relationships and whānaungatanga with local organisations and groups within the community such as Kaupapa Māori services Ngāti Maniapoto Marae Pact Trust and Kokiri Trust to help us identify the needs of our population from their perspective. The idea of this is two-fold: to open conversations about potential barriers to access to health care, thereby giving a consistent voice to some of our most high-needs patients; then to collaborate services in order to provide holistic wrap-around care of the whole whānau and wider community.

Equity module

Ōtorohanga Medical is committed to achieving equitable outcomes. The Equity module encouraged the staff to address any unconscious bias and to ensure the practice culture was inclusive and equitable. They have established permanent and dynamic processes, policies and procedures to ensure equity is an ongoing priority, and all team members continually monitor the status of such.

This year they have implemented nurse-led clinics to increase equitable accessibility and affordability of treatment to patients. Training is under way for nurses to become designated registered nurse prescribers in community health (RNPCH) to prescribe treatment for common conditions. Nurse-led ear micro-suction clinics are under way with great success. They purchased a spirometry machine and have been running regular spirometry clinics this year, with the purpose of engaging their high-needs respiratory patients to ensure they are receiving a high standard of regular monitoring. This flowed into their pre-winter wellness nurse-led clinics which have proactively targeted their patients with chronic respiratory illness, with the goal of keeping them as well as they could be going into the winter season. They also established drop-in free cervical screening and men's health clinics. They worked collaboratively with Te Whatu Ora to provide walk-in immunisation catch-up clinics for scheduled immunisations across the lifespan.

They continue to utilise quarterly equity meetings between management, directors and equity champions to reassess their strategies collaboratively, based on updated targets, statistics, and patients and staff feedback. Quarterly provider meetings involve leaders from outside agencies coming together to discuss ideas, health care changes, updates and strategies within each sector, in a collaborative effort to stay connected and align services where they can. Monthly staff meetings involve equity components to reinforce their understanding of equity challenges and cultural education whilst empowering all staff to engage with their input, ideas and feedback.

Looking back

The modules created an opportunity to reassess their processes and ensure everything was valid and up to date. They have always had strong connections with other health providers within the community, but the modules were useful in ensuring these connections were reinstated following the pandemic.

CQI and Equity modules at **Tōtara Health**

Tōtara Health have undertaken both the Cornerstone Continuous Quality Improvement (CQI) and Equity modules, kindly agreeing to share their experience.

Tōtara Health has two clinics in the Hawke's Bay, serving a population of mostly low-income New Zealanders with a particular focus on Māori, Pacific and other high-needs communities. Tōtara Health has built and grown their practice specifically to serve these communities. As of April 2024, they have 15,455 enrolled patients across their two clinics. Of these patients:

- 6823 (44%) are Māori
- 1963 (12.7%) are Pasifika.
- 2094 (13.5%) are Community Services Card holders or living in quintile 5 areas but not Māori or Pasifika.

This means that 10,880 (70%) of their patients are Māori, Pasifika, Community Services Card holders or quintile 5.

What motivated your practice to complete the modules?

We know that some groups in New Zealand experience inequitable health outcomes and need different approaches to achieve the same health outcomes as other New Zealanders. This is significant given over 70% of our patients experience these inequitable health outcomes day to day.

We completed the Cornerstone modules so we could actively reflect on the work we do in clinic and adapt our approach to improve equity, quality of care and accessibility, with the goal of improving health outcomes for our patients.

We believe our patients deserve the best care possible and more – these modules have helped us to deliver this.

We are also acutely aware of the GP shortages issue, so by completing the Cornerstone modules we can support and grow future GPs in Aotearoa through training.

What did you have to do or think about differently as you worked through the modules?

So many things! It made us think about small and big changes to improve quality of care, accessibility and equity. For example, it made us reflect on the ethnic composition of our staff in comparison to our patients. One of our goals is to increase Māori and Pasifika recruitment to reflect the ethnic distribution of our enrolled patient population. We'd like to increase our Māori and Pasifika GPs but believe this will be unachievable with the national shortage of GPs, so our focus will be on bolstering Māori and Pasifika staff in other areas at the practice.

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Equality

Equity

It also made us consider communication between clinical and non-clinical staff and communication with patients. We discussed the pronunciation of names and what we can do to improve this for patients. Names hold mana, and we're working with our team to ensure they recognise this and ask patients what they would prefer to be called, not asking for another name because their name is "too difficult" to pronounce.

Following completion of the modules, what is the difference for your staff?

The biggest difference is in our regular training for our staff. We have implemented a fortnightly training session for all staff where we can facilitate training in te reo Māori, equity, cultural safety, bias, privacy etc. It also gives us an opportunity to bring in external providers for education and awareness.

We have also incorporated annual training in wait times due to our quality improvement project to ensure staff understand why this is important and ways to improve communication with patients.

And what is the difference for the patient?

The difference is mostly around improved patient experience. For example:

- We advise patients of the estimated wait times. By communicating more openly and consistently with patients about wait times, we can promote relationship building by having respectful conversations, managing expectations, ensuring people understand their options and have time to consider them.
- Our focus when recruiting is to ensure applicants understand equity and how this applies to our patient population in particular. We want our staff to treat our patients with the respect, empathy and compassion they deserve. This has been notable in comments from patients like "*they really care about your health*" and "*staff are always friendly.*" Feedback about reception staff prior was not great, but this has notably improved.
- Health coaches contact new Māori patients to offer an initial free consultation to introduce themselves and provide a tour.
- We now run a free walk-in clinic for mama and their tamariki for immunisations, skin care, blood pressures, initial pregnancy consults, advice and support for pēpi, throat swabs and more.

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New Zealand members of the British College of General Practitioners established a local Council in 1955. In 1974, it became a separate entity, and in 1979, it was granted provision to use "royal", becoming The Royal New Zealand College of General Practitioners.

Published by The Royal New Zealand College of General Practitioners, New Zealand, 2024

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