Hawke's Bay System Level Measures Improvement Plan 2016/17

Signatures

Hawke's Bay District Health Board

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1. Background

The Integrated Performance and Incentive Framework (IPIF) began in 2012. The aim of IPIF was to drive stronger integration across the health system, improve quality and ensure long term system sustainability. IPIF was implemented in 2014 with primary care financial incentives directly linked to performance against the primary care National Health Targets (Better help for smokers to quit, Immunisation and More Heart and Diabetes Checks) and the cervical screening coverage.

The development of the overall IPIF framework was paused during the refresh of the Strategy. In May 2015 the Minister of Health decided not to introduce new performance measures in 2015/16 as he wanted more aspirational measures developed that looked at the performance of the system rather than just primary care. The Minister also wanted to change the focus from looking at outputs and processes to outcomes. The refresh of the Strategy provided the opportunity for this work and has built the case to extend and evolve the IPIF concept of System Level Measures.

The Ministry of Health (the Ministry) has been working closely with the sector to co-develop a suite of System Level Measures that provide a system wide view of performance. These measures have evolved from an initial list of over 100. The new measures engage the health sector more broadly (professions, settings and health conditions) than the previous measures.

The performance of individual clinicians and/or provider organisations, through health activities and processes, are measured by contributory measures. These individual groups must work as one team to improve system level performance. The System Level Measures for introduction in 2016/17 also resonate with the care closer to home, people powered and smart system themes of the Strategy.

The System Level Measures to be introduced rely on the contribution of a wider group of providers. In 2016/17, the focus is on the contributions and performance of DHBs and PHOs. The contribution of the wider groups will be seen over the next 18 months as the Ministry and the DHBs include System Level Measures in a wider range of contracts.

Health Hawke's Bay and the District Health Board are required to work together to develop an improvement plan for the System Level Measures Framework and report against it throughout the year.

2. Development of the Improvement Plan

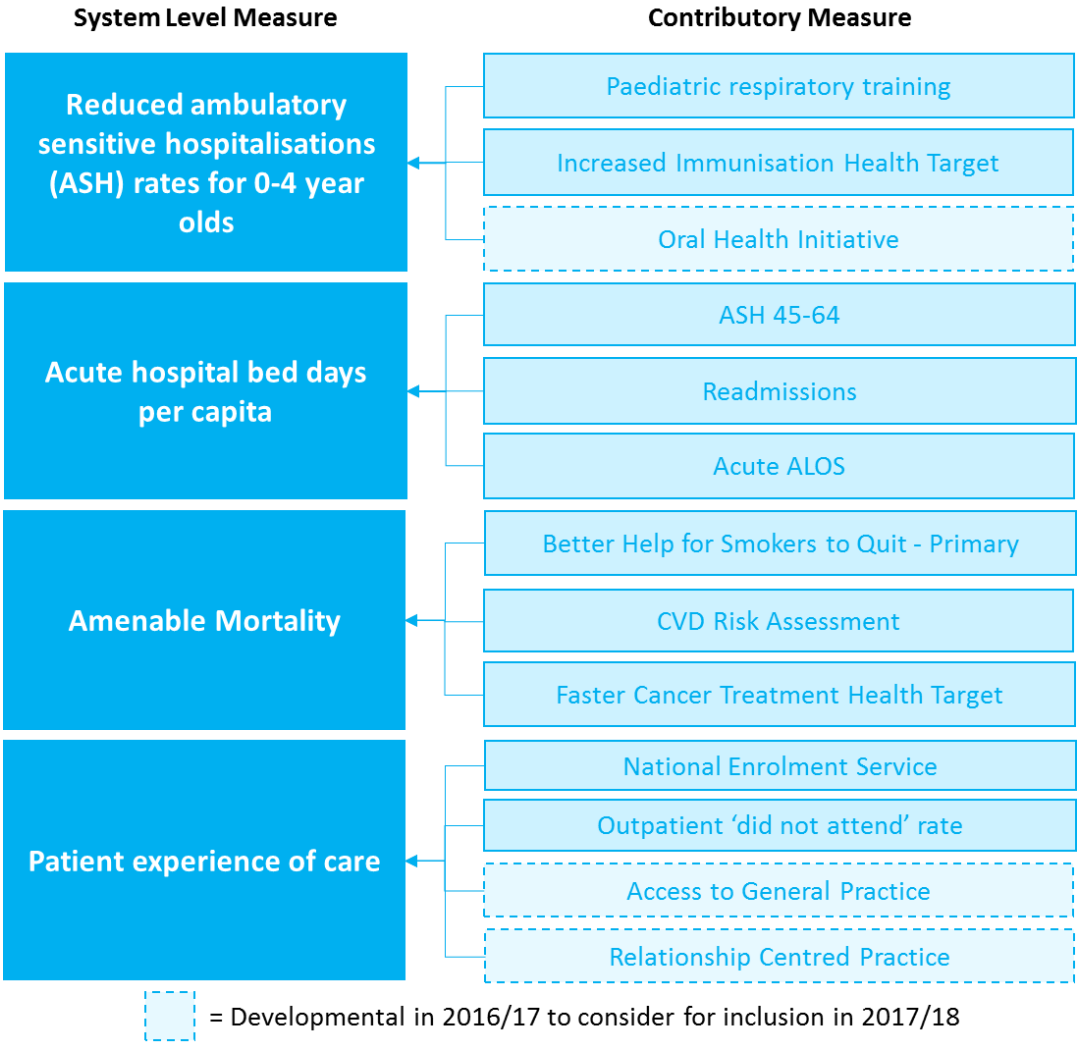
Health Hawke's Bay ran two workshops in conjunction with the Hawke's Bay District Health Board which were attended by both primary and secondary managers and clinicians. The first was also attended by Dr Peter Jones and Kanchan Sharma from the Ministry of Health who explained what SLMs were and what was expected in 2016/17.

The workshops delivered clear themes which were further refined with representatives from primary and secondary care and various governance committees.

In the first year, our aim is to get everyone on board with the concept of System Level Measures and the idea of working together as a whole system. As we move forward we will look to challenge the system more to achieve the desired outcomes.

3. System Level Measures and Contributory Measures

Below is a diagram outlining the System Level Measures and Contributory Measures agreed by Health Hawke's Bay and Hawke's Bay District Health Board. The activities and targets are detailed in the section below.



4. Detailed Improvement Plan

Keeping Children out of Hospital

Measure	Ambulatory Sensitive Hospitalisation 0-4
Milestone	Māori ASH 0-4 rate <5,282 by 30th June 2017
Baseline	12 months to March 2016 Total = 4,725, Māori = 5,336, Other = 3,768

Contributory Measures

Paediatric respiratory training for Practice Champions

Measure	% of Respiratory Practice Champions attending Paediatric Respiratory training offered by DHB		
Target	100%		
Baseline	0%		
Numerator	Number of respiratory practice champions that have attended training		
Denominator	Number of respiratory practice champions (n=35)		
Data Source	PHO		
Rationale for Inclusion	Respiratory infections and Asthma are the most common causes of ASH in 0-4 year olds. The gap between Māori and non-Māori ASH rates for Asthma is increasing. Ensuring appropriate support and treatment at a young age sets a foundation for future healthy lungs.		
Activities	**Activity**	**Lead**	**By when**
	Paediatric respiratory training will be provided to practice champions in primary care.	Service Director WCY	End Q4
	Hawke's Bay's existing respiratory programme will expand to include children as well as adults	HHB Health Programmes Manager	Ongoing
SLM Funding Arrangement	Payment for attendance		
Quarterly Goals			
Q1	Agreed Improvement Plan		
Q2	Systems in place to deliver training		
Q3	50%		
Q4	100%		

Increased Immunisation Health Target

Measure	% of eight months olds will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time.		
Target	≥95%		
Baseline	Oct 2015 to Dec 2015 Total = 93.3%, Māori = 92.6% Pacific = 100%		
Numerator	Health Target Definition		
Denominator	Health Target Definition		
Data Source	Data supplied from Ministry from NIR		
Rationale for Inclusion	Improved immunisation coverage leads directly to reduced rates of vaccine preventable disease, and consequently better health and independence for children, particularly for the most vulnerable groups. The changes which are required to reach the target immunisation coverage levels will lead to more efficient health services for children, because more children will be enrolled with and visiting their primary care provider on a regular basis. It will also require primary and secondary health services for children to be better co-ordinated.		
Activities	**Activity**	**Lead**	**By when**
	Continue to facilitate Hawke's Bay Immunisation steering group quarterly and use this group to monitor coverage rates, equity and outreach activity.	DHB Imms Coordinator	Quarterly
	Continue to implement strategies in the Immunisation Action *Plan 'Improving Childhood Immunisation On Time Rates in Hawke's Bay'*.	DHB Imms Coordinator	Quarterly
	Use Datamart reports regularly to measure the coverage rates by ethnicity and deprivation status, identifying increasing numbers of declining or opt-offs or other gaps in service delivery. Tailor the response to data appropriately using the variety of access options available.	DHB Imms Coordinator	Quarterly
	Support practices to review, audit and manage their Patient management systems for the systematic and timely review of children.	PHO Performance manager	Quarterly
	Health Hawke's Bay and HBDHB to work collaboratively on promotion of Immunisation week in Q4 2017	DHB / PHO	Q3
	Immunisation team to maintain working relationships with age appropriate services such as Tamariki Ora, Plunket, community oral health services and Before School Checks to ensure efficient use of resources for tracking children and appropriate service provision.	DHB Imms Coordinator	Quarterly
SLM Funding Arrangement	Payment for Performance		
Quarterly Goals			
Q1	Agreed Improvement Plan		
Q2	95%		
Q3	95%		
Q4	95%		

Oral Health Initiative

Measure	Developmental: Reduced ASH 0-4 rates due to dental conditions
Rationale for Inclusion	Dental conditions are the 2nd highest contributor to Māori ASH rates for 0-4 years. Primary and secondary care will work collaboratively to determine where effort should be focussed to reduce hospitalisations.
SLM Funding Arrangement	Payment for participation

Using Health Services Effectively

Measure	Acute Bed Days Per Capita
Milestone	<350.6
Baseline	12 months to March 2016 Total = 350.6, Māori = 338.5, Other = 356.2

Contributory Measures

Readmission Rates

Measure	Acute readmission to hospital		
Target	≤7.7%		
Baseline	12 months to Sep 2015 Total = 7.7%		
Numerator	OS8 Definition		
Denominator	OS8 Definition		
Data Source	Data supplied from MoH		
Rationale for Inclusion	An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system. Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of care, in the hospital and/or primary care, ensuring that people receive better health and disability services. Readmission rates should be monitored along with average length of stay when aiming to reduce bed days		
Activities	**Activity**	**Lead**	**By when**
	Continue progress with the 4000 bed days programme and work to avoid readmissions	Improvement advisor Team Leader	Ongoing
SLM Funding Arrangement	Nil		
Quarterly Goals			
Q1	Agreed Improvement Plan		
Q2	≤7.7%		
Q3	≤7.7%		
Q4	≤7.7%		

Average Length of Stay

Measure	Inpatient Average Length of Stay (ALOS) for acute admissions		
Target	≤2.35		
Baseline	12 months to Dec 2015 Total – 2.55		
Definition	The standardised ALOS for acute discharges in any medical or surgical specialty, expressed as the ratio of the observed (actual) to predicted ALOS, multiplied by the nationwide acute inpatient ALOS. The DHB observed ALOS, and the nationwide acute inpatient ALOS, are both defined as the total bed days for acute medical or surgical inpatients discharged during the 12 months to the end of the quarter, divided by the total number of discharges for acute inpatients during the 12 months to the end of the quarter.		
Data Source	National Minimum Dataset (NMDS), Ministry of Health		
Rationale for Inclusion	By shortening hospital length of stay, while ensuring patients receive sufficient care to avoid readmission, the DHB will impact on the Ministerial priority of improved hospital productivity. This will be achieved through freeing up beds and other resources so the DHB can both provide more elective surgery and reduce length of stay in the emergency department.		
Activities	**Activity**	**Lead**	**By when**
	Improve communication to patients about their admission and things they need to know, to ensure family / support people are involved and engaged in the process.	Improvement advisor Team Leader	Ongoing
	Improve patient information in all adult wards including CHB and Wairoa.		
	Electronic Whiteboards in all adult inpatient areas.		
	Criteria Based Discharge - Promote timely discharge, reduce delays across the seven day week. Currently formally introduced in one medical ward this now needs to be enhanced to include a seven day week service and to be introduced to surgical areas and across all medical areas.		
	Increase Knowledge/ access to EngAGE intermediate beds and flag early.		
	Communicate to multidisciplinary teams options for supported discharge via one document and flowchart		
	Identify solutions to gaps if identified.		
SLM Funding Arrangement	Nil		
Quarterly Goals			
Q1	Agreed Improvement Plan ≤2.52		
Q2	≤2.46		
Q3	≤2.41		
Q4	≤2.35		

ASH 45-64

Measure	Ambulatory Sensitive Hospitalisation rate per 100,000 population for 45-64 year olds		
Target	≤3,510		
Baseline	October 2014 to September 2015 Total = 3,510, Māori =6,310, Other = 2,812		
Numerator	Number of ASH admissions for 45 - 64 year olds		
Denominator	Number of 45 - 64 year olds		
Data Source	Data will be released by the Ministry of Health quarterly		
Rationale for Inclusion	Ambulatory sensitive hospitalisations (ASH) are mostly acute admissions that are considered potentially reducible through prophylactic or therapeutic interventions deliverable in a primary care setting. Determining the reasons for high or low ASH rates is complex, as it is in part a whole-of-system measure. It has been suggested that admission rates can serve as proxy markers for primary care access and quality, with high admission rates indicating difficulty in accessing care in a timely fashion, poor care coordination or care continuity, or structural constraints such as limited supply of primary care workers. ASH rates are also determined by other factors, such as hospital emergency departments and admission policies, health literacy and overall social determinants of health. This indicator can also highlight variation between different population groups that will assist with DHB planning to reduce disparities		
Activities	**Activity**	**Lead**	**By when**
	Develop a clinical pathway for Cellulitis to standardise practice by Q1	CPO coordinator (HHB)	Q1
	Implement and socialise the recently developed clinical pathway for Congestive Heart Failure by Q2	Manager – Cardiology (DHB)	Q2
	Secure sustainable funding to continue to provide nurse led respiratory clinics.	Strategic Service Manager – Primary Care (DHB)	Q1
	Develop a reporting structure by Q2 which provide reports to general practices to show their admission rates to hospital and emergency department attendances.	Strategic Service Manager – Primary Care (DHB)	Q2
	Following allocation of funding through new investment prioritisation process, appoint a Congestive Heart Failure nurse practitioner to work in the community alongside primary care with the aim of supporting Heart failure patients to self-manage and avoid hospitalisations	Manager – Cardiology (DHB)	Q4
	Clinical Nurse Specialist and Breathe HB will provide two Respiratory training sessions in Primary Care by Q4	Strategic Service Manager – Primary Care (DHB)	Q4
SLM Funding Arrangement	Payment for participation and data sharing		
Quarterly Goals			
Q1	Agreed Improvement Plan		
Q2	≤3,510		
Q3	-		
Q4	≤3,510		

Prevention and Early Detection

Measure	Amenable Mortality
Milestone	Total ≤ 136.0, Māori ≤ 221.6, Pacific ≤ 250.6,
Baseline	Amenable mortality deaths, age standardised rates, 0-74 year olds 2009-2013 Total = 136.0, Māori = 221.6, Pacific = 250.6, NMNP = 87.8

Contributory Measures

Better Help for Smokers to Quit - Primary

Measure	% of PHO enrolled patients who smoke that have been offered help to quit smoking by a health care practitioner in the last 15 months		
Target	≥90%		
Baseline	Jul 2014 to Sep 2015 Total = 81.2%, Māori 80.8%, Pacific 75.7%, Other 75.7%		
Numerator	Health Target Definition		
Denominator	Health Target Definition		
Data Source	Supplied to the Ministry of Health through the PHO performance programme (PPP) system		
Rationale for Inclusion	Tobacco is a key contributor to health inequity in Hawkes Bay. Our prevalence of tobacco use is higher than the national average and we believe that reducing tobacco consumption remains the best opportunity to improve Māori health, improve equity and reduce amenable mortality.		
Activities	**Activity**	**Lead**	**By when**
	Continue to offer GP Practices and their staff training, support and guidance on Smokefree systems, processes and policy development	DHB Smokefree manager	Q4
	Provide benchmarking data and audit support for high level leadership and governance structures to manage performance of the 'Better help for smokers to quit' Health Target in primary care. Encouraging the identity and development of Smokefree champions in practices where appropriate.	DHB Smokefree manager	Quarterly
	Review the forms used in the primary care Patient Management System to explore the possibility of mandatory Smokefree fields.	PHO Performance manager	Q4
	Fund independent nurses to contact patients and offer them smoking brief advice and cessation support.	PHO Performance manager	ongoing
	Fund general practices for additional resource to contact patients and offer them smoking brief advice and cessation support.	PHO Performance manager	ongoing
	Coordinate and fund a 'text to remind' campaign with Vensa Health	PHO Performance manager	Q3
SLM Funding Arrangement	Payment for Performance		
Quarterly Goals			
Q1	Agree Improvement Plan 90%		
Q2	90%		
Q3	90%		
Q4	90%		

Cardiovascular Disease Risk Assessment

Measure	% of the eligible population who have had their cardiovascular risk assessed in the last five years.		
Target	≥90%		
Baseline	5 years to Dec 2015 Total = 90.3%, Māori 86.3%, Pacific 87.0%, Other 91.7%		
Numerator	PP20 Definition		
Denominator	PP20 Definition		
Data Source	Supplied to the Ministry of Health through the PHO performance programme (PPP) system		
Rationale for Inclusion	According to our Health Equity Report, ischaemic heart disease is the leading cause of avoidable mortality in Hawke's Bay across all ethnicities. However, the potential years of life lost rates for Māori and Pasifika are four and three times higher respectively than the non-Māori, Non-Pasifika population highlighting a significant equity issue. To reduce the risk of developing CVD, five yearly risk assessments should be carried out on the eligible population.		
Activities	**Activity**	**Lead**	**By when**
	Support practices to carry out PMS audits with a particular focus on those who are coming due for Cardiovascular Risk Assessment (CVRA). Including those coming into the cohort, those that are due and those that will require rescreening	PHO Performance manager	Quarterly
	Provide data to assist Practices to manage the total cohort of their screened population and allow internal benchmarking. Where appropriate, the General Practice facilitation team will work with practices to improve those outliers' performance	PHO Performance manager	Quarterly
	Specific outreach nursing services will target workplaces where there is a high volume of Māori men in the work place and offer incentives such as prize draws.	PHO Performance manager	Quarterly
	Meet with key high needs community stakeholders to develop a plan to increase CVDRA for Maori, Pacific and quintile 5.	PHO Performance manager	Q3
SLM Funding Arrangement	Payment for performance		
Quarterly Goals			
Q1	Agree Improvement Plan		
Q2	90%		
Q3	90%		
Q4	90%		

Faster Cancer Treatment Health Target

Measure	% of patients who receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer and a need to be seen within two weeks by June 2017.		
Target	≥90%		
Baseline	6 months to Dec 2015 Total = 77.6%, Māori 78.6%, Other 76.7%		
Numerator	Health Target Definition		
Denominator	Health Target Definition		
Data Source	Data to be supplied by DHBs		
Rationale for Inclusion	Cancer is one of the leading causes of amenable mortality. Cancer services span the continuum from prevention and screening, through treatment and follow-up care. The National Health Target 'Faster Cancer Treatment' (FCT) takes a pathway approach to care, to facilitate improved hospital productivity by ensuring resources are used effectively and efficiently. Cancer treatment is provided by HBDHB through our own provider and in collaboration with a number of other providers. For example, all radiation treatments are provided for Hawke's Bay patients by MidCentral DHB, while some surgical treatments are outsourced from Capital & Coast, Hutt Valley and Auckland DHBs. There is local provision of outpatient-based chemotherapy plus coordination of all Hawke's Bay patients across and through all networked services. This requires a high level of inter-district collaboration to ensure that services are integrated and seamless for patients.		
Activities	**Activity**	**Lead**	**By when**
	Participate in and comply with reviews of current service provision against the tumour standards within the Central Region. Implement any recommended actions from the reviews.	Manager – Oncology	Ongoing
	Work with the local radiology department to support implementation of regional or local outcomes of their review.	Manager – Oncology	Ongoing
	Review the Breast cancer referral pathway to reduce time delays within referral management	Manager – Oncology	Ongoing
	Work with Central Cancer Network (CCN) to investigate and scope future development of multi-disciplinary meetings and processes. Project report to be prepared June 2016.	Manager – Oncology	Ongoing
	Implement the prostate cancer management and referral guidance by Q4	Manager – Oncology	Q4
	Work with the central region to standardise data interpretation	Manager – Oncology	Ongoing
SLM Funding Arrangement	Nil		
Quarterly Goals			
Q1	Agree Improvement Plan		
Q2	≥90%		
Q3	≥90%		
Q4	≥90%		

Person & whānau Centred Care

Measure	Patient Experience of Care
Milestone	≥15 practices have systems in place to participate in the Patient Experience of Care survey by end of June 2017.
Baseline	6 practices

Contributory Measures

National Enrolment Service

Measure	Percentage of general practices live on National Enrolment Service (NES) by end June 2017		
Target	90%		
Baseline	11%		
Numerator	Number of general practices live on National Enrolment Service (NES) by end June 2017		
Denominator	Number of general practices (n=29)		
Data Source	PHO		
Rationale for Inclusion	The NES has been developed to provide a single definitive source for all national enrolment and identity data. The NES is an enabler for the Patient Experience Survey.		
Activities	**Activity**	**Lead**	**By when**
	Dedicated Health Hawke's Bay personnel allocated to be responsible for on-boarding practices in tranches as advised by the MoH.	Health and Social Care IT Liaison (HHB)	Q1
	Health Hawke's Bay provide General Practice with NES and PES education		Ongoing
	Practices on boarded at the rate recommended by the MoH.		Ongoing
	Health Hawke's Bay maintains an active risk management plan to mitigate against any risks associated with not reaching its target of 90% of practices on boarded		Ongoing
	Health Hawke's Bay works with the MoH, patients first and the HQSC to ensure that the PES software is tested and available to General practice in a timely manner		Ongoing
	Risks are escalated to Health Hawke's Bay Clinical and Governance Advisory Group for advice.		Ongoing
SLM Funding Arrangement	Payment for Enrolment		
Quarterly Goals			
Q1	Agree Improvement Plan		
Q2			
Q3	50%		
Q4	90%		

DNA

Measure	Did Not Attend (DNA) Rate		
Target	≤7.5%		
Baseline	October 2015 to December 2015 Total = 8.1%, Māori = 14.9%, Pacific = 18.3%, Other = 5.3%		
Data Source	Internal		
Rationale for Inclusion	Māori and Pacific people have DNA rates that are 3-4 times higher than those of other people in Hawke's Bay and therefore are not gaining the benefit of timely health advice or treatment. These rates have remained stubbornly poor both locally and nationally for many years despite numerous initiatives to make a difference. A high DNA rate suggests there are significant numbers of people whose health may be adversely affected through not receiving timely and appropriate health care advice or treatment. It may also indicate access, systems or other reasons that may be limiting people's ability or willingness to attend. DNA is an important measure of person centred care.		
Activities	**Activity**	**Lead**	**By when**
	Further investigate DNA data to understand the patient journey up until the point of DNA and the patient demographic details.	Project Manager, DHB Health Services	Q2
	Once we have a better understanding of the people who DNA, identify people at risk of DNA and notify kaitakawaenga.		Q3
	Monitor the gaps in patient contact information and use of text to remind service.		Q2 ongoing
	Work with ED and other services to promote verbal confirmation of contact details		Q3
SLM Funding Arrangement	Nil		
Quarterly Goals			
Q1	Agree Improvement Plan		
Q2	≤7.5%		
Q3	≤7.5%		
Q4	≤7.5%		

Access to General Practice

Measure	Developmental: Increase access to General Practice
Rationale for Inclusion	In the 2015 New Zealand Health Survey, Hawke's Bay had the largest proportion of people reporting that they were unable to get an appointment at their usual medical centre within 24 hours.
SLM Funding Arrangement	Payment for participation

Relationship Centred Practice

Measure	Developmental: Relationship Centred Practice
Rationale for Inclusion	Experiencing relationship centred practice is important to our consumers. Relationship centred practice training is being rolled out and measured. We will consider inclusion for 17/18 based on 16/17 learnings.
SLM Funding Arrangement	Nil

5. 2017/18 Planning

1. Developmental Measures

The developmental measures indicated in the plan will be considered over 2016/17 for inclusion in the 2017/18 plan.

2. Early Engagement

The DHB and PHO will ensure early and ongoing engagement with the sector to develop a plan jointly that everyone is committed to.

3. New SLMs

We will continue to engage in discussions on the development of the new SLMs: Youth access to and utilisation of youth appropriate health services; and Number of babies in smoke-free households at six weeks post-natal.