HAWKE'S BAY

2017/18 System Level Measures Improvement Plan

Sharon Mason
Acting CEO
Hawke's Bay DHB

Wayne Woolrich
General Manager
Health Hawke's Bay

Keeping Children out of Hospital

SYSTEM LEVEL MEASURE

Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0–4 year olds

Ambulatory Sensitive Hospitalisations (ASH) reflect hospital admissions for conditions which could potentially be prevented by early access to treatment in care. In many countries ASH is used as a means to assess the performance of primary care and to identify potential barriers to access.

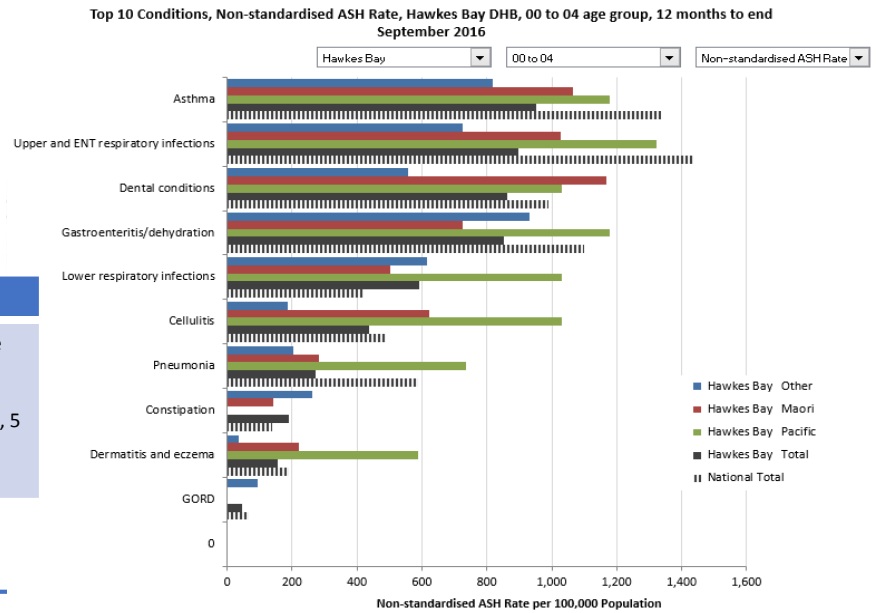
However, while ensuring early access to effective primary care is still likely to be of considerable value in reducing ASH, in countries such as New Zealand, where large socioeconomic and ethnic disparities in child health exist, a greater emphasis may need to be placed on addressing those factors, often outside of the health sector, which drive the underlying burden of disease (e.g. household income, housing, nutrition, exposure to second hand cigarette smoke). This is because, even with optimal access, the ability of a general practitioner to prevent a paediatric pneumonia admission after the first crucial hours may be limited, but the opportunities available for a DHB to prevent paediatric respiratory infections via e.g. healthy housing projects and parental smoking cessation programmes may be considerable.

There is an inequity in the ASH rates 0-4 for Māori, Pacific and other. The largest inequity is observed in dental and we are worse than the National rate in Lower Respiratory Conditions.

The top ASH conditions for Māori are Asthma, Dental conditions, Respiratory Infections- Upper and ENT, Respiratory Infections – Lower, Gastroenteritis/ Dehydration and Cellulitis.

	Baseline*	2017/18 Milestone
Total	5,272	Reduce the difference between Māori and other rate to ≤1,028 (20% reduction in gap, 5 year elimination)
Māori	5,755	
Pacific	8,088	
Other	4,469	

*12 months to September 2016



CONTRIBUTORY MEASURES

Measure	Baseline	Goal
Decreased hospitalisations due to dental conditions for Māori & Pacific 0-4 (rate per 100,000)	Maori: 1,167 Pacific: 1,029 Other: 559 (Sep 2016)	Maori: ≤1,045 (20% reduction in the gap)
Decreased hospitalisations due to respiratory for total population 0-4 (rate per 100,000)	Total: 2,713 (Sep 2016)	≤2,170 (20% reduction)
% of 8 month olds who complete their primary course of Immunisations (HT)	95.3% (Dec 2016)	≥95%

HOW WILL WE ACHIEVE IT?

- Use learnings from the successful adult respiratory programme, designed to reduce adult hospital admissions due to respiratory conditions, to tailor a paediatric programme and roll out to general practices by Q4.
- Increase scope of the Oral Health Project to include a specific focus on reducing ASH rates. The project is generally focused on increasing carried free at 5 years but will now have a workstream designing a collaborative approach to reducing ASH 0-4 through early primary care intervention and investigating the incidence of children experiencing ASH for more than one condition and how they could be better coordinated for risk factors and advice, especially for Māori, Pacific and low decile populations
- Form one whole sector governance group for under 5s for better coordination of initiatives for this age group.
- Design and implement a quality improvement initiative in primary care based on rapid oral rehydration to reduce the number of kids requiring admission for dehydration.

Using Health Resources Effectively

SYSTEM LEVEL MEASURE: Acute hospital bed days per capita

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers. This includes access to diagnostics services.

Reducing acute hospital bed days aligns with our challenge in Transform and Sustain of being more efficient at what we do. We continue to focus our efforts on reducing avoidable admissions through more effective care in the community; and reducing length of stay and readmission rates through better hospital processes and collaboration across the sector.

Ambulatory Sensitive hospitalisation (ASH) rates for 45-64 years are a contributing factor to acute hospital bed days and in their own right are a measure of the whole system working effectively. The largest inequity gap for ASH 45-64 between Māori and other is in COPD and Congestive Heart Failure (CHF).

Two initiatives included in this plan are High Needs Enrolment programme which is enabled through SIA funding to support the initial engagement of high needs patients newly enrolled with a practice by way of funded assessment by Practice Nurse and first GP consult. The other is Hospital Discharge Review Service which receives referrals for patients discharged from Hastings Hospital where their admission is related to specific conditions. The aim being to reduce readmission rates and encourage post discharge engagement with general practice

Baseline:

	Estimated Popn	Acute Stays	Acute Bed Days	Standardised Acute Bed Days per 1,000 Popn		
Year	Year to Sep 2016	Year to Sep 2016	Year to Sep 2016	Year to Sep 2014	Year to Sep 2015	Year to Sep 2016
Māori	41,355	5,848	16,427	649	554	545
Pacific	6,040	891	2,146	755	543	525
Other	113,595	15,002	51,206	373	342	345
Total	160,990	21,741	69,780	420	381	384

2017/18 Milestone: Reduce standardised acute hospital bed days per 1,000 popn for 'Māori' to ≤461

CONTRIBUTORY MEASURES

Measure	Baseline	Goal
Decreased Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 45 – 64 year olds Māori	Total: 4,129 Other: 3,262 Māori: 7,636	Māori: ≤6,761 (20% reduction in gap Māori and other
Increase the number of Maori, Pasifika and Quintile 5 people being referred into the High Needs Enrolment Programme	2016/17 Maori: 167, Pacific 37, Quin5: 47, Total: 251	Maori: 350, Pacific 75, Quin5: 100, Total: 525
Increase the number of referrals into the Hospital Discharge initiative by Maori, Pasifika, Quintile 5 and Quintile 4	2016/17 Maori: 300, Pacific 37, Quin5: 414, Quin4: 269, Total 1036	Maori: 500, Pacific 150, Quin5: 375, Quin4: 375, Total: 1500

HOW WILL WE ACHIEVE IT?

- Recruit to a new position of intern Nurse Practitioner for Heart Failure working between primary and secondary care to facilitate cardiac management and reduce CHF admissions. Focus on developing the role to transition skills into the community, learning from the success of the adult respiratory programme which was centered around improving capacity and capability in primary care.
- Continue with successful Respiratory programme but focus on equity, moving to a whānau based model with more focus on management rather than screening and diagnosis.
- Develop a programme to implement tracer auditing in long term conditions areas of focus e.g Renal and diabetes, respiratory and cardiology.
- Work with general practice to encourage increased use of the High Needs Enrolment Programme, actively promoting the programme across our high needs communities
- Work with general practice and Hastings Hospital staff to encourage increased use of the Hospital Discharge Programme with a particular emphasis on admissions associated with Diabetes, COPD and Heart Failure

Prevention and Early Detection

SYSTEM LEVEL MEASURE: Amenable mortality rates

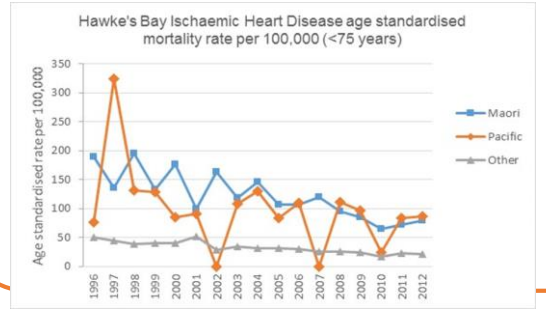
We have seen significant and continued reduction in deaths, which could have been prevented by either prevention or early treatment programmes or better access to medical care. Nearly three-quarters of all deaths before the age of 75 years are avoidable either because of disease prevention or because of effective treatment and health care. Deaths due to these diseases or conditions can be counted and expressed as a rate. Any difference in these rates by ethnicity or by area of residence can therefore be considered to be a health inequity.

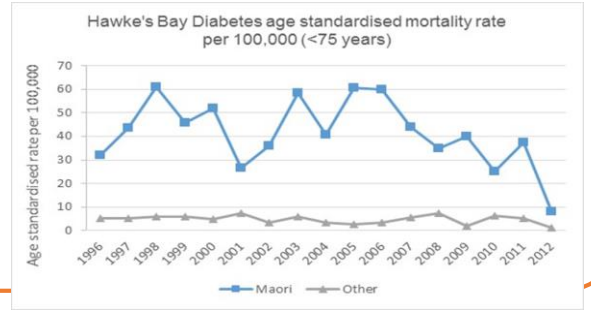
The top five causes of amenable mortality for all populations, in order, is Cardiovascular Disease, Suicide, Cerebrovascular disease, COPD and Female breast cancer. For Māori, it is coronary disease, diabetes, suicide, land transport accidents (excluding trains), cerebrovascular diseases and COPD.

Amenable mortality rates are 2.6 and 3 times higher for Māori and Pacific respectively than non-Māori, non-pacific. This highlights a large inequity in prevention and early detection for Māori and Pacific. Given what we know about our top causes, the system will focus on cardiovascular disease and diabetes, particularly for Māori, and cancer. Youth suicide will be a focus of the 'Youth are Healthy, Safe and Supported' SLM and respiratory will be a focus in Using health resources effectively. All of these will contribute to reducing amenable mortality.

Baseline	2017/18 Milestone
Total = 113.1 Māori = 224.9, Pacific = 260.4, NMNP = 87.6 (Amenable mortality, ages 0-74, 2009-2013) Relative Rate between Māori and NMNP = 2.56	Relative Rate between Māori and NMNP ≤1.8 by 2023, ≤1 by 2028

NB: Given the small number in the pacific population, it is difficult to put a target on reducing the standardised rate however, we will be focussing on services to improve equity for Pasifika as well as Māori.





CONTRIBUTORY MEASURES

Measure	Baseline	Goal
Increased number of Māori males 35-44 yrs have had a CVD risk assessment in the past 5 years	Total = 87.8%, Māori & Pacific males 35-44yrs = 67.2% (5yr to Mar 2017)	≥90%
Better help for smokers to quit (PHO HT)	Total = 87.4%, Māori = 85.1% (Oct-Dec16)	≥90%
Faster Cancer Treatment (HT)	Total = 65.4%, (6m to Dec 16)	≥90%

HOW WILL WE ACHIEVE IT?

- Develop a map of diabetes prevalence based and services based on domicile in order to provide a strategic view of deliver of services against population need and health outcomes.
- Faster Cancer Treatment Group, which includes representation from primary, secondary services and cancer society, to oversee development and implementation of FCT action Plan to improve timeliness of cancer treatment.
- Work with other sectors in Hawke's Bay to develop a Social inclusion action plan and identify the health sector's contribution to delivery of that plan
- Develop an improvement plan informed by data, analysis and information to increase the provision of CVRA in Māori men aged 35-45 years
- Implement the Pre-diabetes Intervention Programme supported by the Otago University research and evaluation project
- Establish a process to identify the number of enrolled patients coded with pre-diabetes referred to a Living Well Programme by 20 June 2017

Person and Whānau-centred Care

SYSTEM LEVEL MEASURE: Patient experience of care

How people experience health care is a key element of system performance that can be influenced by all parts of the system and the people who provide the care. Improved patient experience of care will reflect better integration of heath care at the service level, better access to information and more timely access to care.

Patient experience surveys provide scores for four domains which cover key aspects of a patient's experience when interacting with health care services: Communication, partnership, coordination, and physical and emotional needs.

The purpose of these measures is to ensure patients in New Zealand are receiving quality, effective and integrated health services. Evidence suggests that if patients experience good care, they are more engaged with the health system and therefore likely to have better health outcomes.

This measure captures patient experience in two settings:

- Hospital inpatient surveys (currently undertaken quarterly since 2014)
- Primary care survey (introduced in a phased approach quarterly from Feb 2016)

Our Hospital Inpatient baseline results are as follows:

Domains	Inpatient Results (Oct-Dec 16)
Communication	8.3
Partnership	8.4
Coordination	8.3
Physical and Emotional needs	8.8

SLM 2017/18 Milestone: 100% of General Practices undertaking the primary care survey by March 2017
Baseline: 0%

Although our Milestone is based on rolling out the survey in general practice, our plan is focused on improving uptake and experience across both settings.

CONTRIBUTORY MEASURES

Measure	Baseline	Goal
HQSC primary care survey response rate	Not started	≥10%
HQSC Inpatient survey response rate	21% (Nov 2016)	>27% (current national baseline)
Decreased did not attend (DNA) rate for first specialist appointment (FSA)	Other = 3.8% Māori = 14.2%	≤7.5%
Proportion of staff carrying out relationship centred practice training	DHB: TBC General Practice: 0%	DHB: ≥50% General Practice: ≥10%

HOW WILL WE ACHIEVE IT?

- Roll out the HQSC Patient Experience Survey in primary care.
- Carry out analysis across both surveys to look at who is and is not being represented in the responses to the patient experience survey and work together as a whole system to develop a plan to address these gaps.
- Form a group across both surveys to develop a process where responses are analysed and feedback to services to drive service improvement.
- Facilitate access to health literacy e learning training programme and HB relationship centred practice training, socialising the benefits of completion to General practice and enrolled patients.
- Carry out audits for youth friendly services in general practices involved in free under 18 visits and form a cluster plan based on the audit and youth consumer feedback.
- Deliver monthly seminars on customer service to administration staff for on going development e.g. organisation values and dealing with challenging behaviour.

Youth are Healthy, Safe and Supported

SYSTEM LEVEL MEASURE: Youth access to and utilisation of youth appropriate health services - Developmental

Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or 'risk factors'. Evidence shows that youth are not in the habit of seeking the services or advice of a registered health practitioner when unwell. Generally they cope with illness with advice from friends and whānau as they see fit. Attending a health clinic is often viewed as a last resort instead of a reasonable first choice.

This measure focuses on youth accessing primary and preventive health care services. Research shows that youth whose healthcare needs are unmet can lead to increased risk for poor health as adults and overall poor life outcomes through disengagement and isolation from society and riskier behaviours in terms of drug and alcohol abuse and criminal activities.

Hawke's Bay has a Youth Strategy which conveys a shared vision for young people by identifying a common set of youth outcomes and indicators that cuts across the work of many organisations/services working with youth. The strategy aligns with the youth development approach, focusing on a balance between services designed to prevent, intervene or treat health problems as well as promoting development through preparation, participation and leadership experiences with youth.

The Hawke's Bay Youth Consumer Council has identified Alcohol and Other Drugs and Mental Health and Wellbeing as their two top priorities for the System Level Measure. These areas will be developed with a strong focus on youth experience of the health sector.

A new system is being introduced to ED from 1st of July where all ED admissions will be recorded as alcohol related or not. This has been used as the SLM milestone to

SLM Milestone: 100% of Emergency Department (ED) Presentations for 10 – 24 year olds will have an alcohol-related admission field completed.

Baseline: 0%

CONTRIBUTORY MEASURES

Measure	Baseline	Goal
% of 'unknown' as answer to alcohol related presentation question in ED.	N/A	Define baseline

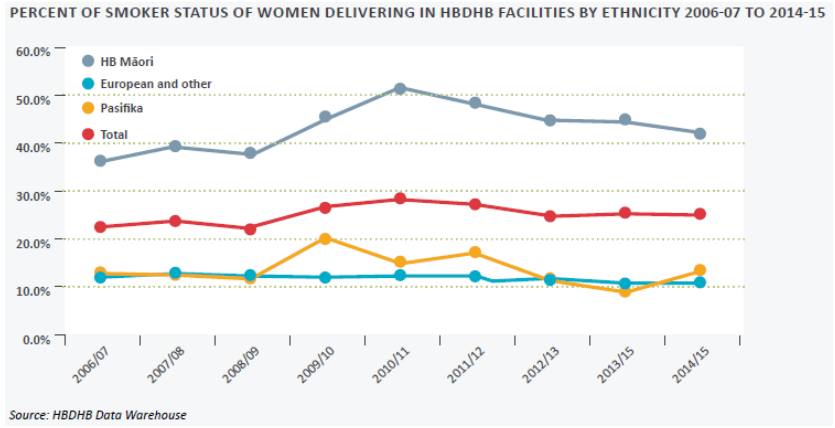
HOW WILL WE ACHIEVE IT?

- Introduce an 'alcohol related presentation' field to be completed for all ED presentations from July 1st 2017.
- Work with ED staff to review the quality of the data that is being collected.
- Hold workshops with youth service providers to map out patient pathways for the two priority areas. Use the maps to identify gaps in service provision for youth and use this to inform decisions for youth services.
- Complete a tender process to procure strengthened youth services in line with the Youth Health Strategy Outcomes
- Implement free GP visits for U18 year olds in Hawke's Bay
- Continue to support and utilise the Youth Consumer Council for decisions relating to Youth Health in Hawke's Bay.
- Include Youth MH and AOD in Clinical Services Plan consultation process in September

Healthy Start

SYSTEM LEVEL MEASURE: Proportion of babies who live in a smoke-free household at six weeks postnatal - Developmental

We know, in Hawke's Bay, we have am alarmingly high number of women, especially Maori women, who smoke during pregnancy (see graph below). This measure aims to reduce the rate of infant exposure to cigarette smoke by focusing attention on both maternal smoking and the home and family/whānau environment to encourage an integrated approach between maternity, community and primary care.



In our first year, we will focus on the data collection at multiple points in the maternity journey and the pathway for smokefree services centered around maternal and whanau smokefree support before, during and after pregnancy.

SLM Milestone: Reduce the number of 'blank' responses to household smoker question.

Baseline: 93% 'Blank'

CONTRIBUTORY MEASURES

Measure	Baseline	Goal
Pregnant women who identify as smokers upon registration with a DHB employed midwife or Lead Maternity Carer who are offered brief advice and support to stop smoking (HT)	Māori: 78.8% Total: 88.5%	≥90%
% of women, by ethnicity, booked with an LMC by week 12 of their pregnancy	Māori: 49.2% Pacific: 54.5% Other: 75.9% Total: 65.7%	≥80%

HOW WILL WE ACHIEVE IT?

- Hold workshops with service providers and population health to map out specific population pathways for smokefree interventions across their lifetime. Use the map to identify areas for improvement. Speak to Maori women who are not smokefree about how their pathway could be improved and why they are not smokefree.
- Carry out a project to gain understanding of why people do not engage with Te Haa Matea following referral and implement changes as a result of that feedback
- Work with WCTO providers and Quality Improvement manager from Central TAS to monitor and improve quality of the smokefree data being recorded
- Form a group with representatives from key providers to progress work in this area.