System Level Measures Improvement Plan

Auckland, Waitemata &
Counties Manukau Health Alliances

2019
2020
FINANCIAL YEAR

***Tawhiti rawa tō tātou haerenga te kore haere tonu, maha rawa wā tātou mahi te kore mahi tonu*.**

We have come too far to not go further and we have done too much to not do more.

- Sir James Henare

Photo Credit (cover): John Hettig Westone Productions

CONTENTS

1. EXECUTIVE SUMMARY

The Counties Manukau Health and Auckland Waitemata Alliance Leadership Teams (the Alliances) have jointly developed a 2019/20 System Level Measures Improvement Plan.

Continuing with the *one team* theme in the New Zealand Health Strategy, the joint approach to development of the single improvement plan will ensure streamlined activity and reporting, and best use of resources within the health system.

Extensive consultation was carried out across the sector in the development of the 2018/19 System Level Measures Improvement Plan. This year's plan is a consolidation of the 2018/19 plan. Some activities have been removed as they have been successfully achieved. Some have been found to be impractical or not easily measurable. These too have been removed. The focus is on areas where there is the greatest need and, where possible, robust data can be used for quality improvement. New contributory measures have been added where data collection processes have been developed in response to identified clinical priorities. Examples of this include alcohol harm reduction and smoking cessation rates. An extensive stocktake of activity against the 2018/19 plan, across primary and secondary care allowed stakeholders to contribute to the prioritisation of activities in the current plan.

The Alliances are firmly committed to including additional well-aligned contributory measures over the medium to longer term, as the structures, systems and relationships to support improvement activities are further embedded. This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples.

The district health boards (DHBs) included in this improvement plan are:

- Auckland DHB;
- Waitemata DHB, and
- Counties Manukau DHB.

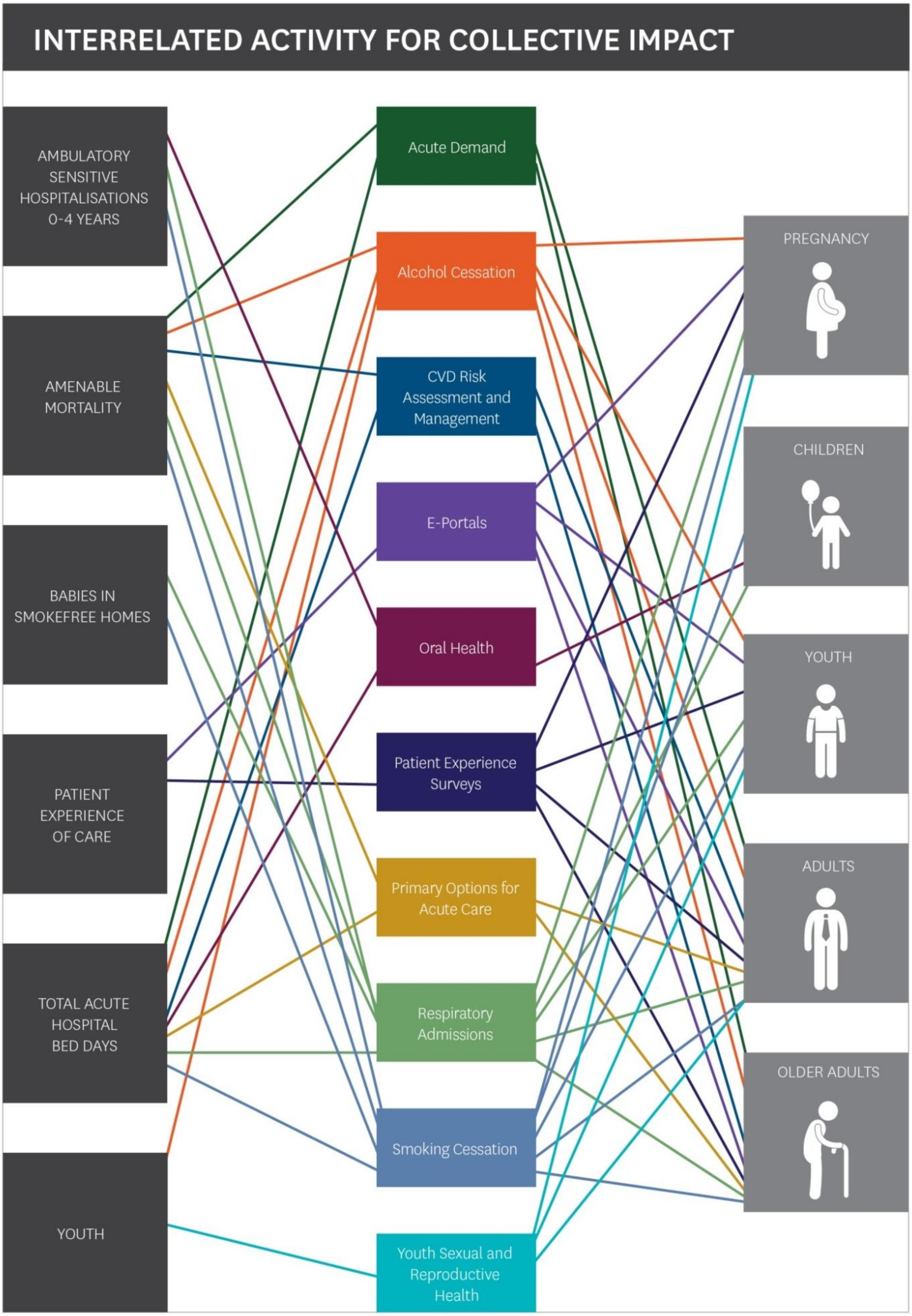
The primary health organisations (PHOs) included in this improvement plan are:

- Alliance Health Plus Trust;
- Auckland PHO;
- East Health Trust;
- National Hauora Coalition;
- ProCare Health;
- Total Healthcare PHO, and
- Comprehensive Care.

The diagram below shows an overview of the relationship between milestones and key activities chosen for the Metro Auckland System Level Measures, and the stage of life they represent. The current plan will maintain this approach of supporting activities and contributory measures that will have impact on multiple milestones.

The plan continues to promote a prevention approach and a strong focus on improving equity of outcome for Māori and other populations with high health need across the greater Auckland region.

2. INTERRELATED ACTIVITY FOR COLLECTIVE IMPACT



3. PURPOSE

This document outlines how the 2019/20 SLM Improvement Plan will be applied across the Metro Auckland region. It summarises how improvement will be measured for each SLM and the activities that will be fundamental to this improvement. Please note that, as further discussed in section 4, implementation planning is developed annually to sit under this document to provide a higher level of detail.

4. BACKGROUND

The New Zealand Health Strategy outlines a high-level direction for New Zealand's health system over 10 years to 2026, to ensure that all New Zealanders live well, stay well and get well. One of the five themes in the strategy is 'value and high performance' 'te whāinga hua me te tika o ngā mahi'. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the Ministry of Health has worked with the sector to develop a suite of SLMs that provide a system-wide view of performance. The Alliances are required to develop an improvement plan for each financial year in accordance with Ministry of Health expectations. The improvement plan must include the following:

a) Six SLMs:
   - ambulatory sensitive hospitalisation rates per 100,000 for 0 – 4 year olds
   - total acute hospital bed days per capita
   - patient experience of care
   - amenable mortality rates
   - youth access to and utilisation of youth-appropriate health services, and
   - babies living in smokefree homes.

b) For each SLM, an improvement milestone to be achieved in 2019/20. The milestone must be a number that shows improvement (either for Māori, total population, or a specifically identified population to address equity gaps) for each of the six SLMs.

c) A brief description of activities to be undertaken by all alliancing partners (primary, secondary and community) to achieve the SLM milestones.

d) Contributory measures for each of the six SLMs that is chosen by the district alliance based on local needs, demographics and service configurations that enable the alliance to measure local progress against the SLM activities.

e) Signatures of all district alliance partners to demonstrate an integrated and partnership approach to the development and implementation of the improvement plan.

In 2016, the Counties Manukau Health and Auckland Waitemata Alliances agreed to a joint approach to the development of the SLM Improvement Plan. This included the establishment of a Metro Auckland Steering Group and working groups for each SLM. Steering Group membership includes senior clinicians and leaders from the seven PHOs and three DHBs. The Steering Group is accountable to the Alliances and provides oversight of the overall process.

In 2019/20, SLMs continue to be business-as-usual. The governance structure of Alliance Leadership and Steering Group continue to guide improvement processes. The responsibility for implementation sits primarily with the Implementation Group. This group has primary care representation and flexible subject matter expertise dependant on topic and requirements. The Implementation Group meet regularly to further develop key actions (particularly at a local level) and inform implementation planning, monitor data, facilitate systems partnerships, and collaboratively guide the ongoing development of the SLMs with the Steering Group and Alliance Leadership Teams.

The work of the Implementation Group is guided by an Implementation Plan which sits under this plan and contains considerably more detail on activities and timeframes, and how a quality improvement approach will be taken for each area. The distinction between this high level plan and an implementation plan is necessary in a relatively complex environment of seven PHOs spanning three DHBs.

We continue to benefit from PHO leadership. The role of PHO lead has been retained from the original working group structure, and leads now have responsibility for diffused matrix management of SLM planning and implementation in their key activity areas. They continue to engage with other systems partners.

Data sharing between primary and secondary care is developing under the Metro Auckland Data Sharing Framework. This allows data matching with primary care and non-primary care data sources, more consistent reporting, establishment of baseline performance across DHBs and PHOs and drives quality improvement facilitated by the Implementation Group.

Reporting processes, both at a local and regional level have been embedded and DHBs and PHOs have access to both static and dynamic reporting in order to monitor progress and identify opportunities for improvement and individual performance is routinely discussed supportively in the Implementation Group.

4.1 Equity Approach, Consultation and Partnership

This plan reflects a strong commitment to the acceleration of Māori and Pacific health gain and the elimination of inequity for Māori and Pacific peoples. In planning, each contributor has been tasked with considering the role of equity for their particular measures, and providing measures and activities that promote improvement for those with the poorest health outcomes.

Consultation prior to and during planning for 2018/19 was more extensive than previous years. This process was extended to better address the expectations of mana whenua, and to discuss decision-making proactively. In addition, the Māori health gain teams across the region were invited to workshop the concepts and various drafts of the plan and provided valuable input. Feedback received from the engagement sessions with stakeholders was incorporated into development of the improvement plan. This included a sector-wide pre-planning workshop, cultural consultation workshops, consumer meetings, and a presentation of draft measures, milestones and interventions to stakeholders, the Steering Group and Alliances. Feedback received from the engagement sessions was incorporated into development of the improvement plan.

The 2018/19 Improvement Plan was shared with the DHB Māori, Pacific and Asian health gain teams and their feedback was incorporated. Consultation with other relevant cultural groups and equity partners has been an essential part of this process. The 2018/19 SLM Improvement Plan was designed to align with DHB Māori Health Plans.

The 2019/20 plan is a consolidation of the 2018/19 plan and therefore continues with a strong focus on equity. There is ongoing engagement and dialog with Māori and Pacific providers with a view to improving service integration.

4.2 Regional Working

As in previous years, a single improvement plan has been developed in 2019/20 for the Alliances and three Metro Auckland DHBs. As a number of PHOs cross the Metro Auckland DHB boundaries and are members of both Alliances this is considered the most practical and achievable approach given limited resources. Improvement milestones and contributory measures have been carefully selected to take into account the context, population and current performance of each DHB in the wider Auckland region. One regional plan also promotes closer regional collaboration between stakeholders, and ensures that patient outcomes are promoted in a consistent way.

4.3 2019/20 Priorities for System Level Measures

The 2019/20 plan continues to focus on cross–system activities which have application to multiple milestones as demonstrated in the ‘interrelated activity for collective impact’ diagram in Section 2. An extensive stocktake was conducted with both primary and secondary care stakeholders to establish the uptake of the SLM activities, identify barriers and focus on the areas for prioritisation for the 2019/20 plan. The results of the stocktake were discussed with the Implementation Group and clinical leaders before being considered by the Steering Group. The aim was to consolidate the plan.

This year we also recognise those activities which enable achievement of the SLM activities and milestones. This essential work is the foundation for quality improvement activities, and illustrates enabling activities such as building relationships, providing support and education, and creating and maintaining essential data management processes.

Overarching priorities for 2019/20 continue to adopt a prevention approach, and focus on improvements in equity of outcome or access. These activities support intervention in high risk populations, and collective impact. They were developed and planned with a population focus that included specific consultation with patients, family and whānau, and community. Some contributory measures aim for improvement in specific populations such as Māori and Pacific, particularly where significant inequity exists. It is expected that activity to improve these measures will also improve results for the total population as the processes are universal with a focus on high risk groups.

5. ENABLERS TO CAPACITY AND CAPABILITY

ENABLERS TO CAPACITY AND CAPABILITY

TRAINING AND EDUCATION	▪ SLM related Continuing Medical Education/ Continuing Nursing Education is filmed and shared regionally ▪ Health literacy improvement ▪ Auckland Regional HealthPathways ▪ Resources and key messages on various SLM work streams ▪ Planned communications of key messages at regular intervals.
DATA AND INFORMATION MANAGEMENT	▪ SLM data definitions, sourcing, analysis and reporting ▪ Ongoing use of the Metro Auckland Data Sharing Framework ▪ Increased use of data to inform implementation and improvement activities ▪ National Child Health Information Platform being rolled out in A/WDHB and Northland. Offers similar functionality to Kidzlink in CMH ▪ Advanced forms for improved data collection ▪ Commitment to equity view in data analysis and reporting, identifying areas for Māori and Pacific health gain.
SYSTEMS PARTNERSHIP	▪ Lead Maternity Carer (LMC) ▪ Well Child Tamariki Ora (WCTO) ▪ Auckland Regional Dental Services (ARDS) ▪ Immunisation Advisory Center (IMAC) ▪ Association with Auckland Regional Public Health Service (ARPHS) ▪ Pharmacy support ▪ Community laboratories ▪ Primary Care teams ▪ Secondary Care services ▪ Māori and Pacific providers ▪ Health navigators and health coaches ▪ School based health services.
QI SUPPORT	▪ Use of improvement methodologies underlying improvement activities ▪ Supported integration of cross-sectorial improvement activities.
CLINICAL LEADERSHIP	▪ Liaison with Metro Auckland Clinical Governance Forum ▪ Population health clinical leadership in planning and implementation.
CULTURAL LEADERSHIP	▪ Stepwise consultation and feedback huis with Māori and Pacific providers ▪ Support from Mana Whenua.

6. SYSTEM LEVEL MEASURES 2019/20 MILESTONES

Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds	
System Level Outcome	Keeping children out of hospital
Improvement Milestone	**3% reduction for total population by 30 June 2020.** **3% reduction for Māori populations by 30 June 2020.** **3% reduction for Pacific populations by 30 June 2020.**

Total Acute Hospital Bed Days	
System Level Outcome	Using health resources effectively
Improvement Milestone	**3% reduction for Māori populations by 30 June 2020.** **3% reduction for Pacific populations by 30 June 2020.**

Patient Experience of Care	
System Level Outcome	Ensuring patient centred care
Improvement Milestone	**Hospital inpatient survey: 5% improvement on Inpatient survey question: ‘Did a member of staff tell you about medication side effects to watch for when you went home?’ by 30 June 2020.** **Primary care survey: 10% relative improvement on PES question: ‘When you ring to make an appointment how quickly do you usually get to see your current GP?’ by 30 June 2020.**

Amenable Mortality	
System level outcome	Preventing and detecting disease early
Improvement milestone	**6% reduction for each DHB (on 2013 baseline) by 30 June 2021.** **2% reduction for Māori and Pacific by 30 June 2020.**

Youth Access to and Utilisation of Youth-appropriate Health Services	
System level outcome	Young people manage their sexual and reproductive health safely and receive youth friendly care Young people experience less alcohol and drug related harm and receive appropriate support
Improvement milestone	**Increase coverage of chlamydia testing for males to 6% by 30 June 2020.** **Reduce ‘unknown’ alcohol related ED presentation status to less than 10% by 30 June 2020.**

Babies in Smokefree Homes	
System level outcome	Healthy start
Improvement milestone	**Increase the proportion of babies living in a smokefree homes by 2% by 30 June 2020.**

7. IMPROVEMENT ACTIVITIES AND CONTRIBUTORY MEASURES

The following section outlines the specific improvement activity plan for the six SLMs for 2018/19. Improvement activities create change and work towards improved outcomes in the various SLM milestones. These activities are measured locally by contributory measures which support a continued focus in each area. Activities support the improvement of the system as a whole. For 2018/19, Auckland Metro region are focused on choosing activities which relate to multiple milestones where possible for best collective impact.

7.1 Ambulatory Sensitive Admissions in 0-4 year olds

Activities	Contributory Measure
Increase uptake of children's influenza vaccination to prevent respiratory admissions by: • Improving vaccination rates in primary care of children aged 0-4 years with previous respiratory admissions through the provision of data, practice-level improvement activities, and following up reporting of vaccination uptake provided throughout the season. • Prioritised vaccination of eligible Māori and Pacific children.	Influenza vaccination rates for eligible Māori and Pacific children. Target 15%.
Promote maternal influenza and pertussis vaccination as best protection for very young babies from respiratory illness leading to hospital admission by: • Implementing the Early Pregnancy Assessment Tool (EPAT) so it can function as a pregnancy register in primary care. • Identifying pregnant women through booking and set immunisation recalls in primary care. • Opportunistic immunisation at antenatal clinics. • Promotion of pregnancy immunisation especially to Māori and Pacific women, through the use of vouchers, in primary care, pharmacy, LMC, and in other pregnancy service providers.	Influenza and pertussis vaccine coverage rates for pregnant Māori and Pacific. Target 50%.
Support a decrease in respiratory admissions with social determinants by: • Increasing e-referrals rates from primary care to healthy housing programmes by identifying practices with low referral rates and prompting referral using EPAT, with a focus on pregnant low income Māori and Pacific women.	Baseline measurement of referrals to Healthy Housing/AWHI.
• Supporting mothers and whānau of babies to live in smokefree homes by increased referrals from LMCs, primary care, healthy housing programmes, pharmacies and other referrers, to pregnancy smokefree services. • Increase referral of pregnant women who smoke for support to stop smoking when they visit general practice to confirm their pregnancy.	Referrals to maternal incentives smoking cessation programmes, for pregnant women. Target each quarter: 27 for ADHB; 58 for WDHB, and 180 for CMH.
Improve the quality of data collected on post-natal smoking, as an indicator of smoking in pregnancy, by supporting Well Child Tamariki Ora providers to improve the quality of smoking status data, through feedback, education and reporting.	
Support population groups who have inequitable child health outcomes by: • Implementing the National Child Health Information Platform (NCHIP) for ADHB and WDHB to align with Kids Link in CMH. • Promotion of enrolment with WCTO providers opportunistically in primary care, particularly for Māori and Pacific children.	

Milestones: The Ambulatory Sensitive Hospitalisations for 0-4 years, Amenable Mortality, Babies in Smokefree Homes and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.2 Youth Sexual and Reproductive Health

Activities	Contributory Measure
Improve chlamydia testing in young people 15-24 years old in particular, and in sexual and reproductive health of youth in general by: • Increasing engagement with young people by working with general practices and other youth healthcare providers to improve the youth friendliness of settings and enrolment rates. • Increasing sexual health screening by improving access to screening (including opportunistic) and screening for pregnant women. • Reporting the rate of chlamydia testing coverage across all youth health specific services, with a view to those with outstanding performance championing best practice in youth healthcare, and services with low testing coverage rates increasing their testing rates. • Implementing chlamydia prevalence reporting to relevant stakeholders, with an expectation that this prevalence will increase as testing improves.	Rate of chlamydia testing (reported by gender and ethnicity) for 15-24 year olds. Target 6% for males.

Milestones: The Youth milestone will be improved by these activities.

7.3 Alcohol Harm Reduction

Activities	Contributory Measures
Improve data collection and reporting on alcohol harm reduction interventions through: • Establishment of an alcohol ABC baseline in primary care for reporting indicators. • Quality improvement activities focused on implementing Alcohol ABC in practice.	Percentage of the enrolled population aged over 14 years with alcohol status documented. Target 40%.
Quality improvement activities focused on data collection for alcohol-related ED presentations, including youth.	Establish a baseline for alcohol-related ED presentations. Reduce 'unknown' alcohol related ED presentation status to less than 10% by 30 June 2020.
Take an integrated approach to alcohol harm reduction by working with other systems partners: • Work with ambulance services and urgent/after-hours services to explore the availability of alcohol-related data and feasibility of adopting/developing alcohol ABC data standard and reporting. • Work with student and other youth health services to explore the availability of alcohol-related data and feasibility of adopting/developing alcohol ABC data standard and reporting.	

Milestones: The Amenable Mortality, Total Acute Hospital Bed Days and Youth milestones will be improved by these activities.

7.4 Smoking Cessation for Māori and Pacific

Activities	Contributory Measure
Patient outcomes related to harm from smoking will be improved by: • Regularly reporting rates of referrals to cessation support and rates of medication therapy in primary care. • Use of a surveillance report to monitor smoking prevalence by ethnicity and age. The importance of smoking cessation as an intervention will be promoted by: • Continued working with cessation providers, including pharmacy, to strengthen relationships and enable access and integrated approaches to care alongside primary and community services. • Further development of smoking indicators for quality, to inform primary care approaches and interventions from PMS. • Development of a communication plan with regular updates to primary care and other referrers (i.e. LMCs, WCTO) to increase engagement in smoking cessation. Data quality will be improved by continued development of the Metro Auckland smoking indicators.	Rate of referral to smoking cessation providers by PHO. Target 6%. Rate of prescribing of smoking cessation medications by PHO. Target 12%.

Milestones: The Ambulatory Sensitive Hospitalisations for 0-4 years, Amenable Mortality, Babies in Smokefree Homes and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.5 Cardiovascular Disease (CVD) Risk Assessment and Management

Activities	Contributory Measure
Primary care and systems partners work together to support equitable CVD Risk Assessment (RA) for Māori by: • Provision of prioritised lists of eligible patients for risk assessment to practices, with Māori and Pacific first. • Referral of highest risk Māori to culturally appropriate providers for self-management and wellness support. Identification of and support to enrol Māori patients who are seen by Māori providers and are not enrolled in primary care. Implement a process to ensure all PHOs will have the ability to calculate and update CVD risk consistent with the National Consensus Statement for Assessment and Management of CVD in Primary Care. Continued reporting of the indicator 'prescribed dual therapy for those with CVD RA greater than 20%', with a view to emphasis of the importance of this intervention, throughout change created by the implementation of the National Consensus Statement for Assessment and Management of CVD in Primary Care.* Where the equity gap for Māori and Pacific has closed, PHOs are to identify other populations with unequitable access and facilitate interventions for those groups Reporting and improvement of clinical management through prescribing is facilitated through: • Continued development of NHI level reporting in secondary prevention. • Comparing dispensing data to prescribing data and identifying any opportunities for improvements.	CVDRA rates for Māori. Target 90%. Percentage of Māori with a previous CVD event who are prescribed triple therapy. Target 70%.
Improved outcomes for patients with a high risk of CVD event are sought by: • Patients who have previously had a CVD event and who are eligible receive the funded influenza vaccination. Monitored by DHB and ethnicity. Coverage will be monitored for the 65 – 74 year age group • Interventions to improve uptake of triple therapy for Māori and Pacific people. Opportunities to improve data collection and quality are advanced through: • Development and baselines for a set of quality indicators to support the implementation of CVD consensus statement (with a focus on coding specified conditions e.g. IHD, AF, CKD, diabetes). ***Note:** We anticipate a disruption in the data for primary prevention with the implementation of the new CVD Consensus Statement therefore this has been removed as a contributory measure for this year, although monitoring will continue.	Influenza vaccination rate for patients with a prior CVD event under 65 years of age. Target 35%.

Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.6 Complex Conditions and Frail Elderly

Activities	Contributory Measures
Māori and Pacific patients with ASH conditions (e.g. CHF, CVD, COPD, AF/Stroke and Cellulitis) receive appropriate clinical support: • Māori and Pacific patients aged 45-64 with ASH conditions who are eligible receive the funded influenza vaccination. • Māori and Pacific patients who present in primary care with ASH conditions, or comorbidities which contribute to ASH conditions, are referred to appropriate self-management or wellness support services.	ASH rate for both Māori and Pacific adults aged 45-64 years old. Target 2% reduction. Baseline influenza vaccine coverage for patients with an eligible ASH condition and establish an improvement target.
Improve coding in primary care for specified long term and complex conditions (e.g. COPD and CHF) by matching ICD10 codes from secondary care with PHO registers and developing a process to supplement coding as clinically appropriate.	
Primary care collaborates with Māori providers to identify the Māori primary care population with long term conditions with a view to additional support.	
Increase referral of patients at high risk of falls to an appropriate Strength and Balance Falls Prevention Programme.	Rates of referrals of eligible older people to appropriate Strength and Balance Falls Prevention Programmes.

Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.7 Primary Options for Acute Care (POAC)

Activities	Contributory Measure
Primary and secondary care will work together with the POAC team to increase utilisation of POAC for high needs populations, particularly Māori and Pacific people aged 45-64 by: • Promotion of POAC and referral pathways within general practice. • Focussing on increasing utilisation of POAC for ASH conditions, particularly, CHF, COPD and cellulitis. • Linking with ambulance services to increase POAC utilisation where patients are able to be best managed in the community, if transport or social requirements are met. • Investigation of options for supportive, early discharge from hospital, such as usage of POAC, interim care, or early discharge services managed by primary, community or secondary care providers.	POAC initiation rate for 45-64 year old Māori and Pacific people with ASH conditions. Target 3 per 100 for each PHO.

Milestones: The Amenable Mortality and Total Acute Hospital Bed Days milestones will be improved by these activities.

7.8 E-portals

Activities	Contributory Measure
Continued support for patient enrolment (logon) to e-portals by practices (given that unique email addresses are a critical dependency) by carrying out the following activities: • Receptionist training and socialisation. • Linking with practice accreditation processes. • Ensuring information and resources are available to practice teams. • Greater visibility on 'How to' log on is promoted in practices.	Percentage of each PHO's enrolled population with login access to a portal. Target 30%.

Milestones: The Patient Experience of Care milestone will be improved by these activities.

7.9 Patient Experience Surveys in Primary and Secondary Care

Activities	Contributory Measure
Primary care will improve patient experience by: • Working with early adopter practices to champion engagement. • Prioritising feedback from Māori and Pacific patients. • Participating in CQI activity via 'PES to PDSA' or 'You said – We did activity/Kōrero mai'. • Developing a PDSA activity focussed on Māori and Pacific. • PHO to practice support continues in monitoring and managing reports post survey week. • Practices utilise feedback from patients and whānau when making changes in the practice.	Practice participation rate in the PHC PES as at end June 2019. Target: maintain or increase current rates. Percentage of valid email addresses in the PMS for patients invited to participate in the PES.
Secondary care will improve patient experience by: • Focusing on the medication safety question in the National Inpatient Survey with a multidisciplinary approach. • Focussing on culturally appropriate patient centred information • Co-design of patient experience initiatives with a focus on Māori and Pacific people (CMDHB) • Develop an integrated approach to feedback so patient stories can be heard outside of traditional survey collection mechanisms (ADHB and WDHB). • Develop a Māori Patient Experience plan endorsed by Māori Health Equity Committee (WDHB) • Convene Consumer Council to advise on DHB priorities, strategy, health literacy and patient experience (WDHB) • Sharing learnings with primary care through established networks and forums. • Improving visibility of reporting of Māori and Pacific response rates, with a view to encouraging awareness via activities as noted above.	Average score in Inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?'. Target 5% improvement.
Primary and secondary care will work together to explore the underlying data for Māori and Pacific patients enrolled in primary care to identify barriers to participations in the PHC PES.	
Milestones: The Patient Experience of Care milestone will be improved by these activities.	

8. SYSTEM LEVEL MEASURE MILESTONES IN DETAIL

8.1 Ambulatory Sensitive Hospitalisation Rates per 100,000 for 0 – 4 Year Olds

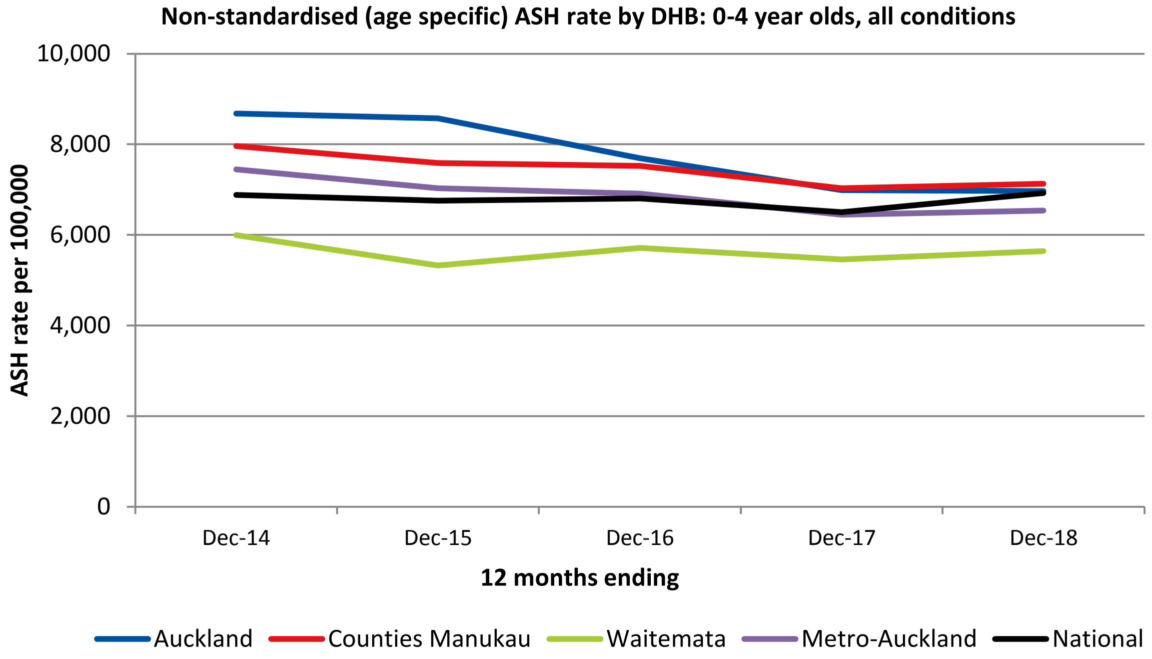
System Level Outcome	Keeping children out of hospital
Improvement Milestone	**3% reduction for total population by 30 June 2020.** **3% reduction for Māori populations by 30 June 2020.** **3% reduction for Pacific populations by 30 June 2020.**

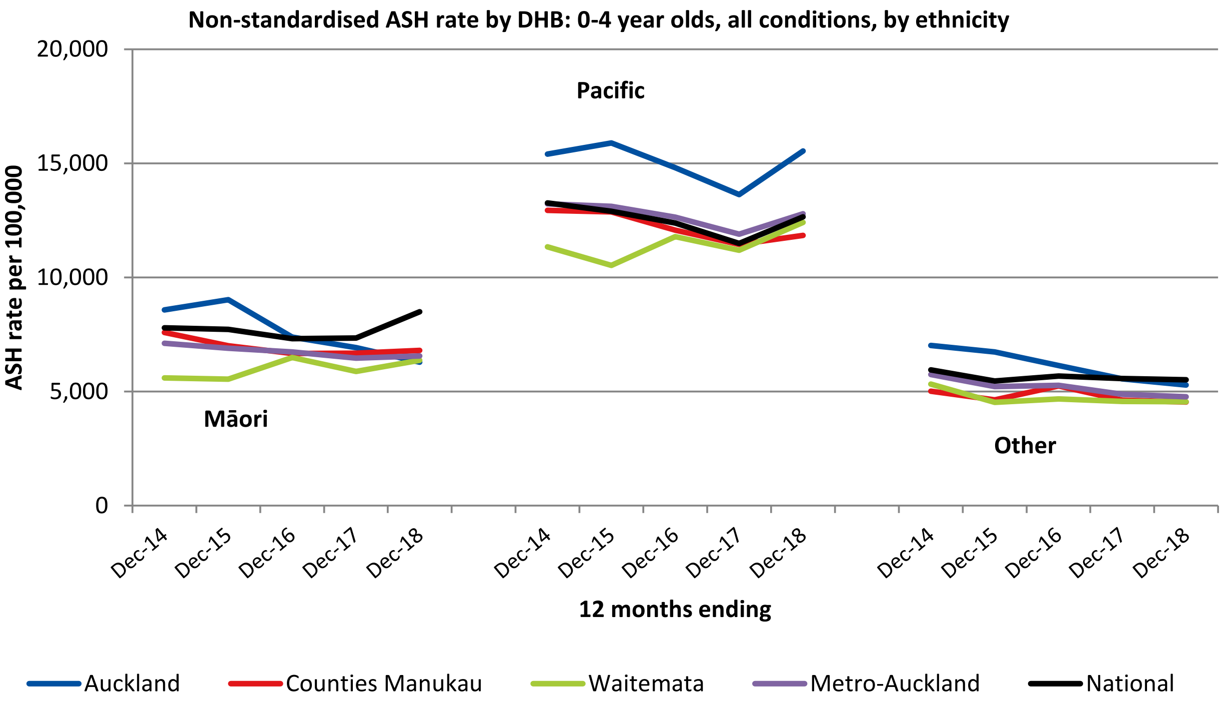
Ambulatory sensitive hospitalisations are admissions considered potentially preventable through pre-emptive or therapeutic interventions in primary care. The admissions included are made up of a specified set of discharge codes considered to be ambulatory sensitive, and are assigned based on the primary diagnosis. This is a challenging indicator as social determinants of health are a significant contributor. The amount realistically amenable to timely access to quality primary care has not been quantified and there is little evidence about what works outside of immunisation for vaccine preventable diseases. Despite these challenges there are many promising approaches.

In addition to paediatric and maternal immunisation, smoking cessation and improving the housing environment are important for improving this milestone. This year we have chosen to focus on these aspects of the Child and Adolescent Asthma Guidelines, fitting with a broader focus on respiratory admissions, which is the largest contributor to Ambulatory Sensitive Hospitalisations in 0-4 across the three DHBs.

We plan to build on improvements in immunisation rates and spread the methodology to other high risk cohorts which will improve outcomes in acute hospital bed days.

This year we aim to continue our focus on equity with an improvement for Māori and Pacific rates.




Non-standardised ASH rate by DHB: 0-4 year olds, all conditions, by ethnicity
ASH rate per 100,000
20,000
15,000
10,000
5,000
0
Pacific
Māori
Other
Dec-14
Dec-15
Dec-16
Dec-17
Dec-18
Dec-14
Dec-15
Dec-16
Dec-17
Dec-18
Dec-14
Dec-15
Dec-16
Dec-17
Dec-18
12 months ending
Auckland
Counties Manukau
Waitemata
Metro-Auckland
National

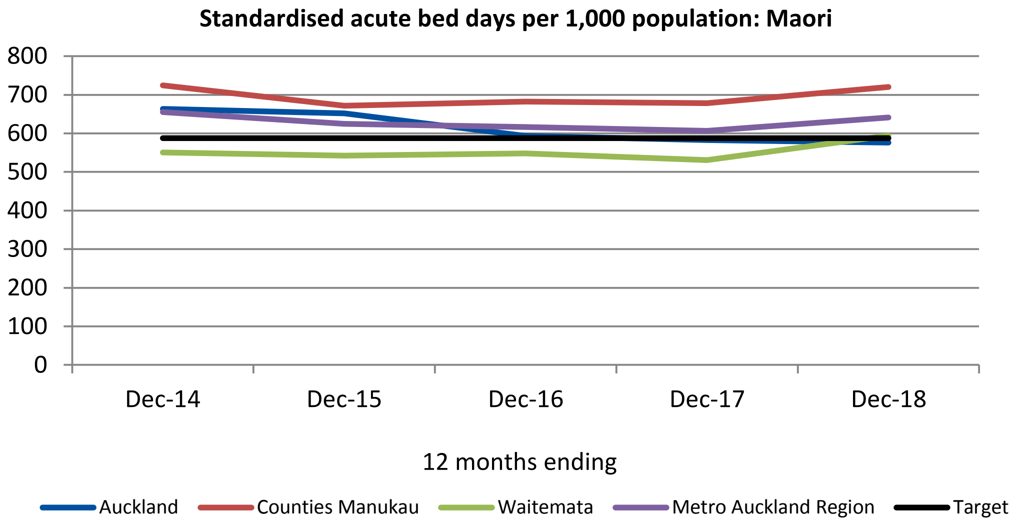
8.2 Total Acute Hospital Bed Days

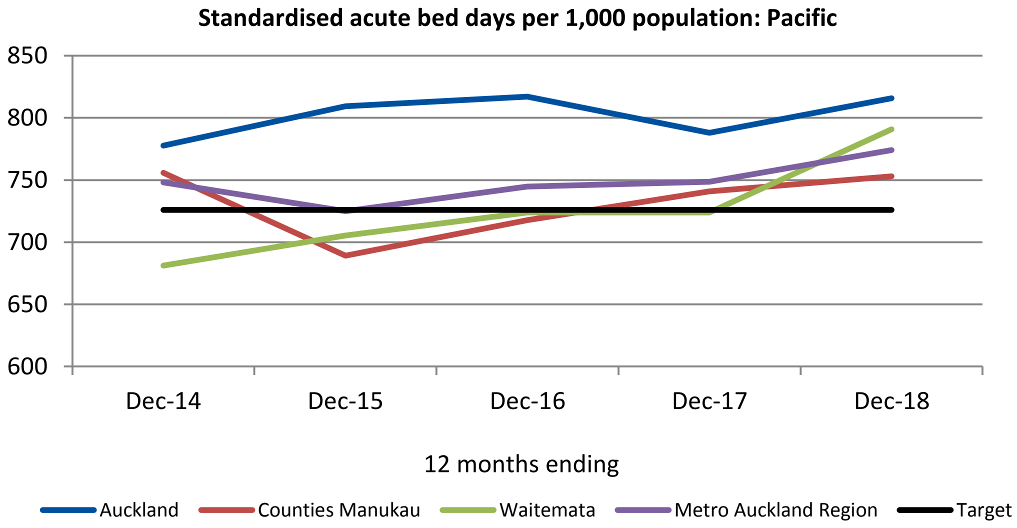
System Level Outcome	Using health resources effectively
Improvement Milestone	**3% reduction for Māori population by 30 June 2020.** **3% reduction for Pacific population by 30 June 2020.**

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by efficiencies at a facility level, effective management in primary care, better transition between community and hospital settings, optimal discharge planning, development of community support services and good communication between healthcare providers. The intent of the measure is to reflect integration between community, primary and secondary care, and it supports the strategic goal of maximising the use of health resources for planned care rather than acute care. We will achieve a greater reduction in acute bed days for higher risk populations via targeted initiatives to improve the health status of Māori and Pacific peoples in particular. Specific targets for these populations are higher due to the inequity when compared to the total population.

We plan to target populations most likely to be admitted or readmitted to hospital, and focus on prevention and treatment of conditions that contribute the most to acute hospital bed days. Priority areas include alcohol harm reduction, CVD management, influenza vaccination for high risk groups and effective use of POAC. Conditions identified as highest priority include congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). Coding for these conditions in primary care will be improved so effective interventions can be targeted.

Total acute hospital bed days for 2018/19 for Māori and Pacific identify marked inequities when compared to non-Māori, non-Pacific rates, so we will continue to focus on patients from this population in addition to the prioritised conditions.





8.3 Patient Experience of Care

System Level Outcome	Ensuring patient centred care
Improvement Milestone	**Hospital inpatient survey: 5% improvement on Inpatient survey question: 'Did a member of staff tell you about medication side effects to watch for when you went home?' by 30 June 2020.** **Primary care survey: 10% improvement on PES question: . 'When you ring to make an appointment how quickly do you usually get to see your current GP?' by 30 June 2020.**

Patient experience is a good indicator of the quality of 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. The Health Quality and Safety Commission (HQSC) patient experience survey (PES) domains cover key aspects of a patient's experience when interacting with health care services: communication, partnership, coordination, and physical and emotional needs.

The 2019/20 plan reflects a shift from response rates to improvement in low scoring survey questions.

Hospital Inpatient PES: This has been in place since 2014. The milestone for 2019/20 focuses on the knowledge patients have about possible medication side effects when they are discharged from hospital. This will be achieved by multidisciplinary teams focusing on patient empowerment, health literacy, equity, and community awareness. This will be supported by continued work on culturally appropriate communication and health literacy.

Primary Health Care PES: The PHC PES was developed more recently and has continued to be implemented in practices over the 2018/19 year. The focus this year is to increase engagement of patients with the survey and strengthening a culture of quality improvement. This use of patient feedback and PDSA improvement cycles will lead to changes in practices that are important to patients.

8.4 Amenable Mortality

System level outcome	Preventing and detecting disease early
Improvement milestone	**6% reduction for each DHB (on 2013 baseline) by 30 June 2021.** **2% reduction for Māori and Pacific by 30 June 2020.**

Two contributory measures have been consistent in amenable mortality improvement planning to date, those that have the greatest evidence-based impact – cardiovascular disease (CVD) management and smoking cessation. In 2019/20 we aim to build on the work already by continuing to prepare for the new Consensus Statement for Assessment and Management of CVD. We plan to achieve a 2% reduction in our milestone for each DHB to contribute to our 2021 target.

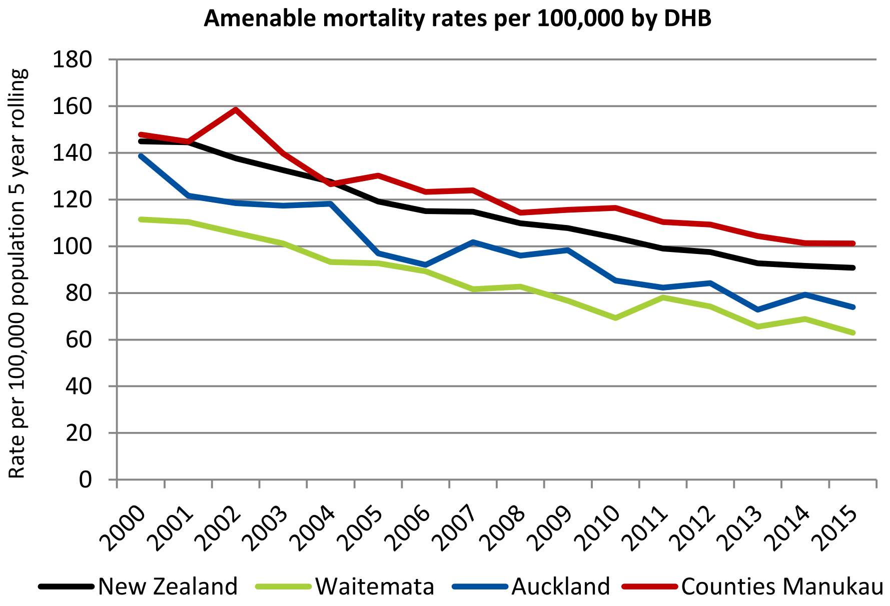
CVD is a major cause of premature death in New Zealand and contributes substantially to the escalating costs of healthcare. Modification of risk factors, through lifestyle and pharmaceutical interventions, has been shown to significantly reduce mortality and morbidity in people with diagnosed and undiagnosed CVD. Patients with established CVD (and those assessed to be at high CVD risk) are at very high risk of coronary, cerebral and peripheral vascular events and death, and should be the top priority for prevention efforts in clinical practice.

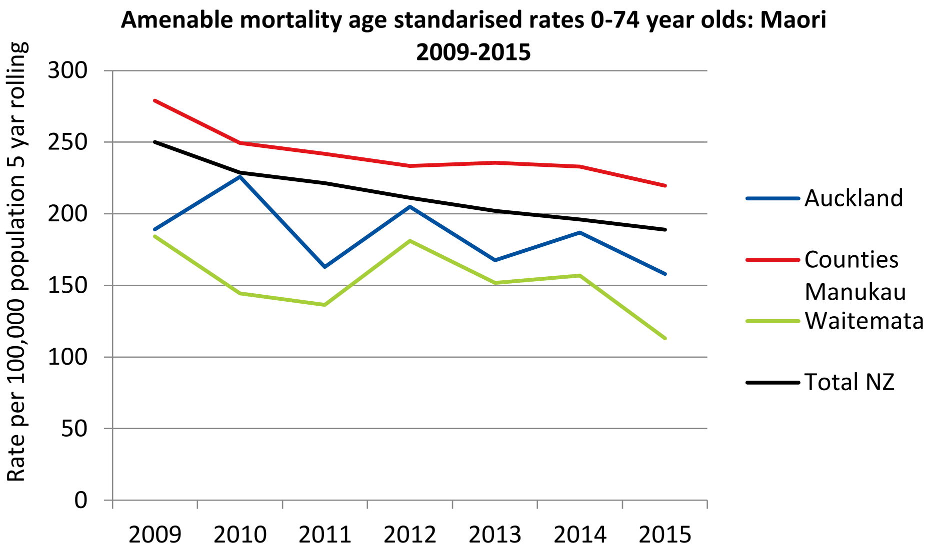
The burden of CVD falls disproportionately on Māori and Pacific populations, and there are well-documented inequities in CVD mortality, case fatality and incidence. Reducing these inequities is a high priority and can be achieved through increased use of evidence-based medical management of high-risk patients.

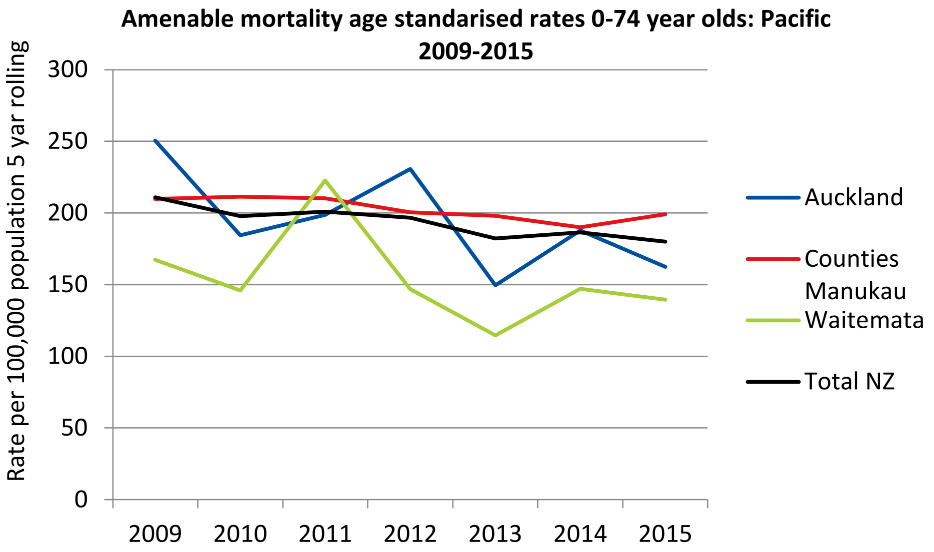
Tobacco smoking is a major public health problem in New Zealand. In addition to causing around 5,000 deaths each year, it is the leading cause of disparity, contributing to significant socioeconomic and ethnic inequalities in health. In 2011, the Government set a goal of reducing smoking prevalence and tobacco availability to minimal levels, essentially making New Zealand a smoke-free nation by 2025. In 2013, 15% of New Zealanders smoked tobacco every day. That rate was even higher among Māori (33%) and Pacific people (23%). Differences continue to be evident in the prevalence of smoking between the three ethnicity groupings of European/Other, Māori and Pacific.

We plan to connect this work with the Better Help for Smokers to Quit indicator which will support improved outcomes.

The 2019/20 plan will also focus on implementation of the Alcohol ABC programme. This is an evidence based programme to decrease harm from excessive alcohol consumption




Amenable mortality age standarised rates 0-74 year olds: Maori 2009-2015
Rate per 100,000 population 5 yar rolling
300
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
Auckland
Counties Manukau
Waitemata
Total NZ


Amenable mortality age standarised rates 0-74 year olds: Pacific 2009-2015
Rate per 100,000 population 5 yar rolling
300
250
200
150
100
50
0
2009
2010
2011
2012
2013
2014
2015
Auckland
Counties Manukau
Waitemata
Total NZ

8.5 Youth Access to and Utilisation of Youth-appropriate Health Services

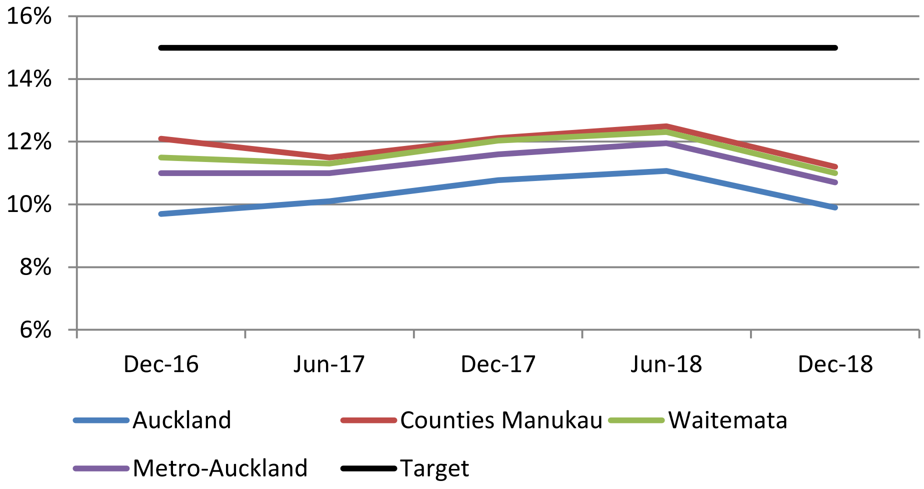
System level outcome	Young people manage their sexual and reproductive health safely and receive youth friendly care Young people experience less alcohol and drug related harm and receive appropriate support
Improvement milestone	**Increase coverage of chlamydia testing for males to 6% by 30 June 2020.** **Reduce 'unknown' alcohol related ED presentation status to less than 10% by 30 June 2020.**

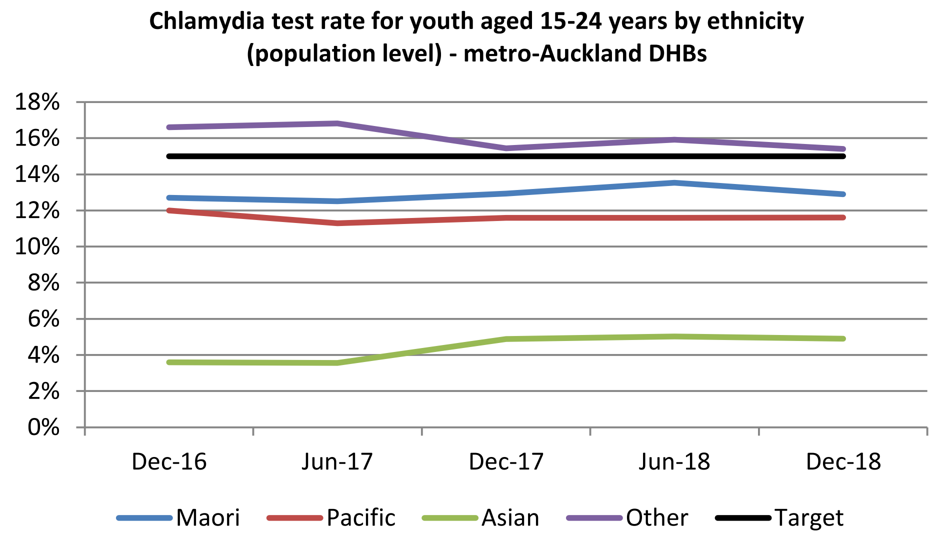
Youth have their own specific health needs as they transition from childhood to adulthood. Most youth in New Zealand successfully transition to adulthood but some do not, mainly due to a complex interplay of individual, family and community stressors and circumstances, or risk factors. Research shows that youth whose healthcare needs are unmet may progress to adults with an increased risk for poor health and overall poor life outcomes through disengagement and isolation from society and riskier behaviors, in terms of drug and alcohol abuse and criminal activities.

Chlamydia testing coverage: This is an indicator of young people's access to confidential youth appropriate comprehensive healthcare. For those young people 15 years and older who have been, or are sexually active, access to chlamydia testing is an indicator of access to condoms, contraceptives, and to a discussion with a clinician about consent, sexuality and other harm minimisation. For some young people this may mean addressing their safety, unmet mental health needs, or alcohol and drug problem.

Chlamydia is the most commonly reported sexually transmitted infection in Auckland. It is most often diagnosed in females aged 15-19 years and in males aged 20–24 years. Māori and Pacific young people have substantially higher rates of chlamydia than non-Māori non Pacific youth. In addition, when tested, males are more likely to test positive, although this may be because they are only presenting when they have symptoms. In the UK, data from the youth screening programme shows that more than 50% of 16–24 years olds with chlamydia have no or non-specific symptoms. For testing coverage to be effective in reducing the prevalence of chlamydia it needs to target those who have the highest risk of infection, namely males, and Māori and Pacific youth of either gender.

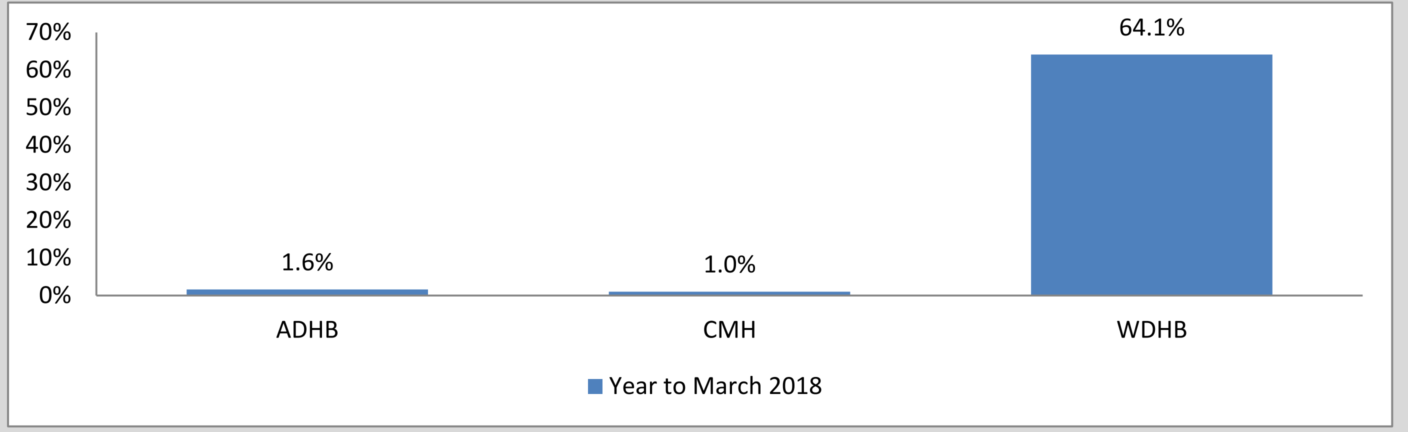
Chlamydia test rate for youth aged 15-24 years (population level)





Alcohol-related ED presentations: Identifying and monitoring alcohol-related ED presentations will enable better understanding of alcohol harm and which populations and communities are most affected. From July 2017, a mandatory data item was added to the National Non-admitted Patient Collection. In some DHBs, full implementation and reporting to the Ministry is not complete. The mandatory question is “Is alcohol associated with this event?” Possible answers are: yes, no, unknown and secondary (e.g. passenger in car driven by drunk driver, or victim of violence where alcohol is involved). It should be noted that the response recorded may be a subjective assessment by healthcare staff and not confirmed by alcohol testing. Data quality is still poor, with significant missing data in some areas, therefore the 2019/20 plan will focus on quality improvement for alcohol data collection across primary care, youth services, and emergency departments.

Alcohol-related ED presentations – Percentage of total ED attendances with ‘unknown’ alcohol relationship status



8.6 Babies in Smokefree Homes

System level outcome	Healthy start
Improvement milestone	**Increase the proportion of babies living in smokefree homes by 2%**

The definition of a smoke-free household is one where no person ordinarily resident in the home is a current smoker. This measure is important because it aims to reduce the rate of infant exposure to cigarette smoke by focusing attention beyond maternal smoking to the home and family/whānau environment. It will also encourage an integrated approach between maternity, community and primary care. It emphasises the need to focus on the collective environment that an infant will be exposed to – from pregnancy, to birth, to the home environment within which they will initially be raised. Of note, smoking during pregnancy and exposure to tobacco smoke in infancy is highest for Māori and Pacific.

The definition of this indicator has recently changed so we only have one data point and cannot compare with older data.

Babies living in smokefree homes at 6 weeks postnatal

Reporting period	DHB of Domicile			
	New Zealand	Auckland	Counties Manukau	Waitemata
Jan 18 - Jun 18	53.8%	66.8%	52.8%	61.9%

There is still some work to be done, as data does not reflect live births. This may be improved by an increase in the proportion of births enrolled with WCTO providers. This work should support both smoking intervention in pregnancy and the post-natal period, and continued quality data collection in the Well Child Tamariki Ora space.

9. GLOSSARY

ABC	Assessment, Brief Advice, and Cessation Support
ADHB	Auckland District Health Board
AF	Atrial Fibrillation
ARDS	Auckland Regional Dental Service
ARPHS	Auckland Regional Public Health Service
ASH	Ambulatory Sensitive Hospitalisations
A/WDHB	Auckland Waitemata District Health Boards
CHF	Coronary Heart Failure
CKD	Chronic Kidney Disease
CME/CNE	Continuing Medical Education/Continuing Nursing Education
CMH	Counties Manukau Health (referring to Counties Manukau District Health Board)
COPD	Chronic Obstructive Pulmonary Disorder
CVD	Cardiovascular Disease
CVD RA	Cardiovascular Disease Risk Assessment
DHB	District Health Board
ED	Emergency Department
GP	General Practice/General Practitioner
HQSC	Health Quality Safety Commission
IHD	Ischaemic Heart Disease
IMAC	Immunisation Advisory Center
LMC	Lead Maternity Carer
MACGF	Metro Auckland Clinical Governance Forum
MADSF	Metro Auckland Data Sharing Framework
PDSA	Plan, Do, Study, Act
PES	Patient Experience Survey
PHC PES	Primary Healthcare Patient Experience Survey
PHO	Primary Healthcare Organisation
PMS	Practice Management Systems
POAC	Primary Options for Acute Care
SLM	System Level Measure
SMI	Serious Mental Illness (refers to schizophrenia, major depressive disorder, bipolar disorder, schizoaffective disorder as per the National Consensus Statement for Risk Assessment and Management of CVD in Primary Care)
STI	Sexually Transmitted Infection
UK	United Kingdom
WDHB	Waitemata District Health Board
WCTO	Well Child Tamariki Ora