Capital & Coast DHB

System Level Measures Improvement Plan 2016/17

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on behalf of the CCDHB Integrated Care Collaborative (ICC) Alliance

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Signatories

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SIGNED on behalf of Well Health Trust PHO by:

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Introduction

Background

A System Level Measures Framework (SLMF) has been developed with a system-wide view of performance, building on the previous Integrated Performance Incentives Framework (IPIF). This is in response to a desire to lift performance measurement from a transactional approach to one based on outcomes, and aligns with the refreshed New Zealand Health Strategy. The Ministry of Health has worked with the sector to co-develop a suite of system level measures to support this whole-of-system view of performance.

CCDHB has committed to work in partnership to jointly develop and agree the 2016/17 Improvement Plan with the Integrated Care Collaborative Alliance Leadership Team (ALT) to be submitted to the Ministry of Health by 20 October 2016. The following plan includes the following:

- Improvement Milestones for four System Level Measures(SLMs)
- A set of contributory measures for the above SLMs, including quantitative year-end goals
- District ALT stakeholder agreement to the plan, milestones and measures (DHB and PHO at a minimum).

In addition the DHB has local Improvement Plan material that includes:

- Activities to meet the Improvement Milestones for SLMs and the quantitative goals for selected contributory measures
- An investment logic, including the above activities and key stakeholder contributions (dollars or resource)
- A local reporting and accountability framework.

2016/17 System Level Measures

The four System Level Measures (SLMs) being implemented from 1 July 2016 are:

- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
- Acute hospital bed days per capita
- Patient experience of care
- Amenable mortality rates under 75 years.

Two additional measures are being developed in 2016/17 for implementation in 2017/18:

- Proportion of babies who live in a smoke-free household at six weeks post natal
- Youth access to and utilisation of youth-appropriate health services.

The following three SLMs and two primary care Health Targets will be incentivised through the Primary Health Organisation (PHO) Services Agreement in 2016/17:

- Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0-4 year olds
- Acute hospital bed days per capita
- Patient experience of care
- Better help for smokers to quit
- Increased immunisation for eight month olds (95 percent of eight months olds will have their primary course of immunisation - six weeks, three months and five months immunisation events - on time).

CCDHB SLM Plan Development 2016/17

Collaborative Development Teams

The ICC ALT and Programme Board provided direction for the development processes undertaken. The development has been led by a collaborative SLM Development Group that has been led by the ICC Programme Manager. The SLM Development Group has including the following:

- PHO CE and/or Clinical Quality Leads
- Hospital Services Quality Team
- Director of Nursing, Primary & Integrated Care
- CCDHB GP Clinical Advisor
- Primary/Secondary Clinical Governance Group Chair
- ICC ALT Programme Manager & Co-ordinator

Additional Groups that have been engaged with and/or provided with progress updates:

- CCDHB Primary/Secondary Clinical Governance Group
- ICC Child Health Steering Group
- Pacific Director, CCDHB
- Maori Directorate, CCDHB
- Child Health Team, SIDU
- GM, Mental Health & Addictions, SIDU

Development Stages

The SLM Development Group convened with sector wide membership, and discussions were facilitated by the ICC Programme Manager to progress the CCDHB SLM Improvement Plan. In the first instance the Group gained a shared understanding of the purpose and processes required to deliver the collaborative CCDHB SLM Plan. To support development a horizon scan of measures across the CCDHB Annual Plan, ICC ALT framework, PHO Quality Measures and Hospital Quality measures was undertaken. The Group then identified key system principles to guide the focus for the Improvement Plan development. These were then translated to the first cut selection of system goals, SLM milestones, contributory measures and potential improvement processes, which have collectively been refined to this CCDHB SLM Improvement Plan. The Group has also identified the opportunity to better configure oversight and governance of the CMs across the sector. Following agreement of the Improvement Plan by the Group, endorsement and approval has been sought by all key partners.

The final draft plan has been presented, and endorsed by the following:

- CCDHB Strategic EMT (with hospital and primary care leadership representation)
- Compass Health
- Cosine Primary Care Network Trust
- HHS Executive Team
- Ora Toa PHO
- Well Health Trust PHO

Future SLM Development

The ICC ALT and SLM Development Group have recommended that the development of future SLM Improvement Plans will be linked with discussions underway during the Annual Planning processes. This will enable them to be closer linkage with the improvement initiatives that may be introduced in subsequent years, and in the long term build on the Health Service Planning that is underway. Consideration will be made for the inclusion of measures including the uptake of the shared care plan, Advance Care Plan volumes, falls management measures and other cross sector developments that are on the horizon.

Principles for Improvement 2016/17

The ICC ALT and the Development Group agreed that the milestones for the SLMs should take into consideration the strategic priorities across the sector, focus on inequity and be attainable while supporting the current good performance of CCDHB.

In selecting the contributory measures the following principles were applied:

- Linked to current strategic priorities
- Relevant to family & whanau; clinicians; managers
- Focus that reduces inequity
- Relevant to vulnerable populations including but not limited to older people and children
- Impact on a reasonable sized population
- Balancing a mix of outcomes and outputs
- Performance can be influenced through stakeholders and partners engaged with the DHB
- Return on input investment

It has also been recognised that there are there are a number of contributory measures that would actually lead to improvements in a number of SLMs. However, the CCDHB SLM Development Group agreed that they would not be replicated across the SLMs.

Ambulatory Sensitive Hospitalisations 0-4yo: The CCDHB system will aim to maintain rates lower than the national average for 2016/17. For 0-4yo population, CCDHB has performed close to national average over the years and would like to move to a position to be lower than the national average with this plan. There are a number of initiatives underway, with a particular focus on Maori and Pacific populations, with likely further developed SLM for the following years. It is recognised that some of the preventative and proactive related work will require a significant time-lag for impact, so these have been identified as well as some more acute management approaches in the plan. Future plans and targets will reflect these, and aim to have further improvement in ASH rates for all populations.

Patient Experience of Care: The CCDHB system will aim for a target of >7.5 in the 4 patient experience domains in 2016/17. The plan includes a local composite measure of the hospital and PHO Patient Experience of Care. It is acknowledged that the data set will increase for the Primary Care Survey over time that could impact the composite, but the composite recognises the local PHOs/practices progress in the use of their survey and provides a clearer logic pathway for the improvement processes that CCDHB is looking to focus on. For each domain in the hospital survey and primary care survey, the results have been added together and then divided by two to give a local composite score. This approach has been discussed with the HQSC, who are supportive of this as local "interim composite". In setting the target we have aimed to maintain good performance across all elements, but make some provision for potential impact of the expansion of the primary care survey. Future plans may be more ambitious, as the use of patient experience surveys are spread across the sector.

Acute Bed Day: The CCDHB system will aim for a target of <400 acute bed days (ABD) per 1000 for 2016/17. While 400 ABD/1000 is higher than 2015/16 performance, CCDHB is aware that there continues to be growing complexity of their population, some of which will require hospital care. CCDHB has already achieved a relatively low acute bed day rate, through its effective length of stay management activities within the hospital and strong primary health care sector, and will continue on this focus as is evident in the logic provided. In the future we are looking to make improvements in acute bed days, however realise that the preventative, proactive and even new ways of acute care delivery that CCDHB has invested in are likely to require a significant time-lag for impact on the overall measure. There is also a need to recognise the growing complexity of the population groups in terms of setting the target for 2016/17. Future plans and targets will aim to continue to sustain good performance for admissions and length of stay in CCDHB.

Amenable Mortality: The CCDHB system will aim for a target of <80 in 2016/17 plan. The target recognises that the CCDHB system aims to continually deliver effective services, but recognises the growing morbidity of its population. Similar to initiatives for the other SLMs, there will be a significant time lag for some of the current initiatives. Nonetheless, these are recognised as important for the population and aim to focus on vulnerable populations as well as specific conditions that have been identified as significant contributors.

Improvement Plan

The following section outlines the agreed CCDHBs SLM improvement plan per 2016/17:

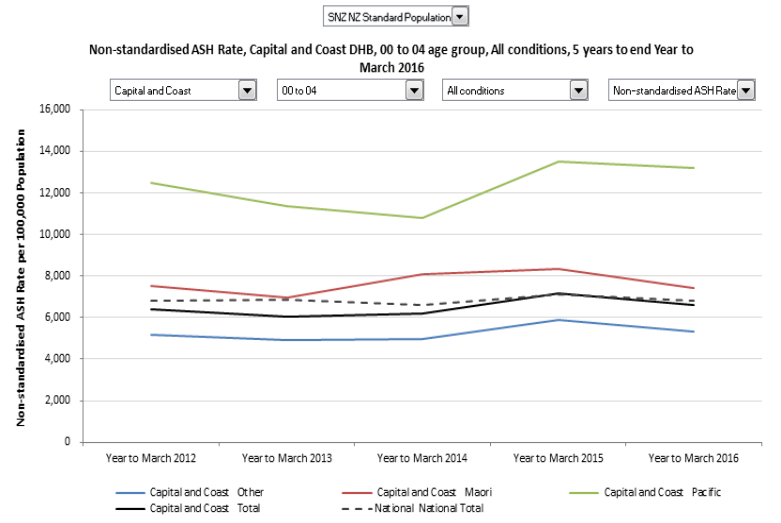
Ambulatory Sensitive Hospitalisations 0-4yo

Where we want to be

As a CCDHB system we want to our children to have a healthy start in life. One of the DHBs strategic goals is to improve child health and child health services in the Wellington Region. Our system will empower all families to maximise their children's health and potential. In doing so CCDHB will maintain rates lower than the national average rates for ASH 0-4yo in 16/17 and in the longer term look to make further improvements in ASH with a focus on reducing inequity.

Where we are now?

- Most years CCDHB rates are lower than national (excl 2015) average
- For specific conditions respiratory related conditions (resp infections, pneumonia), skin related (cellulitis, dermatitis, eczema) and dental are included in the Top 10
- Inequities are evident particularly with Pacific children whose rates are double that of total population. There are also inequities with Maori, but to lower extent
- It is also noted that while the rates for Pacific children are relatively higher, the actual volumes of ASH related presentations are considerably lower than for the total. (Yr to March 2016 by volume Pacific 269, Maori 268, Other 686)



How will we get there?

Empower all families to maximise their children's health and potential

ASH 0-4yo 16/17 milestone: Maintain rates lower than national average

Preventative Care
Babies and children who have a smoke free home; are breastfed and are fully immunised have better outcomes.

Proactive Care
Children that are proactively screened for early identification of health issues that can be then managed have better outcomes.

Acute Care
Children that do become unwell may be supported within the community and/or can be supported to prevent future presentations to the hospital.

Local Breastfeeding Network support
Breastfeeding rates

General Practice and Immunisation Network improvement initiatives
Babies are fully immunised (8mo & 2yo)

B4 School Check Quality Improvement
B4 School Check referral rates for obesity

Support improvements in dental care
Dental enrollment

Child ICC Porirua Respiratory Project (improving referrals on discharge)
Asthma & respiratory infections rates
Asthma support referral numbers

Pacific Navigation Service support for children
Referral rate to Pacific Navigation

All contributory measures above will be monitored by Maori, Pacific & Total Population.

Patient Experience of Care

Where we want to be

The CCDHB system encourages patient involvement and feedback to support improvement initiatives that will lead to improved patient experience of care. One of the DHBs local priorities is to monitor patient experience to ensure better health outcomes are achieved. In doing so CCDHB will maintain a composite score rates of >7.5 in the 4 patient experience domains in the 16/17, and in future years continue this performance across the sector in combined patient experience domains.

Where we are now?

- CCDHB is on national average for 4 core elements: communication, coordination, partnership, physical & emotional needs for most quarters
- No major deviations with a minor drop in physical & emotional needs in terms of cultural support

NB: The composite data presented is a combination of the hospital and PHO Patient Experience data

	Primary Care (Aug 2016)	National Average	Hospital (Feb 2016)	National Average	Composite
Communication	8.3	7.8	8.1	8.2	8.2
Partnership	6.9	6.7	8.4	8.5	7.7
Co-ordination	7.8	7.9	8.2	8.4	8.0
Physical & Emotional Needs	7.7	7.7	8.3	8.7	8.0

How will we get there?

Better patient experience & outcomes

Patient experience 16/17 milestone: Achieve scores >7.5 of composite measure for all elements)

Better Communication

Effective Coordination

Enhanced Partnership

Physical & Emotional Needs

Patient Portal uptake support by PHOs
Portal uptake & activation

Health information access supported
Health Navigator access numbers

Shared Electronic Health Record uptake
% of patients with record available

PHO & Practice promotion of the experience survey
National Enrollment Service uptake by practices
Practice uptake of the experience survey

Hospital experience survey uptake
Return rate of hospital patient experience survey

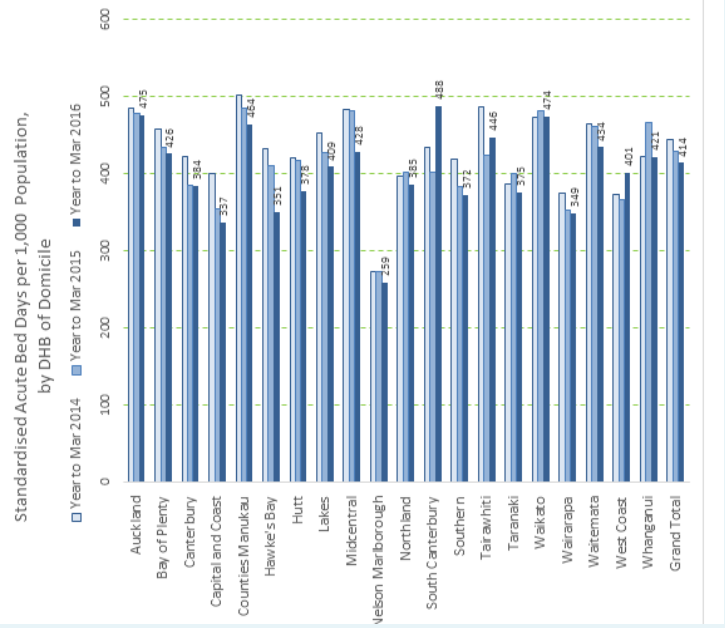
Acute Bed Days

Where we want to be

Better health and independence for people, families and communities is the CCDHB vision. As a CCDHB system we want to our population to be well in the community and be supported to receive appropriate care when they are not well. In doing so CCDHB will maintain <400 acute bed days per 1000 population in 16/17 and in the future aim to progress to make improvements in acute bed days per 1000.

Where we are now?

- CCDHB is 2nd lowest in NZ, with continued improvement over the last few years
- Compared to other age bands, >85yo have the highest bed day per 1000
- Inequities evident, with Pacific population having the highest bed day rate, which also increased in the last year. Maori population have lower rates than the "other" population.
- Rehabilitation, respiratory infection and heart failure are the Top 3 diagnosis (DRG) for acute bed days per 1000
- Acute length of stay and elective length of stay in CCDHB continued to reduce over recent quarters
- ED attendance rate had been increasing more quickly than the national rate however has slowed in the last two years



How will we get there?

Better health and independence for people

ABD 16/17 milestone: Maintain ABD<400/1000

Preventative Care
The prevention and management of risk factors for is essential to reducing the development of health conditions.

Proactive Care
Working with people to plan their care will reduce exacerbations, slow progression and help to keep them well.

Acute Care
For people who are significantly unwell they have options to be managed effectively in the community, and if in need of hospital care are provided with great care.

Patient flow in hospital
The efficient flow of patients through and out of hospital supports the focus of keeping people in the community.

Smoking cessation in primary care
Quit Rate (By M, P, O)

Flu vaccination in primary care
Vaccination rates in >65yo

Risk stratification of those at high risk of admission
Number of practices that identified population at risk of admission and are implementing support processes

Primary Options for Acute Care
DVT & Cellulitis Uptake/ED presentations
POAC range

Health Care Home embedding Primary care model
HCH Enrolled population (by M, P & O)

Total (Acute & Elective) LOS Improvement activities
LOS changes (by M, P & O)

Amenable Mortality

Where we want to be

We want to have an effective CCDHB health system, for the individual and population. The DHBs strategic goals and local priorities align with this and in doing so CCDHB will continue to maintain its amenable mortality rates below 80 in 2016/17 and in future years achieve reduced rates despite the increasing morbidity of the population.

Where we are now?

- 5th lowest in the NZ, with small fluctuations
  Inequities evident with the Pacific population having the highest mortality rates, followed by Maori and then the other population
- Ischaemic Heart Disease (IHD), diabetes and suicide and are ranked the Top 3 conditions for CCDHB

Amenable mortality deaths, age standardised rates, 0-74 year olds, 2013
Calculated using estimated resident population as at June 30

	2013		2009-2013
	Number of deaths	Age standardised rate	Average 4 highest
Northland	280	117.0	137.8
Waitemata	443	63.5	73.3
Auckland	370	70.8	85.1
Counties Manukau	587	102.0	111.1
Waikato	485	97.3	112.9
Lakes	160	119.1	136.8
Bay of Plenty	309	105.6	112.3
Tairawhiti	93	152.3	157.3
Hawkes Bay	224	102.3	114.6
Taranaki	150	93.9	115.6
Midcentral	244	106.9	115.0
Whanganui	95	107.2	136.7
Capital & Coast	282	78.4	77.4
Hutt Valley	173	96.7	93.3
Wairarapa	76	119.0	121.1
Nelson Marlborough	165	75.6	85.1
West Coast	58	131.4	131.2
Canterbury	597	89.1	91.8
South Canterbury	80	94.1	118.5
Otago	209	73.3	96.1
Southland	142	90.8	101.2
Overseas and undefined	52	...	...
Total New Zealand	5274	90.8	100.7

Please note that 2013 data is provisional

How will we get there?

Effective health system for the individual and population

AM 16/17 milestone: Maintain AM<80

Preventative Care
The prevention and management of risk factors is essential to reducing the development of morbidity.

Proactive Care
Working with people to plan their care will reduce exacerbations, slow progression and help to keep them well.

Equitable access
People of all ethnicity and deprivation are supported and enabled to access appropriate care. Standardised best practice care is implemented across the system.

Obesity Management Plan
Green Prescription Plus uptake

Suicide screening for at risk populations
HEEADSSS assessment rate

Cervical screening in primary care
Screening rate (by M, P & O)

Diabetes collaborative management strategies
Number of people with HbA1C>64mmol/mol and not on insulin
Microalbuminuira & not on ACEI

Cardiovascular risk management
High (>20%) CVD risk and on statin (by M, P & O)

3DHB Health Pathways promoted in primary care
Number of pathways & utilisation

Primary care access supported in primary care
Access ratio by M, P & O)