System Level Measures - Annual Plan Guidance 2018/19

Implementation of the System Level Measures (SLMs) continues in 2018/19. The *Guide to Using the System Level Measures Framework for Quality Improvement* (SLM guide) has been updated and should be used for the development of the 2018/19 Improvement Plans.

The SLM Annual Plan guidance complements the SLM guide and provides detailed expectations for 2018/19 Improvement Plans and PHO payment details.

SLMs provide a framework for continuous quality improvement and integration across the health system. Equity gaps for Māori and Pacific populations are evident in all System Level Measures and in nearly all districts. This framework provides a great opportunity for DHBs and PHOs to work with health system partners in their district to address equity gaps, one of the government priorities. Where equity gaps exist, the district alliances are expected to focus their improvement milestone, quality improvement activities and contributory measures specifically to address these gaps.

Current System Level Measures

The two developmental measures, *Babies living in smokefree homes and Youth access to and utilisation of youth appropriate health services,* have been finalised and will become active SLMs from 1 July 2018.

From 1 July 2018, the System Level Measures are:

1. Ambulatory sensitive hospitalisations (ASH) rates for 0 -4 year olds
2. total acute hospital bed days per capita
3. patient experience of care
4. amenable mortality rates
5. babies living in smokefree homes
6. youth access to and utilisation of youth appropriate health services.

The *Measures Library* contains the definitions for all SLMs and contributory measures. SLMs are nationally defined and must be used to set the improvement milestones.

Districts should refer to the Measures Library first for contributory measures. However if the contributory measures available in the library are not suitable, districts may choose to use other measures that are clearly defined (including a numerator and denominator), and that contribute to the SLMs.

In the spirit of collaboration, the expectation is that if a district has a contributory measure that supports progress towards the SLMs that is not in the library, they submit it for inclusion in the library, so it can be shared with other districts. Districts can directly add contributory measures in the Measures Library. Follow the instructions on the *Health Quality Measures New Zealand* website to request your own account, log in and either comment on existing measures, or add you own contributory measures.

District alliance expectations

District alliances

District alliances are local leadership teams. They are clinically led groups that use a joint decision making approach to system integration and service planning. Form and function of alliances vary across the country with some being a partnership of the DHB of domicile and its PHOs only. Others have much broader alliance partners that include consumers, ambulance, pharmacy, midwives, Well Child Tamariki Ora providers, public health units etc.

Given the maturity of the SLM programme and with the addition of two new SLMs, the Ministry is expecting the alliance leadership teams to have more inclusive membership than DHB and PHOs. The Improvement Plan should demonstrate how the alliance has involved their patients and communities, Māori and Pacific health teams, maternity, ambulance, pharmacy, Well Child Tamariki Ora providers and youth health providers (such as Youth One Stop Shops and school based nurses) in the development and implementation of the SLMs.

DHBs, on behalf of their district alliance, submit the Improvement Plan to the Ministry.

Improvement Plan Requirements

The SLM Improvement Plan is still part of the DHB Annual Plan. However, due to a delay in the DHB Annual Planning processes and the need to pay PHOs on time, the submission processes and dates for the SLM Improvement Plan will not be aligned with the 2018/19 DHB Annual Plans. The first draft of the DHB Annual Plans are expected to be submitted on the 16 July.

In order for the 50% capacity and capability payment to be made as agreed in the PHO Services Agreement, the final draft SLM Improvement Plan has to be submitted to the Ministry by 2 July and approved by the Ministry by 31 July. This allows sufficient time for payments to be calculated, funds drawn down and paid into DHB accounts by 5 September to be paid to PHOs on 15 September.

The Improvement Plan must include:

- Improvement milestones that is 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.
- Brief description of activities to be undertaken by all alliancing partners (primary, secondary and community) to achieve the SLM milestones.
- Contributory measures for each of the six SLMs that is chosen by the district alliance based on local needs, demographics and service configurations that enables the alliance to measure local progress against the SLM activities.
- Signatures of all district alliance partners to demonstrate an integrated and partnership approach to the development and implementation of the improvement plan.

Improvement Plan assessment by the Ministry

Questions and Answers on the Ministry website provide further information on what the Ministry is looking for when assessing and approving the Improvement Plan, in particular questions 6-11.

Past experience has shown that an iterative process starting early with the first draft is useful. This is a complex programme and there is usually a lot of discussion and analysis at the district alliance and working group levels to inform the plan which may not be included in the plan. District alliances are encouraged to share early drafts of their plan with the SLM National Programme Manager and Clinical Lead at the Ministry or involve them in the local discussion. The Ministry may request teleconferences and/or face-to-face visits with district alliances to understand the development of the Improvement Plans.

The Ministry would like to facilitate a collaborative approach with the development and implementation of the SLMs by sharing Improvement Plans and alliances' stories through the *Nationwide Service Framework Library*. Please advise Ministry via the SLM inbox if your alliance does not want to share their Improvement Plan via NSFL website.

Quality improvement approach

One of the insights gained from the implementation of the SLMs is the order in which district alliances develop their Improvement Plans. Some district alliances or their SLM working groups have in the past chosen the contributory measures first, then set the improvement milestone and finally retro-fitting activities to achieve the milestone. Using improvement science methodology, the recommended process is:

1. Formation of working groups for each SLM that at the minimum includes clinical, managerial and analytic expertise from across the primary, secondary and community care.
2. Examination of SLM data, both at aggregate and NHI level to understand what is driving local SLM rates to define the problem. This enables the district alliances to: understand the health needs of their population; identify patients and population groups that experience disparity in access to healthcare and health outcomes; and target their activities and investment to provide equitable health care and improve their health outcomes. The SLM guide provides tools and approaches that could be used for this process.
3. Identifying the improvement milestone. If there are equity gaps, the milestone should focus on reducing these gaps.
4. Identifying the activities that will result in achieving the improvement milestone. These activities should be practical, achievable in one year and targeted to the local population needs. This process should be led by clinicians with input from patients and local communities.
5. Choosing the contributory measures that will enable the district to monitor local progress. The contributory measures should be measures with defined numerator, denominator and data source that will enable you to report progress on activities to the district alliance. They are not the goals of the activities and are not reported to the Ministry.
6. A final review to ensure a clear line of sight between the improvement milestone, quality improvement activities and the contributory measures.

SLMs – in detail

Ambulatory sensitive hospitalisations (ASH) rates for 0 - 4 year olds

The top four conditions contributing to the national ASH 0-4 year old rates remain the same: respiratory, dental, skin and gastroenteritis. There are large equity gaps, particularly for Pacific people. The Ministry is providing unencrypted NHI level data for districts, by DHB and PHO. The district alliances are expected to form a working group that brings together clinical, managerial and analytic expertise from across the health system (primary, secondary and community care that includes pharmacy and ambulance) to examine their data, understand the top conditions contributing to ASH rates for 0-4 year olds in their district, identify equity gaps and focus their improvement activity on reducing equity gaps for Māori and Pacific populations. ASH is related to broader social determinants of health such as housing and poverty and therefore the Public Health Units can support this measure through their advocacy and public health policy activities. The improvement milestone can focus on improving an ASH condition for a specific population group.

Total acute hospital bed days per capita

This is a measure of acute demand and patient flow across the health system. The over 65 years age group are the biggest contributors of bed days and there are equity gaps for Māori and Pacific populations. The Ministry provides unencrypted NHI level data for districts, by DHB and PHO. Similar to ASH, district alliances are expected to form a working group that brings together clinical, managerial and analytic expertise from across the health system (primary, secondary and community care that includes pharmacy, aged residential care and ambulance) to:

- examine their data
- understand the top conditions contributing to bed days in their district

- identify and understand how each part of the health system in the district contribute to this SLM
- identify and understand the system enablers and barriers
- identify equity gaps
- work with partners from across the health system to determine improvement milestone, activities and contributory measures.

The improvement activities should focus on improving access to primary and community care, and patient flow across the whole health system (before and after the hospital admission), especially for Māori and Pacific populations.

Patient experience of care

This measure is made up of adult hospital and primary care patient experience surveys. The hospital survey has been in place since 2014 and reports are published on the *Health Quality & Safety Commission website*.

The primary care patient experience survey is in implementation phase and most practices are expected to be participating in the survey by June 2018.

Both surveys have been developed and are administered by the Health Quality & Safety Commission (HQSC). Both surveys have four domains: communication, coordination, partnership, and physical and emotional needs.

The first national report for the primary care patient experience survey is published on the *Health Quality & Safety Commission website*. There were approximately 19,000 responses from first pilot to May 2017. Key findings from this report are:

- >85% felt wait times inside GP surgeries were acceptable
- very positive results for respect and kindness
- areas of improvement
  - communication around medication – 8% believe they were dispensed wrong drug or dose in the last 12 months
  - coordination across the health sector – care plans for people with LTCs and flow of information between primary care and hospital
  - patients' involvement in their own care – appears as the weakest area
  - cost barrier and coordination areas show marked ethnic disparities – European reporting better experiences than all others
  - people with mental health conditions report worse experiences of care throughout the survey.

The Ministry contracted Sapere Research Group to evaluate the primary care survey tool between June and November 2017. Key findings of the evaluation were:

- current response rate of 22% is about right internationally
- SMS response and completion rates are much lower than email invites
- majority (80%) of email invitees complete the survey once they start it
- length or content of the survey does not appear to be a deterrent
- there are opportunities to increase response rates with young people, Māori, and Pacific people
- it takes most people 15 mins to complete the survey.

The full evaluation report is available on the *Health Quality & Safety Commission website*.

The recent focus of this SLM has been on the implementation of the primary care patient experience survey. However the focus in 2018/19 needs to shift to increasing response rates for the survey from Māori and

Pacific populations; PHOs and practices reviewing and understanding the survey results; and using the results to improve delivery of quality and coordinated care.

Improvement milestone and activities for this SLM could focus on:

- improving response rates for one or both surveys for Māori and Pacific populations. The Ministry and HQSC are working with Māori and Pacific advisors on a range of options that will be available by late May.
- one of the four domains that is consistently scored lower than others
- group of questions in the domains that highlight an issue eg: health literacy, medication reconciliation and adherence, flow of information between PHO/practice to specialists or hospitals
- nationally low scoring questions based on the *national report from the first year of pilots* that include:
    - medication communication questions
    - care plans for patients with long-term conditions
    - GP or nurse awareness of medical history
    - patient/whānau involvement in decisions about care
    - explanation of test results
    - conflicting information from different healthcare professionals.

The following information can be found on the *Health Quality & Safety Commission website*:

- Videos available in English, Te Reo, Samoan and Tongan that can be played in practice waiting rooms to inform patients about the survey
- The guide for practices on using the results for quality improvement
- The survey tool and its development
- The Privacy Impact Assessment
- The survey schedule
- Frequently Asked Questions.

Amenable mortality rates

The *Guide to using Amenable Mortality as a System Level Measure* has been updated and explains the concept of amenable mortality, how it is measured, and how this measure can be used to improve health system performance and reduce health inequity for Māori and Pacific.

Whilst the equity gap between the Pacific and Māori populations have reduced, the gap between Māori, Pacific and total population remains. District alliances can set a long term milestone for this SLM (eg improvement to be achieved over three or five years) and are expected to focus their improvement milestone, quality improvement activities and contributory measures on reducing amenable mortality rates for Māori and Pacific populations.

Babies living in smokefree homes

This SLM aims to reduce the rate of infant exposure to cigarette smoke by focussing attention beyond maternal smoking to the home and family/whānau environment. The measure at six weeks aligns with the first core contact which is when the handover from maternity to Well Child Tamariki Ora (WCTO) providers and general practitioners occur.

Previous research has shown that Māori women aged between 18 and 24 years stand out as a group of particular concern, with 42.7% of this group reporting regular (daily) smoking, compared with 8.6% of non-Māori women of the same age. Young Māori women who are regular smokers are three times more likely to live in a household where there are other smokers compared with those who do not smoke.

This measure promotes the roles which collectively, service providers play in the infant's life and the many opportunities for smoking interventions to occur. The patient benefit of this measure is improved health outcomes for babies with no exposure to cigarette smoke at home. This includes benefit for whoever is smoking in the house becoming an ex-smoker.

District alliances are expected to engage with midwives, WCTO nurses, primary care nurses and those involved in the broader 'stop smoking' programmes in their district to determine the improvement milestone and activities for this SLM.

Data for this measure is collected by WCTO providers. The Ministry, upon request, has provided unencrypted NHI level data to DHB and PHOs for January to June 2017 period for development of 2017/18 SLM Improvement Plans. Aggregate level data for July to December 2017 period will be available on the *Nationwide Service Framework Library* by end of May. Unencrypted NHI level data for this period is available on request.

The Ministry has been working with the WCTO providers to improve the quality and accuracy of data collection including developing a data standard, changes to the IT system to make the data field mandatory and amending the data submission process and reporting template. The Ministry will provide data for this SLM at six monthly intervals ie January to June 2018 data will be available in September and July to December 2018 data will be available in March 2019. Changes being implemented to improve the quality and accuracy of data will take some time.

District alliances should focus on improving the data quality and improving the rates of Māori babies living in smokefree homes.

Data collected by LMCs at registration and two weeks post natal can be used as contributory measures.

Youth access to and utilisation of youth appropriate health services

This SLM is made up of five domains with corresponding outcomes and national health indicators. Further information is available on the *Ministry website*.

The Youth Service Level Alliance Teams should lead the implementation of this measure. This team needs to ensure that there is perspective from all appropriate youth health providers (such as Youth One Stop Shops and school based nurses) and youth from their district to understand the needs of their population and choose the appropriate domain to focus on. The alliance is expected to choose at least one domain and use the corresponding national indicator to set their improvement milestone. For example, if the team decides to focus on 'alcohol and other drugs' domain, their milestone will be set using the 'alcohol related ED presentations' indicator. There needs to be a clear line of sight between the population need, domain, national indicator, activities and contributory measures.

Quarterly Reporting

DHBs are responsible for submitting the quarterly reports on behalf of their district alliance, as part of the regular quarterly reporting process, through the DHB quarterly reporting database.

Quarters one, two and three – the alliance reports whether they are on track with the implementation of their Improvement Plan. If the alliance is not on track, the report must include mitigation plans to get back on track. This may include changes to their Improvement Plan, in agreement with the Ministry. These reports will be assessed by the Ministry and feedback provided via the DHB quarterly reporting database.

Quarter four – performance against the implementation of the Improvement Plan and whether the improvement milestone was achieved by the alliance. If the Improvement Plan was not fully implemented and/or the milestone was not achieved, the report should include clear and reflective thinking from the

alliance on how the Improvement Plan was developed and implemented, reasons for not implementing the plan or achieving the milestone and insights from the year that will be used for development and implementation of following year's plan.

Reporting templates (including examples of mitigation plans and year end reflections) are available on the *Nationwide Service Framework Library*.

PHO financial incentives for 2018/19[1]

The $23 million primary care performance funding will continue to be used to build quality improvement and analytic capacity and capability in primary care (PHOs and their contracted providers) that may include clinical and non-clinical infrastructure eg building continuous quality improvement competencies and culture, implementation of primary care patient experience survey, improving information technology and analytics, enabling clinical leadership and outreach services.

At least 50% of the funding must have direct financial benefit to PHO contracted providers.

Achievement of the SLMs is reliant on the contributions of a variety of health partners. DHBs are expected to consider how the participation of other health partners (eg hospital, pharmacy, aged care services, youth health providers, WCTO providers and midwives) is resourced to contribute to the development and implementation of Improvement Plans.

The following table shows the payment process for the approach to financial incentives in 2018/19.

Size of Payment	Purpose	Paid When
25%	'Up front' capacity/capability payment to PHOs	15 July 2018
50%	Capacity/capability payment to PHOs on Ministry approval of the Improvement Plan	15 September 2018
25%	'At risk' and paid to PHOs based on Q4 performance (see below).	15 September 2019

The last 25% 'at risk' payment will be used to incentivise the following three SLMs and the two primary care National Health Targets through the PHO Services Agreement in 2018/19:

- Acute hospital bed days per capita,
- ASH rates for 0-4 year olds,
- Patient experience of care;
- National Health Target Better help for smokers to quit; and
- National Health Target of Increased immunisation for eight-month olds.

The 25% PHO incentive funding is equally weighted across all five incentivised measures.

If the district alliance has not achieved the improvement milestone(s) but had a Ministry approved Improvement Plan that was fully implemented by all alliance partners, it is still possible for PHOs to receive the 'at risk' performance payment.

[1] Subject to PSAAP negotiations and changes to government policies/priorities

Decision for this payment is made by the Ministry based on the quarter four report from the district alliance. This takes into consideration the following:

- maturity of the alliance
- level of clinical leadership and engagement
- focus on patient experience and safety
- use of quality improvement science and tools
- use of commissioning to target investment.

Additional resources

The following information can be found on the *Nationwide Service Framework Library*:

- the Guide to Using the System Level Measures Framework
- the Guide to using Amenable Mortality as a System Level Measure
- System Level Measure Improvement Plans
- examples of different alliance approaches to development and implementation of System Level Measures Improvement Plans
- trend data for the System Level Measures.

There is also SLM information including *Questions and Answers*, and *SLM in a nutshell* brochure available on the Ministry website. The SLM brochure explains SLMs in plain English and is a useful tool for communicating with clinicians and board members.