SYSTEM LEVEL MEASURES

IMPROVEMENT PLAN 2016-17

Auckland Waitemata & Counties Manukau Health Alliances

CONTENTS

1. EXECUTIVE SUMMARY

The Counties Manukau Health (CM Health) and Auckland Waitemata Alliance Leadership Teams (ALT / Alliance) have undertaken a joint approach to the development of a System Level Measures (SLM) improvement plan. Building on the *one team* theme in the New Zealand Health Strategy, the Alliances have co-developed a single improvement plan to ensure streamlined activity and reporting and best use of resources within the health system. Milestones and contributory measures for each of the SLMs have been carefully considered for the 2016-17 year in the recognition that there will be a very short timeframe for implementation. The Alliances are firmly committed to including more meaningful measures from 2017-18 and over the medium to longer term, once the structures, systems and relationships to support improvement activities are more firmly embedded.

The DHBs included in this improvement plan are:

- Auckland DHB
- Waitemata DHB
- Counties Manukau DHB

The PHOs included in this improvement plan are:

- Alliance Health Plus Trust
- Auckland PHO
- East Health Trust
- National Hauora Coalition
- ProCare Health
- Total Healthcare PHO
- Waitemata PHO

2. SUMMARY OF SELECTED CONTRIBUTORY MEASURES AND TARGETS

SLM	SLM Target	Contributory Measure	2016-17 Milestone/Target
Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds	No anticipated reduction in 2016-17. In 2017-18 - an annual reduction in ASH rates for 0-4 year olds of 5%.	Newborns enrolled with a PHO within the first three months of life	The National Target is 98%. 2016-17 – Aim for PHOs to achieve 90% by 30 June 2017. Develop a measure for enrolment with a PHO by 6 weeks of age.
		Babies fully immunised by 8 months of age	This is a National Target. 95% of babies fully immunised by 8 months of age each quarter.
Acute Hospital Bed Days per Capita	The target for 2016-17 is to aim for a 2% reduction in this rate to 447.6 bed days/1,000 population by June 2017 from 456.7	ED Presentation Rate	Maintain current performance 49.3/1000 population by quarter ending 30 June 2017. Therefore the target in year one is to establish the baseline and ongoing methodology in order to set a target for ED presentations in the 2017-18 year.

SLM	SLM Target	Contributory Measure	2016-17 Milestone/Target
		Acute Readmission Rates at 28 days 2016-17	The target is to have a reduced readmission rate at 28 days to 7.7% by 30 June 2017
Patient Experience of Care	Maintain current state and continue to improve on the DHB Adult Inpatient Survey - Maintenance of an aggregated 8/10 score for all four domains across the three DHBs.	The DHB Adult Inpatient Survey	Maintain and continue to improve response rates for the DHB inpatient survey. Maintenance of an aggregated score for the 4 domains of 8 out of 10 for each of the 3 Auckland DHBs (Current national response rate 27%, ADHB: 17%, CMDHB: 13% and WDHB 34%).
		E-Portal (PHC Specific)	40% of PHO practices are registered with a portal and 10% of the PHO population have access to a portal.
Amenable Mortality Rate	Maintain the overall current status at the current rate of: WDHB: 2352 deaths – at Rate of 84.9% ADHB: 2007 deaths – at Rate of 98.7% CMDHB: 3001 deaths –at Rate of 135.6%	Decrease in mortality associated with Cardiovascular Disease	Increase coverage of Maori to 90% Increase triple therapy by 5% for those with a prior CVD event, those with a CVD RA of ≥ 20% and with a particular focus on patients with diabetes
		Decrease in mortality associated with smoking related diseases through increased quit attempts and increased support to quit	Increase support to quit - 10% from the baseline/DHB
		Decrease in mortality associated with Breast Cancer	The target for 2016-17 is to increase coverage in Maori women in particular to reach 70%
		Reducing Mortality from Hepatitis C	By June 2018 10% of those identified in PMS' will be treated (measured through quarterly reports) 30% of those identified in secondary care will be treated (measured through quarterly reports)

3. INTRODUCTION

3.1 Purpose

The purpose of this document is to provide the Ministry of Health (MoH) with the SLMs improvement plan for the CM Health and Auckland Waitemata Alliances. The document outlines the improvement milestone and contributory measures for each SLM. A description of the joint process taken by the CM Health and Auckland Waitemata Alliances is provided along with the Rationale for developing a single plan for the region.

4. BACKGROUND

The New Zealand Health Strategy outlines a new high-level direction for New Zealand's health system over the next ten years to ensure that *all New Zealanders live well, stay well, get well.* One of the five themes in the Strategy is *value and high performance*. This theme places greater emphasis on health outcomes, equity and meaningful results. Under this theme, the MoH has been working with the sector to develop a suite of SLMs that provide a system-wide view of performance. Alliances are required to develop an improvement plan in accordance with MoH guidelines and one or more local plans for the year to 30 June 2017. The improvement plan will include:

a) four SLMs to be implemented from 1 July 2016:
   - 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.

b) for each SLM, an improvement milestone to be achieved in 2016-17. The milestone must be a number that either improves or maintains performance from the district baseline or reduces variation to achieve equity;

c) for each SLM, a set of contributory measures which show a clear line of sight to the achievement of the improvement milestones, have clear attribution and have been validated locally.

The CM Health and Auckland Waitemata Alliances agreed to a joint approach to the development of a SLMs improvement plan. This includes the establishment of an Auckland Metro steering group and working groups for each SLM. Steering group membership includes senior clinicians and leaders from the seven PHOs and the three DHBs. The steering group is accountable to the two ALTs and provides oversight of the overall process. Working groups are responsible for drafting contributory measures and identifying the related interventions to be included in the local improvement plans. Each working group is chaired by a PHO lead and supported by a DHB public health physician. Working group membership consists of senior primary care and DHB clinicians, personnel and portfolio managers.

The working groups completed in-depth analytics to inform development of the improvement plan. This included review of national and regional data, analysed by DHB, facility, ethnicity, deprivation and condition. The groups considered both an overarching approach and a condition specific approach for the SLM. Among the factors considered were the number of hospitalisation events (as well as rates), readmission rates, bed days, GP visits, DHB inpatient experience survey rates, condition specific amenable

mortality rate recent trends, evidence to support improvement activities and most importantly the ability to address equity gaps.

Working groups have engaged more broadly with key stakeholders in the process of drafting and selecting contributory measures. Stakeholder engagement included a sector-wide socialisation workshop and a presentation of draft measures, milestones and interventions to the ALTs. Feedback received from the engagement sessions was incorporated into development of the improvement plan.

A single improvement plan has been developed for the two ALTs / three Auckland Metro DHBs. The rationale for this are that a number of PHOs cross Auckland Metro DHB boundaries and are members of both alliances. It was not considered to be practicable or achievable given limited resources, to have two improvement plans with different contributory measures. 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. Individual local improvement plans for both alliances are currently being developed. These plans will include district-specific targets and measures to ensure that contributory measures and SLM milestones are met. Reporting processes, both for the local improvement plans and the overall regional improvement plan are also in development, with a clear line of sight to performance-level reporting requirements for Quarter 4 2016-17.

The ALTs are strongly committed to improving performance where it matters most over the medium to longer term. Contributory measures and SLM milestones have been chosen for the current year to reflect the fact that realistically there will only be 6-8 months in which to implement initiatives leading up to 20 June 2017. The intention is to build on the 2016-17 improvement plan with additional measures and activities, e.g. by including a diabetes-specific contributory measure for the amenable mortality SLM, in the 2017-18 year.

5. COUNTIES MANUKAU AND AUCKLAND WAITEMATA ALLIANCE LEADERSHIP TEAM SYSTEM LEVEL MEASURES IMPROVEMENT PLAN

The following section of this document describes each SLM outcome measure and its selected contributory measures in details along with justifications for setting targets and the activities/initiatives identified to achieve stated targets.

5.1 Ambulatory Sensitive Hospitalisations (ASH) Rates per 100,000 for 0 – 4 year olds

5.1.1 Definition

ASH are admissions considered potentially preventable through prophylactic 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 assigned. Children counted in this measure are in the preschool ages of 0-4 years and are assigned to a DHB based on their place of domicile. 'Hospitalisation' includes any discharge coded ED or inpatient stay >3 hours. Ministry of Health data does not differentiate between ED and inpatient admission. The measure is expressed as a rate (per 100,000 children in the census population).

5.1.2 Context and Rationale

ASH is a challenging indicator as it is so much driven by the social determinants of health. 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 the working group recognise that there are many promising approaches that could be taken. To support decision making the working group analysed regional data on ASH for the last five years, by DHB and facility, ethnicity, deprivation and condition. The group considered both an overarching approach and a condition specific approach. The group considered factors such as the number of hospitalisation events (as well as rates), readmission proportions, recent trends, evidence to support improvement activities, work currently underway and equity issues. Stark ethnic disparities exist, with Pacific children experiencing significantly higher rates than all other ethnicities. Māori also have higher rates than non-Māori non Pacific children. Therefore, activities that may reduce these disparities are prioritised. There was vigorous debate about whether the milestone for this indicator should be a reduction in Pacific and Māori ASH only or a total population reduction.

5.1.3 Improvement Milestone

There will be **no improvement milestone for this SLM in 2016-17**, as it will take time to implement and embed improvements. In 2017-18, the overall improvement milestone recommended will be an annual reduction in ASH rates for 0-4 year olds of 5%. There is no ethnic specific target reduction set at present, however ethnic specific rates must be monitored and reported and interrogation of approach to ensure that interventions reduce not worsen inequalities.

5.1.4 Selected Contributory Measures

Two contributory measures have been selected for 2016-17:

1. **Percentage of newborns enrolled with a PHO within the first three months of life.** The national target is 98%. However, given current PHO performances, an achievable goal would be for all PHOs to **reach 90% by 30 June 2016-17, by ethnicity.** Another milestone for the 2016-17 year is to develop a process measure for the timeliness of enrolment with a PHO by 6 weeks of age, to align with the timing of the first set of childhood immunisations. Associated activities are for work to occur in PHOs, general practice and DHBs to improve timely B code and full enrolment; significant work is already underway. A project to implement multi-enrolment with WCTO and oral health will also have an impact.

2. **(Health Target) Percentage of babies fully immunised by 8 months of age each quarter**. The goal would be to achieve the national target of **95% coverage** per quarter, for all ethnicities. To achieve this goal, the current whole-of-pathway focus of the immunisation programme would continue.

5.1.5 Contributory Measures 2016-17 - Analysis and Justifications

1. Newborns enrolled with a PHO within the first three months of life

Item	Details
Name	**Newborns enrolled with a PHO within the first three months of life**
Definition	Numerator: Number of infants under 3 months enrolled with a PHO Denominator: Number of births reported to the NIR
Rationale &	Babies not enrolled with General Practitioners have less access to

<table>
<tr><th>Item</th><th>Details</th></tr>
<tr><td>Justification</td><td>and engagement with primary care.
Newborn enrolment is also an important factor in timely immunisation</td></tr>
<tr><td>Data Collection</td><td>The Ministry of Health currently collects data on this measure using the National Immunisation Register (NIR) and PHO Age Sex Registers.</td></tr>
<tr><td>Target & Target Justification</td><td>The National Target is 98%
2016-17: Aim for PHOs to achieve 90% by 30 June 2017
Develop a measure for enrolment with a PHO by 6 weeks of age (which would be a more useful measure as it aligns with the timing of the 6 week immunisations) by 30 June 2017.</td></tr>
<tr><td>Current Performance</td><td>Results for the Auckland Metro PHOs for 2015-16 are shown below:
<table>
<tr><th>PHO</th><th>Q1 Sept 2015</th><th>Q2 Dec 2015</th><th>Q3 Mar 2016</th><th>Q4 Jun 2016</th></tr>
<tr><td>Alliance Health Plus</td><td>85%</td><td>62%</td><td>78%</td><td>79%</td></tr>
<tr><td>ProCare</td><td>79%</td><td>66%</td><td>78%</td><td>80%</td></tr>
<tr><td>Total Healthcare</td><td>76%</td><td>73%</td><td>94%</td><td>80%</td></tr>
<tr><td>National Hauora Coalition</td><td>89%</td><td>66%</td><td>81%</td><td>86%</td></tr>
<tr><td>East Health Trust</td><td>77%</td><td>83%</td><td>80%</td><td>80%</td></tr>
<tr><td>Waitemata PHO</td><td>76%</td><td>66%</td><td>84%</td><td>79%</td></tr>
<tr><td>Auckland PHO</td><td>82%</td><td>71%</td><td>86%</td><td>75%</td></tr>
</table></td></tr>
<tr><td>Reporting Frequency</td><td>Quarterly</td></tr>
<tr><td>Improvement Activities</td><td>2016-17: Work in PHOs, general practice, DHBs and with midwives to improve timely B code and full enrolment at practices.
CMDHB and the PHOs in its Alliance are developing a joint action plan for completion in November 2016. Similar activities to be considered in Auckland Waitemata Alliance.</td></tr>
</table>

2. Babies fully immunised by 8 months of age

Item	Details
Name	**Babies fully immunised by 8 months of age**
Definition	Percentage of eight months olds who will have their primary course of immunisation (six weeks, three months and five months immunisation events) on time. Numerator: PHO enrolled children who are enrolled on the NIR in the CI Programme and have completed the last dose of their age appropriate vaccinations on the day they turn 8 months Denominator: PHO enrolled children who are enrolled on the NIR in the CI Programme who have turned 8 months
Rationale & Justification	Immunisations are required to prevent serious communicable childhood illnesses, which can lead to hospitalisations. In the last few years coverage in the Auckland region has hovered near 95%, however, consistent energy and focus is required to maintain these

<table>
<tr><th>Item</th><th>Details</th></tr>
<tr><td></td><td>levels.
Furthermore, rates of hospitalisations for partially vaccine preventable illnesses such as pneumonia and gastroenteritis remain high.</td></tr>
<tr><td>Data Collection</td><td>The Ministry of Health currently collects and reports on this measure using data from the National Immunisation Register (NIR) at a DHB and PHO level each quarter. No changes to the current data collection system would be required.</td></tr>
<tr><td>Target & Target Justification</td><td>95% of babies fully immunised by 8 months of age each quarter. This is a National Target.</td></tr>
<tr><td>Current Performance</td><td>Results for the Auckland Metro DHBs for 2015/16 are shown below:
<table>
<tr><th>DHB</th><th>Q1 September 2015</th><th>Q2 December 2015</th><th>Q3 March 2016</th><th>Q4 June 2016</th></tr>
<tr><td>ADHB</td><td>95.0%</td><td>93.8%</td><td>94.4%</td><td>93.7%</td></tr>
<tr><td>CMDHB</td><td>95.2%</td><td>94.7%</td><td>94.2%</td><td>94.9%</td></tr>
<tr><td>WDHB</td><td>93.2%</td><td>94.9%</td><td>93.1%</td><td>92.4%</td></tr>
</table></td></tr>
<tr><td>Reporting Frequency</td><td>Quarterly</td></tr>
<tr><td>Improvement Activities</td><td>2016-17 and subsequent years - The current immunisation programme to continue as business as usual. Specific activity to improve Maori coverage should continue to be developed. Coordinate and embed systems across the Auckland region to increase the coverage of influenza immunisation for children aged 0-5 who are eligible for the free vaccine.</td></tr>
</table>

5.1.6 Remarks

Additional Contributory Measures for 2017-18:

1. **Reduced rate of hospitalisations for serious skin infections**. There is a high and growing rate of hospitalisations for serious skin infections in this age group. To date, skin infections have not received sufficient attention in primary care and community settings. There is a lack of consistent messaging and educational resources for families on how to manage skin infections. Activity to achieve reduced hospitalisations during the first year will include the distribution of a recently developed (Skin Infection working group; Regional Child Health Network), consistent, health literacy based resource. It will take some time to implement and embed the improvements activities, therefore a target for reduced hospitalisations will not be in place until 2017-18. A reporting system will be developed and an improvement milestone agreed during 2016-17.

2. **Improved oral health**. Rates of poor oral health in this age group are worsening; hospitalisations due to dental conditions are significant and increasing. Furthermore, there are large disparities across ethnicities - rates for Pacific children are much higher than other groups. There are currently several measures of oral health, but none give a sufficiently clear view of the oral health of all 0-4 year olds. During 2016-17, enrolment with oral health services will be monitored as a placeholder. The improvement activity will be to develop a regional pre-school oral health strategy, which will include a suitable contributory measure and improvement activities for subsequent years.

Overarching Activities
There are opportunities for a set of overarching and disease-specific activities to address the ASH System Level Measure. There is already substantive activity in business-as-usual and projects underway; leveraging expertise and current programmes of work to accelerate progress will be a focus of the remainder of year one activities. From year two there will be further disease-specific and educational activity underway with further development of process and outcome indicators associated with these. The working group recognises that the contributory measures selected for year one include enrolment measures rather than outcome measures, however, PHO enrolment is an important facilitator of timely and quality care, and is important to recognise in year one. The immunisation Health Target is incorporated into ASH as a recognition for the specific contribution that immunisation makes and the large programme of work across the system to maintain and incrementally improve immunisation coverage and equity.

5.1.7 Intervention Logic
Please refer to 5.2.1

5.2 Acute Hospital Bed Days Per Capita

5.2.1 Definition
Acute hospital bed days per capita is a measure of acute demand on secondary care that is amenable to good upstream primary care, acute admission prevention, good hospital care and discharge planning, integration of services and transitions between care sectors, good communication between primary and secondary care, can all help reduce unnecessary acute demand. Good access to primary and community care and diagnostics services is part of this.

The measure is the rate calculated by dividing acute hospital bed days by the number of people in the New Zealand resident population. The acute hospital bed day's per capita rates will be illustrated using the number of bed days for acute hospital stays per 1000 population domiciled within a DHB with age standardisation.

5.2.2 Context and Rationale
Data contributing to understand the bed days were examined and performance analysed. It is vital that the current state is fully understood so that the best interventions can be identified to have an impact on the indicator.

Conditions which result in unplanned hospitalisation and other contributory factors i.e. referral process to ED (self, provider variation, ambulance etc) were identified as below:

- Mental health conditions
- Cellulitis
- Chronic Obstructive Pulmonary Disease (COPD)
- Heart Failure
- Respiratory infections
- Abdominal pain
- Kidney and Urinary Tract Infections
- Chest Pain

Primary care interventions attributes to practice level and have impact on hospitals are likely to have a much larger impact in the short term particularly the decisions made at the 'front door' of the hospital:

- The use of POAC – reducing variability and increasing targeting of certain conditions
- Planned proactive care – predictive risk modelling, risks stratification, care planning, action plans, Advance Care Plans (ACP) and a framework to ensure clinical pathway implementation for those at the highest risk of acute hospitalisation.
- Contact by a GP Team within 48 hours of discharge

5.2.3 Improvement Milestone

The overall improvement milestone recommended for this SLM is modest in year one because we believe it will take some time for the initiatives to have an impact. We have calculated the Auckland Metro acute bed days rate per thousand population is **456.7 in 2016 and** we believe it is reasonable to aim for a **2% reduction** in this rate to **447.6 bed days/1,000** population by June 2017. In out-years we would plan for a more ambitious reduction in real terms. However, it must be noted that any new beds opening will need to be adjusted for as supply side changes will impact this indicator in a stepwise fashion.

Two measures with associated targets have been decided for the 2016-17 year and they are:

- ED presentation Rate/1,000 population
- Readmission rate at 28 days

5.2.4 Selected Contributory Measures

The first two contributory measures and associated activities are identified for 2016-17; other four will be placed in a placeholder for the following year and is as follows:

1. **ED presentation rates.** This will provide practices with a sense of their relative utilisation and to be able to track whether the trend is changing. Overall reduction in ED presentations will result in less admissions and bed day use. There is some complexity involved in this measure however we believe that this will directly correlate with actual admissions and also potentially avoidable admissions so it is a good marker. The difficulty will come from wide confidence intervals for the measurement at a practice level. It is likely that we may use proxies (e.g. Access (timely urgent care), POAC utilisation rates, planned proactive care) for practice level reporting but that the ED presentation rates is still the best measure at a system/PHO level. We will establish the best methodology and set a target for the 2017-18 year based on this. The target in year one is to establish an accurate baseline and methodology for ongoing reporting.

2. **Acute readmission rates at 28 days – current measure (acute readmission).** Avoidance of readmission to hospital following a recent discharge from hospital. The target is to have a reduced readmission rate at 28 days to 7.7% by 30 June 2017.

The remaining four measures will be monitored over the 2016-17 year with a view to setting targets for the 2017-18 year, should they prove a useful way to monitor impact on the SLM:

- Average length of stay
- Stranded patients at 21 days
- 5% of risk stratified patients on a structured care plan
- Ratio of arranged admission/acute admission

5.2.5 Contributory Measures 2016-17 - Analysis and Justifications

1. ED presentation rate

Item	Details
Name	**ED presentation rates**
Definition	The number of ED events in Auckland public hospitals expressed as a rate per 1000 patients domiciled in ADHB, WDHB and CMDHB
Rationale & Justification	For every 100 people in New Zealand, 15 were ED patients at least once during the year Pacific population had the highest age-standardised rate of ED use in 2014/15 (193 per 1,000 population per quarter), followed by Māori (180 per 1,000 population per quarter). The rate of ED use increased with each level of neighbourhood deprivation One in three ED events ended with the patient being admitted to hospital.
Data Collection	Data source: The data is derived from NNPAC
Target & Target Justification	The current quarterly ED presentation rate for Auckland Metro is 49.3/1000 population per quarter. However this figure is not adjusted for DHB of domicile and there is seasonal variation and also wide confidence intervals (large standard error to the mean), so further work is required. The analysts are working on an autoregressive integrated moving average (ARIMA) methodology to be able to negate some of these effects and we feel that this may provide greater utility for this measure. Clearly further work is required to fully understand the best methodology and trends using DHB of domicile data. We don't believe in this current year that this can be changed dramatically and the trend has been increasing each year. Therefore the target in year one is to establish the baseline and ongoing methodology in order to set a target for ED presentations in the 2017-18 year. Future targets will be monitored by ethnicity to prevent increasing inequalities and to ensure that high needs populations (Maori, Pacific Island, and high deprivation) have the appropriate access to health services. By national standards, the Auckland DHBs perform relatively well in terms of lower use of emergency department. What is known, is that the rate of growth in ED attendance rates is not only higher than the rate of population growth, but is also variable across DHBs and the causes of this variation need to be better understood, however may not be easily addressed.
Current Performance	49.3/1000 population/quarter (Auckland Metro population – raw data)
Reporting Frequency	Proposed quarterly reporting of this indicator
Improvement Activities	POAC Planned Proactive Care Improving access and after hours services

2. Acute readmission rates at 28 days 2016-17

<table>
<tr><th>Item</th><th>Details</th></tr>
<tr><td>Name</td><td>Acute readmission rates at 28 days 2016-17</td></tr>
<tr><td>Definition</td><td>An unplanned acute hospital readmission may often (though not always) occur as a result of the care provided to the patient by the health system. Reducing unplanned acute admissions can therefore be interpreted as an indication of improving quality of care, in the hospital and/or primary care, ensuring that people receive better health and disability services. Through the intermediate outcome that people receive better health and disability services, the measure contributes to the high level outcome of New Zealanders living longer, healthier and more independent lives while receiving better care closer to home.</td></tr>
<tr><td>Rationale & Justification</td><td>Reducing unplanned readmissions can therefore be interpreted as an indication of improving quality of care in the hospital and/or primary care ensuring that people receive better health and disability services.</td></tr>
<tr><td>Data Collection</td><td>Numerator: Total number of acute readmissions within 28 days per DHB of domicile per year
Denominator: Inpatient discharged events
Data Source: The data is derived from NNPAC
This Ministry of Health KPI is currently under development</td></tr>
<tr><td>Target & Target Justification</td><td>The target is to have a reduced readmission rate at 28 days to 7.7% by 30 June 2017.
The target has been decided to reduce the variation across the three DHB’s to align to the best performing DHB.</td></tr>
<tr><td>Current Performance</td><td>Standardised readmission rate 12 months to March 31 (NNPAC):
<table>
<tr><th>DHB/Country</th><th>Rate 2016</th></tr>
<tr><td>ADHB</td><td>8.1%</td></tr>
<tr><td>CMDHB</td><td>7.7%</td></tr>
<tr><td>WDHB</td><td>8.0%</td></tr>
<tr><td>NZ</td><td>7.9%</td></tr>
</table></td></tr>
<tr><td>Reporting Frequency</td><td>Data will be released by the Ministry of Health quarterly</td></tr>
<tr><td>Improvement Activities</td><td>Patients contacted by primary care within 48 hours of discharge</td></tr>
</table>

5.2.6 Remarks

Some of the interventions listed to support the contributory measures (especially Care Planning and POAC utilisation) represent both direct opportunities to affect the SLM, but also indirect opportunities to implement infrastructure or platforms that can be leveraged for more efficient implementation of subsequent initiatives such as clinical pathway implementation, integrated health & social services, targeted intense care through risk stratification and others.

Other initiatives not clearly described in this plan also will affect this SLM over the longer term. These initiatives include implementation of the Health Care Home model in general practice. This model will increase general practice capacity and promote more effective and fit for purpose models of care within practices, specifically targeting acute care, planned proactive care and preventative care in tailored and person-centred ways. Another initiative is the potential implementation of the Northern Electronic Health Record, which has the

potential to improve the safety and efficiency of care delivered across the entire patient journey if fully implemented.

Measures in Placeholder

1. **Average Length of Stay – current measure.** This will be monitored; however will not be included in the selected contributory measure for this SLM.
2. **Stranded patients whose stay is 21 days or longer.** Tracking this will allow us to see if we are being effective at preventing the very long admissions which are often complicated by social factors. This should be measured and tracked, but is not recommended as a contributory measure in the current plan.
3. **Top 5% of patients on risk stratification reports are in a structured care programme.** Planned proactive approach to long-term condition management. Recent data has demonstrated that patients who are in the top 5% of the risk stratification reports are 6 times more likely to have an acute medical admission within 6 months. With a planned proactive care approach we believe many of the patients in this 5% will have reduced acute hospital admissions, therefore we recommend this as a third contributory measure, noting that in order for it to be viable, the planned proactive care programme must be in place. Therefore this measure is contingent upon the selection of the recommended interventions in section 1.2 of the plan.
4. **Ratio of Arranged Admission (AA)/Acute Admission (AC).** This indicates better linkages between primary care and the hospital to improve the outcome. We believe more work should be undertaken to better understand the use of this measure, but note that it could in future be considered as a contributory measure.

5.2.7 Intervention Logic

Please refer to 5.2.2

5.3 Patient Experience of Care

5.3.1 Definition

MoH definition for "Person centred 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. Integration has not happened until people experience it. The intended outcome for this SLM is improved clinical outcomes for patients in primary and secondary care through improved patient safety and experience of care.

5.3.2 Context and Rationale

The DHB Adult Inpatient Survey: Nationally applied and conducted quarterly since 2014 and. For the first year, the SLM milestone for patient experience should focus on the Adult Inpatient Experience Survey. This survey captures 4 measured domains-**communications, partnership, coordination, physical and emotional needs**

Related interventions to improve patient experience scores in the 4 domains to promote survey uptake and use the results to improve quality. Individual DHB need to improve the survey uptake results, particularly equity aspects and foster greater regional collaboration. This may include working with Maori, Pacific; Asian provider teams within the hospital to facilitate feedback from recently discharged patients, and/or language specific initiatives.

Related interventions to improve response rates include exploring other modality options (e.g. use of tablets at the time of discharge), increasing email uptake during administration

processes, and promoting the patient experience survey to patients via pamphlets and other resources.

Primary Health Care Patient Experience Survey (PHC PES) is currently in pilot phase. In Auckland ProCare (38 practices) and National Hauora Coalition (12 practices) PHOs are currently involved in the pilot. According to the HQSC, this will be implemented in all practices by May 2017, but it is critically dependent on establishment of the National Enrolment System, which has not yet been implemented in any practices.

E-Portals - patient portal is defined as "a secure online website that gives patients convenient 24-hour access to personal health information from anywhere with an Internet connection" Data are managed by health care organisations, and enable patients to access information like recent doctor visits, discharge summaries, medications, immunizations, allergies, lab results. They may also enable patients to request prescription refills, schedule non-urgent appointments, and exchange secure messaging with their providers. Patient portals are still in their infancy in New Zealand, and most primary care portals only currently have the functionality for patients to access lab results, book appointments, and order repeat prescriptions. Research has shown that the use of patient portals is associated with higher patient retention rates (which is related to continuity of care) and lower appointment no-show rates. Studies have documented high rates of patient satisfaction with portals, improvements in patient-provider communication and an increase in patients feeling that they were able to take a more active role in medical decision making. For those with a chronic illness such as diabetes, patient portals can also provide a vehicle to receive ongoing self-management support.

Considering this measure as it is clearly indicated in the measures library, more general practices are offering patient portals and there is scope within PHC to positively impact the SLM milestone. This can be enabled through alternative access point/navigation for the patient, enabling **coordinated** self-managed care provision; maintaining and providing online **communication**; and **partnering** with the patient to work collaboratively online (lab results, appointment bookings, care monitoring-**physical needs**).

5.3.3 Improvement Milestone

Improvement milestone for the 2016-17 year is as follows:

The DHB Adult Inpatient Survey - Maintenance of an aggregated 8/10 score for all four domains across the three DHBs. It is suggested to maintain current state and continue to improve.

5.3.4 Selected Contributory Measures

1. The **DHB Adult Inpatient Survey** This is consistent with MoH patient experience, captured via nationally applied patient feedback survey.

2. **E-Portals -** 40% of PHO practices are registered with a portal and 10% of the PHO population have access to a portal.

5.3.5 Contributory Measures 2016-17 - Analysis and Justifications

1. The DHB adult inpatient survey

Item	Details
Name	**The DHB adult inpatient survey**
Definition	The HQSC has designed a 20 item adult inpatient survey

<table>
<tr><th>Item</th><th>Details</th></tr>
<tr><td></td><td>(commenced July 2014) which is routinely used within hospitals to measure patient experience on a quarterly basis. The 4 key domains of patient experience are: communication, partnership, co-ordination, and physical and emotional needs. A selection of adults (n=400) who have spent at least one night in hospital are sent an invitation via email, text or post inviting them to participate in the survey. Responses are anonymous, unless patients choose otherwise.</td></tr>
<tr><td>Rationale & Justification</td><td>A nationally applied measure, therefore uniform across the 3 DHBs and has been directed by the MoH. A focus on the 4 domain areas and the scoring for these will maintain the intervention for the first 12 months and start to highlight areas within each of the domains that need attention and intervention. For example, a CQI focus on the domain of communication may be fostered through a customer service training initiative for frontline staff. The challenge for equity allowance needs addressing, so by targeting this as a CM we may actively start to consider options to support the diverse Auckland Metro population, such as survey translation into other languages; survey via APPs.</td></tr>
<tr><td>Data Collection</td><td>(1) Aggregated score for the 4 domains (out of 10) for each of the 3 Auckland DHBs;
(2) No. of hospitalised patients aged ≥15y that provided feedback via the adult in-patient survey/No. of hospitalised patients aged ≥15y who are surveyed.
Source: DHBs/HQSC
Responsible persons: Jo Rankine (Quality Assurance Manager, CMDHB); Sarah Devine (Online Participation Manager, ADHB); David Price (Director, Patient Engagement, WDHB)</td></tr>
<tr><td>Target & Target Justification</td><td>Maintenance of an aggregated score for the 4 domains of 8 out of 10 for each of the 3 Auckland DHBs;
Maintain and continue to improve response rates for the DHB inpatient survey.
Maintain current state for next 12 months.
Focus on 1-2 domains, e.g. Communication to address risk areas tabled above and broaden equity lens.</td></tr>
<tr><td>Current Performance</td><td>Results as at May 2016:
<table>
<tr><th></th><th></th><th colspan="4">Score out of 10</th></tr>
<tr><th></th><th>Response Rate</th><th>Communication</th><th>Coordination</th><th>Partnership</th><th>Physical & emotional needs</th></tr>
<tr><td>National</td><td>27%</td><td>8.3</td><td>8.3</td><td>8.4</td><td>8.3</td></tr>
<tr><td>ADHB</td><td>17%</td><td>8.3</td><td>8.3</td><td>8.4</td><td>8.3</td></tr>
<tr><td>CMDHB</td><td>13%</td><td>8.2</td><td>8.0</td><td>8.4</td><td>8.0</td></tr>
<tr><td>WDHB</td><td>34%</td><td>8.4</td><td>8.4</td><td>8.3</td><td>8.7</td></tr>
</table></td></tr>
<tr><td>Reporting Frequency</td><td>Quarterly
Review of aggregated score for each of the four domains (communication, coordination, physical and emotional needs, partnership) each of the 3 DHBs of ≥8/10 is achieved</td></tr>
<tr><td>Improvement Activities</td><td>Related interventions to improve patient experience scores in the 4</td></tr>
</table>

Item	Details
	domains include investing in formal quality improvement methods such as Continuous Quality Improvement, widely promoting survey results among managers and front-line staff to encourage quality improvement, holding more frequent patient experience events (such as listening events), encouraging patient stories. The need to build on individual DHB endeavours to improve on the survey, particularly equity aspects (noted later) and foster greater regional collaboration. This may include working with Maori, Pacific, Asian provider teams within the hospital to facilitate feedback from recently discharged patients, and/or language specific initiatives. Related interventions to improve response rates include exploring other modality options (e.g. use of tablets at the time of discharge), increasing email uptake during administration processes, and promoting the patient experience survey to patients via pamphlets and other resources.

2. E-Portal (PHC Specific)

Item	Details
Name	**E-Portals (PHC specific)**
Definition	A single gateway for patients to gain access to their general practice information which can include: booking appointments, ordering repeat prescriptions, checking lab results, and viewing clinical notes/records.
Rationale & Justification	E-Portals are clearly indicated in the measures library, more general practices are offering patient portals and there is scope within PHC for them to positively impact the SLM milestone. This can be enabled through alternative access point/navigation for the patient, enabling coordinated self-managed care provision; maintaining and providing online communication; and partnering with the patient to work collaboratively online (lab results, appointment bookings, care monitoring-physical needs).
Data Collection	(1) no. of practices with access to online GP portals/no. of GP practices; (2) pts that have an active username & login to use GP portals/no. of enrolled pts Source: Provider dependent PHO/MoH Responsible persons: PHO/MoH (Judy Eves (MoH)
Target & Target Justification	40 % of PHO Practices are registered with a portal 10 % of PHO population who have access to a portal (appt; labs/results; repeat Rx; clinical notes) Not all Auckland Metro PHOs have uptake, so applying this improvement milestone to achieve an increase in practices offering a portal and patients registered to use one will support patient experience. With a focus on 1-2 domains of the SLM Milestone, e.g. Communication, gains can be made via an alternative communication point for patients with their General Practice Team (GPT), for blood result monitoring, repeat prescriptions, appointment bookings, and similarly with coordination, it may

<table>
<tr><td></td><td>support reducing travel for some elderly patients or those with long term conditions to obtain information (www.patientportals.co.nz)</td></tr>
<tr><td>Current Performance</td><td>
<table>
<tr><th>PHO</th><th>Practices with portal</th><th>%</th><th>Pts with login access</th><th>%</th></tr>
<tr><td>Waitemata</td><td>20/50</td><td>40</td><td>12838/247727</td><td>5.2</td></tr>
<tr><td>Total Health Care</td><td>7/7</td><td>100</td><td>309/101059</td><td>0.3</td></tr>
<tr><td>NHC</td><td>0/26</td><td>0</td><td>0/84420</td><td>0</td></tr>
<tr><td>East Health</td><td>8/22</td><td>36.4</td><td>16323/100282</td><td>16.3</td></tr>
<tr><td>ProCare</td><td>88/182</td><td>48.4</td><td>45713/819432</td><td>5.6</td></tr>
<tr><td>Auckland</td><td>10/25</td><td>40</td><td>4256/68814</td><td>6.2</td></tr>
<tr><td>AH+</td><td>23/33</td><td>39.4</td><td>1675/106354</td><td>1.6</td></tr>
</table>
</td></tr>
<tr><td>Reporting Frequency</td><td>Quarterly
Review of Number of Practices with a portal (and total number of practices)
Review of % of practices with a portal
Review of Patients with access to a Portal (and total number of enrolled Patients)
Review of % of patients with portal access.</td></tr>
<tr><td>Improvement Activities</td><td>Activities in this area are not currently coordinated, number of e-portal ambassadors appointed by the National Health IT board who are able to talk with GPs and practices about the benefits of e-portals, but there is no current regular, structured programme for championing e-portals. Individual practices have their own procedures for notifying patients of available e-portals and giving out login instructions, but there is no regional/structured procedure.</td></tr>
</table>

5.3.6 Remarks

The patient experience of care improvement approach is limiting in this first phase/year. The SLM milestone and associated two contributory measures have been identified, based on the MoH preferred direction. This includes an SLM milestone for Adult Inpatient Survey and E-Portal uptake (specific in this period to primary health care activity).

For associated contributory measure activity, refer to the Patient experience of Care Logic model (Appendix 5.2.3). It is critical to note this year's improvement planning focuses on maintenance of the DHB inpatient survey (with further exploration on refining this more appropriately) and expansion of E-Portal uptake specific to PHC.

Mapping for ongoing 2-5 year proposed activity in the areas of NES, PHC PES and Compassionate Care is provided. This work can only be enabled through the commitment, drive and review of a regional collaborative group (already established with patient experience position holders and experts across Auckland Metro) with the recommendation they meet at least on a monthly basis.

5.3.7 Intervention Logic

Please refer to 5.2.3

5.4 Amenable Mortality

5.4.1 Definition

Premature deaths that could potentially be avoided given effective and timely care. That is, deaths from diseases for which effective health interventions exist that might prevent death before an arbitrary upper age limit (usually 75)

5.4.2 Context and Rationale

Amenable mortality contributory measures for the 2016-17 have been selected based on the following criteria;

1. To improve current gaps in equity
2. Have evidence based interventions available to reduce mortality
3. Have gaps in current performance,
4. Will align with regional activities already being undertaken in these areas,
5. Ability for sector to deliver on

Literature review confirms that early mortality could be prevented with early screening, adequate coverage of screening, access to evidence based interventions, access to newly funded treatment and use of evidence based clinical pathways would lead to a reduction in mortality in the contributory measures selected.

List of 35 amenable mortality conditions have been grouped into six super-categories:

1. Infections
2. Maternal and infant conditions
3. Injuries
4. Cancers
5. Cardiovascular diseases and diabetes
6. Other chronic diseases.

5.4.3 Improvement Milestone

Improvement milestone for the 2016-17 year is as follows:

It is recommended to maintain the overall current status at the current rate of:

DHB of Domicile	Total	
	Deaths	Rate
Waitemata	2352	84.9
Auckland	2007	98.7
Counties Manukau	3001	135.6

MoH-Amenable mortality, ages 0-74, 2009-2013 (Calculated using projected 2011 population data)

The main focus of the work will be condition specific, which will impact positively on the overall amenable mortality rate.

5.4.4 Selected Contributory Measures

The following contributory measures will be implemented in the 2016-17 year:

1. **CVD Risk Assessment** – to increase coverage of Maori to 90%
2. **CVD Management** - to increase triple therapy by 5% for those with a prior CVD event, those with a CVD RA of ≥ 20% and with a particular focus on patients with diabetes

3. **Reduction in smokers** through increase support to quit - 10% from the baseline/DHB
4. **Increase in Maori breast screening** rates to reach 70% in all 3 DHBs
5. **Identification and treatment for patients with Hepatitis C**

The working group acknowledge that there are other areas of focus which will have a greater impact on amenable mortality at a population level and these are listed as placeholders to develop as resources and sector ability to implement matures:

5.4.5 Contributory Measures 2016-17 - Analysis and Justifications

1. Decrease in mortality associated with cardiovascular disease

Item	Details
Name	**CVD risk assessment and management – primary and secondary prevention**
Definition	90% CVD RA for all ethnicities with a particular focus on Maori coverage Improved CVD management for Secondary and Primary Prevention
Rationale & Justification	Equity gap is clear for Maori CVD risk assessment for Maori is lower than 90% National Target NRA reports have shown a marked gap in CVD management.
Data Collection	NRA benchmarking reports and PHO quarterly reports.
Target & Target Justification	By June 2018: 90% coverage for Maori – National target which has not yet been achieved. By June 2018: 5% increase in dual/triple therapy for those with a high CVD risk (≥ 20%), those with a prior CVD event and a particular focus on diabetes status. This target reflects the Northern Region Cardiac KPI goal. By June 2017 a 2.5% increase in dual/ triple therapy for primary and secondary prevention cohorts. (2017 Target to be confirmed)
Current Performance	Māori CVD risk assessment rates for CMDHB: 88.8% ADHB: 89.3 % WDHB: 86.9% Young male Māori screening rates are well below the target with CMDHB currently screening only 72.6% of the eligible population, while ADHB have screened 76.2% and WDHB 71.2% as at the 30th of June 2016. CVD Management of patients with a prior CVD event:

NRCN results (12mo ended 31Mar16) PRIOR **CVD ON TRIPLE**	ADHB	CMDHB	WDHB
Numerator	4018	5975	6565
Denominator	7610	10,356	12,157
Percentage	52.8%	57.7%	54.0%

NRCN Prior CVD on Triple	Māori	Pacific	Asian	Indian	Other	People with Diabetes
Auckland						

	Denominator	623	1004	819	770	4394	2620
	Percentage	49.3%	57.0%	49.0%	62.3%	51.4%	62.6%
	Counties Manukau						
	Denominator	1627	2107	595	866	5161	4207
	Percentage	54.1%	60.8%	50.9%	67.8%	56.6%	67.5%
	Waitemata						
	Denominator	803	764	825	479	9286	3461
	Percentage	55.5%	59.7%	46.2%	62.4%	53.6%	65.9%

NRCN results (12mo ended 31Mar16) **CVDRA OVER 20% ON DUAL**	ADHB	CMDHB	WDHB
Numerator	3303	7180	4126
Denominator	8017	14563	9918
Percentage	41.2%	49.3%	41.6%

NRCN Prior CVD on Triple	Māori	Pacific	Asian	Indian	Other	People with Diabetes
Auckland						
Denominator	833	1918	919	885	3462	4671
Percentage	40.1%	48.2%	44.7%	43.5%	36.0%	53.0%
Counties Manukau						
Denominator	2442	5002	903	1503	4712	9902
Percentage	48.8%	54.9%	42.0%	51.9%	42.2%	59.2%
Waitemata						
Denominator	946	1214	1024	583	6151	5085
Percentage	42.8%	49.4%	38.9%	44.9%	40.0%	54.9%

Reporting Frequency	Quarterly PHO reports, 6 monthly Northern Region Cardiac Network reports Evaluation will be determined by the movement towards the goals through quarterly PHO reports and 6 monthly
Improvement Activities	CVD RA access improvement & Improving CVD management for those with a high CVD risk (≥ 20%) , those who have had a prior CVD event 2^{o} prevention management and patients with diabetes

2. Decrease in mortality associated with smoking related diseases through increased quit attempts and increased support to quit

Item	**Details**
Name	**Reduction in smoking rates**
Definition	A documented increase in smoking cessation attempts using the following Cessation Support codes: ZPSC10 – Referral to smoking cessation support ZPSC20 – Prescribed smoking cessation medication ZPSC30- Provided smoking cessation behavioural support.
Rationale & Justification	The Auckland Metro DHBs have achieved the 'brief advice 'better help for smokers to quit health target since 2012. However, the routine provision of brief advice has not resulted in a substantial number of smokers accepting the offer of help to quit. The rate for Cessation Support for quarter 4 2015-16 was

<table>
<tr><th>Item</th><th>Details</th></tr>
<tr><td></td><td>24.1% for CMDHB
26.8% for ADHB
33.7% for WDHB</td></tr>
<tr><td>Data Collection</td><td>The codes above are collected through PHO PMS data extraction
Data will also be provided by the new smoking cessation providers</td></tr>
<tr><td>Target & Target Justification</td><td>Working towards the 2025 Smoke Free Target :
ADHB
Currently estimated there’s 47,000 smokers aged 15+ in ADHB (based on 2013 smoking prevalence). By 2025 we need to reduce this to around 24,500 to be below 5%. This equates to around 2,500 smokers each year that need to quit.
For Maori and Pacific there are around 16,500 adult smokers and we need to reduce this number to 4,100 by 2025 to reach 5% within this group.
This equates to around 1,400 Maori and Pacific adults needing to quit each year.
However, given that it will take time to carry out activities to improve referral and prescribing rate the target for 2017 will be current activity as listed above and an increase of 10%. (Baseline is 26.8%)
WDHB
Currently estimated there’s 57,000 smokers aged 15+ in WDHB (based on 2013 smoking prevalence). By 2025 we need to reduce this to around 27,700 to be below 5%. This equates to around 3,350 smokers each year that need to quit. For Maori and Pacific there are around 16,600 adult smokers and we need to reduce this number to 4,300 by 2025 to reach 5% within this group.
This equates to around 1,400 Maori and Pacific adults needing to quit each year.
However, given that it will take time to carry out activities to improve referral and prescribing rate the target for 2017 will be current activity as listed above and an increase of 10%. (Baseline is 24.1%)
CMDHB
Current quit activity is unlikely to achieve a Smokefree CMDHB district by 2025, based on recent Census data. To achieve this goal, increased quit volumes are needed to encourage Maori and Pacific people who smoke to quit.
Between 2016 and 2025, an average of about 2,400 Maori and Pacific people who smoke are required to quit each year. In terms of volume of supported quit attempts this is about 7,200 extra supported quit attempts/year
However, given that it will take time to carry out activities to improve referral and prescribing rate the target for 2017 will be current activity as listed above and an increase of 10%. (Baseline is 33.7%)</td></tr>
<tr><td>Current Performance</td><td>
<table>
<tr><th></th><th>Current smoker or recently quit</th><th>Eligible population with recorded smoking status</th><th>Rate</th></tr>
<tr><td>WDHB</td><td></td><td></td><td></td></tr>
<tr><td>Maori</td><td>10,156</td><td>29,411</td><td>35%</td></tr>
</table>
</td></tr>
</table>

Item	Details			
	Pacific	4,767	22,083	22%
	Other	34,858	303,840	11%
	ADHB			
	Maori	8,692	25,527	34%
	Pacific	12,011	55,040	22%
	Other	29,204	313,874	9%
	CMDHB			
	Maori	21,878	51,688	42%
	Pacific	21,677	80,875	27%
	Other	25,859	231,031	11%
Reporting Frequency	Quarterly from PHO Quarterly from smoking cessation providers Analysis on a quarterly basis on movement towards the target of baseline activity + 10% for each DHB			
Improvement Activities	Smoking Cessation			

3. Decrease in mortality associated with breast cancer

Item	Details
Name	**Increasing the coverage rate of beast screening across the Auckland Metro region with a particular focus on Maori women.**
Definition	Number of women accessing breast screening by ethnicity
Rationale & Justification	Breast screening programmes achieving coverage of 70% eligible women can reduce mortality from breast cancer by 30-35% for women who are screened compared to those who were not.
Data Collection	Quarterly data from Breast screen providers in WDHB, ADHB and CMDHB.
Target & Target Justification	The target for 2016-17 is to increase coverage in Maori women in particular to reach 70%

DHB June 2016	Ethnicity	Census projection number of women	Women screened in last 2 years	2 year coverage %	Number of women required to reach 70% target
Waitemata	Maori	4,380	2,813	64.2%	253
	Pacific	3,310	2,540	76.7%	
	Other	60,220	40,287	66.9%	1,867
	Total	67,910	45,667	67.2%	1,870
Auckland	Maori	3,400	2,035	59.9%	345
	Pacific	4,520	3,365	74.4%	
	Other	42,710	27,270	63.8%	2,627
	Total	50,630	32,772	64.7%	2,669
Counties	Maori	6,210	4,091	65.9%	256
	Pacific	8,340	6,274	75.2%	
	Other	41,290	28,076	68.0%	827
	Total	55,840	38,464	68.9%	624
National	Maori	58,860	38,385	65.2%	2,817
	Pacific	22,830	16,527	72.4%	
	Other	475,975	342,921	72.0%	
	Total	557,665	398,440	71.4%	

Item	Details
	Over the coming years the focus will then shift towards supporting women to treatment – particularly Pacific women.
Current Performance	As above
Reporting Frequency	Quarterly reporting from Breast Screen Providers Movement towards the goal of 70% coverage by June 2018, particularly for Maori women.
Improvement Activities	Three Hundred Campaign - Improving Breast Screening Rates across Auckland

4. Reducing mortality from Hepatitis C

Item	Details
Name	**Identification and treatment for patients with Hepatitis C**
Definition	Identification and Treatment for patients with Hepatitis C – targeting the following communities at risk: • People whom inject drugs • Tattooing or piercing in an unlicensed parlour • Ever been in prison • Medical procedure overseas or in NZ pre-1992 (blood screening started) • Lived in high risk countries (Middle Eastern, Indian Subcontinent, Southeast Asia, Eastern Europe, Russia) • Born to a mother with Hep C
Rationale & Justification	• Harm from illicit drugs makes up 1.2% of NZ's health loss and there are significant productivity losses from chronic liver diseases. • There are very large ethnic and deprivation inequalities in Hep C harm. • Hepatitis C affects 1.1% of population in NZ with 50,000 patients infected nationally. • Auckland Metro has approximately 18,000 patients, • In the Northern Region there are 2,100 patients identified in secondary care, with another estimated 8-10,000 patients identifiable within primary care PMS audits. (i.e. 40-60% of people are not aware they have HCV) • There were 580 new patients in Auckland Metro area in 2015. • It is anticipated that in this first year of having Treatment for genotype 1's (57% of all Hep C) available this will increase to somewhere between 4,000-4,500 new diagnosis for year 1 of the project • There is new funded Direct Acting Antivirals available • There is a new clinical pathway for the identification and management of Hepatitis C available • There is a simplified process of screening through reflex blood testing on positive results • There will be an e-referral mechanism for liver elastography scan referrals
Data Collection	Obtained from PHO PMS, Testsafe and DHB reporting systems
Target & Target	By June 2018

Item	Details
Justification	10% of those identified in PMS' will be treated (measured through quarterly reports) 30% of those identified in secondary care will be treated (measured through quarterly reports)
Current Performance	Currently there is less than 1% access to interferon based funded treatment.
Reporting Frequency	PHO quarterly reports DHB quarterly reports Evaluated by Movement towards the primary care and the secondary care targets.
Improvement Activities	Hep C Treatment

5.4.6 Remarks

The contributory measures chosen for the first year relied on activities already underway and the ability of sector to deliver on given the short time frame. Some contributory measures have had to be delayed until further analysis is completed. Challenges to collect PHO data will need to be addressed to reduce variations amongst selected contributory measures.

Additional contributory Measures for 2017-18:

There are other areas of focus which will have a greater impact on amenable mortality at a population level. In particular a diabetes suite of indicators will be incorporated into the 2017 and 2018 workplan. The ADHB/WDHB Diabetes Service Level Alliance and the evaluation of the CMDHB Modified Diabetes Care Improvement Programme are to be used to inform the 2017-18 improvement plan. Similarly, 2017 will also be used as a research and analysis year for strategies to improve HPV Vaccination coverage.

1. **Diabetes ***
   - HbA1c glycaemic control
   - Blood pressure control
   - Management of microalbuminuria

* Diabetes as a contributory measure will be included in the 2017/2018 out years. The reason for the delay is awaiting the completion of the evaluation of the modified Diabetes Care Improvement Package in CMDHB and the ADHB/WDHB Diabetes Service Alliance Business Case completion, both of which are due in March/April 2017.

In the meantime, in 2016-17 there will be a particular focus on CVD management for patients with diabetes who have had a prior CVD event or have a CVD Risk Assessment of ≥ 20%.

2. **HPV vaccination coverage –** although the numbers of deaths associated with cervical cancer are low as a result of the cervical screening programme, the vaccine is a preventative measure for oropharyngeal cancer associated with HPV and will reduce the frequency of cervical screening. The coverage rate for HPV vaccination in CMDHB and WDHB is low (61.7% and 60.2%) respectively compared with ADHB (83.3%). It is proposed that 2017 will be used as a research and analysis year to understand the discrepancy and improve visibility of declines to primary care.

3. **Bowel Cancer** identification and screening – awaiting the National roll out of the bowel screening programme
4. **Mental health** – improved screening coverage for high risk patient populations and for those at risk of suicide
5. **Endometrial Cancer** identification and treatment
6. **Melanoma** identification and treatment
7. **Atrial fibrillation** will need consideration in future years

5.4.7 Intervention Logic

Please refer to 5.2.4

6. APPENDIX

6.1 Glossary

ACP	Advanced Care Plan
ADHB	Auckland District Health Board
ALOS	Average Length of Stay
ALT	Alliance Leadership Team
ARDS	Auckland Regional Dental Services
ARI	At Risk Individuals
ASH	Ambulatory Sensitive Hospitalisation
CMDHB	Counties Manukau District Health Board
CM Health	Counties Manukau Health
DHB	District Health Board
FFT	Family and Friends Test
GP	General Practitioner
HCV	Hepatitis C virus
HPV	Human Papilloma Virus
HQSC	Health Quality and Safety Commission
IPIF	Integrated Performance and Incentive Framework
MoH	Ministry of Health
NCHIP	National Child Health Information Platform
NES	National Enrolment System
NNPAC	National Non-Admitted Patient Collection Data Mart (NNPAC DM)
PHC PES	Primary Health Care Patient Experience Survey
PHO	Primary Health Organisation
POAC	Primary Options for Acute Care
SLMs	System Level Measures
UK	United Kingdom
WDHB	Waitemata District Health Board

6.2 Intervention Logic

The intervention logic and outcomes framework summarises the key priorities that inform this 2015/16 Annual Plan, including the key measures we monitor to ensure that we are achieving our objectives. Our outcomes framework enables the DHB to ensure it is achieving its vision and delivering the best possible outcomes across the whole system for our population.

6.2.1 Ambulatory Sensitive Hospitalisations (ASH) Rate	 ASH - Logic Model 14.10.16.pdf
6.2.2 Acute Hospital Bed Days Per Capita	 Acute Bed Days - Logic Model 14.10.16
6.2.3 Patient Experience of Care	 Pt Exp of Care - Logic Model 14.10.16
6.2.4 Amenable Mortality	 Amenable Mortality - Logic Model 14.10.20