# BAY OF PLENTY ALLIANCE LEADERSHIP TEAM

## SYSTEM-LEVEL MEASURES FRAMEWORK– IMPROVEMENT PLAN

### 2016 - 2017

**Foreword:**
This Improvement Plan is the outcome of collaboration across the primary / secondary provider networks within the Bay of Plenty health system.

The initiatives and agreed actions set out within have been developed to identify a range of Contributory Measures that will positively impact current performance of nationally agreed Service-level Measures that reflect the health outcomes from our system overall.

It is recognised that a sound platform must be created to support further improvement work to be progressed in subsequent years. It is our collective view that this Improvement Plan seeks to create that platform and enhance further opportunities to identify and build on improvement outcomes for our communities. A key enabler to that development is a sound, accurate and effective data capture and dissemination framework. The following sets out a broad approach to this development and acts as a reference to key initiatives set out within this Improvement Plan:

## DATA REQUIREMENTS ACROSS MULTIPLE MEASURES

- That an information system be developed that can provide practices with the following data regarding their enrolled patients
    - Patients who have attended ED
    - Patients who have been admitted to hospital acutely
    - Current inpatients including predicted date of discharge where available
    - Patients with pending elective admissions, reason for admission and expected date of admission
    - Patients with pending outpatients appointments and investigations, including the date and type of appointment
    - Patients receiving on-going support from community allied health and nursing services
    - Patients who have not attended/missed an appointment
    - Patients <75 years of age that have died
- This data is being presented so that general practice can consider future opportunities for supporting their patients with their interactions with specialist services and identifying those that might be managed in the community. This data can also be used to help practices identify those people who may be living in a household where the housing is contributing to morbidity.
- This data set has the potential to support innovation and improvement in the following
    - ASH for 0-4 year olds
    - Amenable mortality
    - Acute bed days
    - Patient experience through the reduction of DNA rates

We acknowledge that there are equity gaps between Maori and non-Maori and are committed to reducing these disparities in the following measures which are causative of these gaps.

**AMBULATORY SENSITIVE HOSPITALISATIONS – 0-4 YEAR OLDS:**
**BASELINE:** OVERALL ASH RATE: 7785, WHICH EQUATES TO 1146 EVENTS[1] MAORI: ASH RATE: 8612 (546 EVENTS) OTHER: ASH RATE: 7160 (600 EVENTS)
**MILESTONE:** A 2.5% REDUCTION IN OVERALL ASH RATE BY 30 JUNE 2017 (NB: Given start time for current year, 2.5% is considered reasonable. A full year reduction would be 5%)

| **Contributory Measure:** | **Input:** | **Output / Measure:** | **From / By When:** |
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| Collective understanding of ASH activity for 0-4 year olds | • Refer to data requirements as set out above. Report sets to cover; ASH activity and Emergency Department Frequent Attender presentations. | • Effective, accurate and timely data report-sets are developed and distributed to all relevant stakeholders on at least a quarterly basis. | • By 1 January 2017 |
| Early Enrolment for New-borns. | • New-born enrolment notification across the system will be significantly improved from Birthing Centres and NIR for accurate early notification for enrolment at the right GP practice. | • Approved Enrolment processes improved and implemented across service environment.<br>• 90% of new-born children will be enrolled with a General Practice within 3 months of birth.<br>• 95% Maori preschool children will be enrolled in a dental clinic. | • By 1 January 2017<br>• By 1 April 2017<br>• 30 June 2017 |
| **HQMNZ Library Reference:** http://www.hqmnz.org.nz/library/Newborns_Enrolled_in_a_Primary_Health_Organisation | | | |
| Vaccination of eligible children for Seasonal Influenza. | • Develop and promote an awareness campaign across primary and secondary care providers on eligibility of children with respiratory conditions to fully subsidised seasonal influenza vaccinations. | • All providers are aware of eligibility criteria for free access to seasonal flu vaccinations for this patient cohort.<br>• Provider Arm to vaccinate eligible hospitalised children pre discharge.<br>• Primary Care providers actively identify and offer free vaccinations to eligible children. | • By 1 March 2017<br>• 1 October 2017 |

[1] Sourced from: http://nsfl.health.govt.nz/system/files/documents/pages/ash_reportv12_0.xlsm

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| | | • Impact of initiative to be reported by % of eligible children vaccinated. | |
| Improving outcomes for children living in environments that may be adversely impacting their health. | • Identify within the ASH data subset, those events where housing conditions may be a contributing factor.<br>• Develop a housing assessment tool. | • Effective liaison arrangements are in place to support engagement with and referral to external agencies where housing conditions may be addressed.<br>• Number of referrals to healthy homes<br>• Reduction in ASH respiratory events where housing conditions are a contributing factor. | • By 1 April 2017 |
| **<u>Justification</u>**<br>• Upper Respiratory Conditions significantly above National Average – 80 events above the national average (301 to 221)[2] – Rank 18th (of 20)<br>• Lower Respiratory Conditions significantly above National Average – 38 events above the national average (101 to 63) – Rank 20th<br>• Very poor rates of Oral Health – 19 events above the national average (159 to 140) – Rank 11th<br>• Particularly for Maori – 41 events above the national average (97 to 56)_- Rank 13th comparison of Maori ASH rates per DHB for dental conditions | | | |

[2] Once normalised for Bay of Plenty's 0-4 population

**AMENABLE MORTALITY:**
**BASELINE:** STANDARDISED AMENABLE MORTALITY RATE 105.6 (2013 PROVISIONAL)[3]
INCLUDE MAORI BASELINE: STANDARDISED AMENABLE MORTALITY RATE 244.6 (2009-2013 DATA, WITH 2013 PROVISIONAL – FOR COMPARISON AMENABLE MORTALITY RATE OF 133.5 FOR TOTAL POPULATION OVER THE SAME PERIOD[4]
**MILESTONE:** A MINIMUM 2.5% REDUCTION IN THE STANDARDISED AMENABLE MORTALITY RATE FOR BOTH TOTAL POPULATION AND MAORI.

| **Contributory Measure:** | **Input:** | **Output / Measure:** | **From / By When:** |
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| Improved management of patients with significant (>10%) CVD risk factors. | • Adoption of an effective risk stratification capability to report against patients with significant risk factors including; HbA1c, CVD Risk, Lipid levels and Hypertension. | • Reporting and benchmarking by practice on risk stratification profile with an agreed risk stratification tool.<br>• Number of high risk patients who have were referred to and participated in a self-management Lifestyle Wellness programme by ethnicity.<br>• Number attending a diabetes self-management programme by ethnicity. | • By 1 January 2017<br>• From 1 July 2017<br>• From 1 July 2017<br>• From 1 July 2017 |
| **HQMNZ Library references:** http://www.hqmnz.org.nz/library/HbA1c_test_results<br>http://www.hqmnz.org.nz/library/Improved_Management_of_Long_Term_Conditions_(Diabetes)<br>http://www.hqmnz.org.nz/library/Cardiovascular_disease_risk_assessment | | | |
| Reduced mortality through improved outcomes from smoking cessation support | • System capability to monitor smoker prevalence over time, allowing Practices to analyse impact of initiatives to support smoking cessation. | • Continued improvement in existing performance against the national Health Target of 90%<br>• Achievement and ongoing maintenance against this target of 90%.<br>• 5% of regular smokers across BoP are enrolled in the Hapainga Regional Stop Smoking service. | • By 1 October 2016<br>• From 1 January 2017<br>• Ongoing |

[3] Sourced from: http://nsfl.health.govt.nz/system/files/documents/pages/amenable_mortality_dhb_summary_201603_0.xls
[4] Sourced from: http://nsfl.health.govt.nz/system/files/documents/pages/amenable_mortality_dhb_ethnicity_rates_summary_201603_0.xls

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| | | • Of those enrolled in the Hapainga service 50% have validated quit rates at 4 weeks. | |
| **HQMNZ Library references:** http://www.hqmnz.org.nz/library/Primary_Health_Organisation_(PHO)_enrolled_patients_who_smoke_have_been_offered_help_to_quit_smoking_by_a_health_care_practitioner_in_the_last_15_months | | | |
| Weight Management and Lifestyles Self-management Group | • Development of a Self-Management Group for people with a BMI >35 and/or CVD risk >20% | • Referral and active participation of patients within accessible SMGs to support weight reduction and CVD management and improved lifestyle choices. | • By 1 January 2017 |
| **HQMNZ Library references:** http://www.hqmnz.org.nz/library/Cardiovascular_disease_risk_assessment | | | |

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| Improved Breast and Cervical Screening rates for all eligible women. | • Increased focus on ensuring all eligible women, but particularly priority women are referred to and/or access effective screening for both breast and cervical cancers. | • Achievement of and/or improved performance against national Breast and Cervical screening target rates.<br>• Reduction in the gap between priority groups and Total population of eligible women.<br>• Achievement of breast and cervical targets for Maori wahine | • By 1 January 2017, ongoing.<br>• By 1 January 2017<br>• By December 2017 |
| **HQMNZ Library references:** http://www.hqmnz.org.nz/library/Cervical_screening | | | |
| **Justification:**<br>• Breast Cancer – second highest National rate<br>• Pulmonary – second highest rate Nationally<br>• COPD – tenth highest rate Nationally<br>• CVD – sixth highest rate Nationally<br>• High Rates of Obesity – well above National Average | | | |

**ACUTE BED DAYS:**
**BASELINE:** AGE STANDARDISED RATE OF ACUTE HOSPITAL BED DAYS PER 1000 POPULATION FOR THE 12 MONTHS TO MARCH 2016 – 425.5; NON-STANDARDISED – 511.9[5]
**MILESTONE:** A 2.5% REDUCTION IN THE STANDARISED RATE OF ACUTE HOSPITAL BED DAYS (to align with national average)

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| Improved management of patients with COPD within the community | • Development of an agreed clinical pathway that supports effective management of patients with COPD within a community setting. | • Implementation of a strategy to reduce COPD admissions. This will include:-<br>• Clinical pathway for effective management of COPD patients within the community.<br>• CME and CNE to support good practice<br>• Provision of tools and resources to support general practice | • By 1 April 2017 |
| General Practice responsiveness to acute bed day utilisation | • Identified data subset to be developed and reported against for this System Level Measure.<br>• Work with ACC to develop a falls pathway for at risk people over 65 in the community. | • Regular reporting at individual Practice-level of acute bed day utilisation.<br>• Work collaboratively with Tauranga & Whakatane hospitals to introduce emergency ambulatory care which is supported by general practice.<br>• Work collaboratively with Tauranga & Whakatane hospitals to reduce admissions by 10% in frail elderly who occupy hospital level beds in ARC<br>• Completion of Bay Navigator falls pathway. | • By 1 April 2017<br>• 30 April 2017 |

[5] Sourced from: http://nsfl.health.govt.nz/system/files/documents/pages/abd_rpt_2016q1_dhb_bay_of_plenty.xlsb

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| Acute Demand Management Plans | • General Practice development of acute demand management plans to ensure timely responsiveness to at risk patients, thereby minimising need to access services elsewhere. | • Acute Demand Management plans have been developed and adopted within each General Practice. | • By 1 April 2017 |
| Maintained and improved Cardio-Vascular Disease Risk Assessment of eligible population. | • Effective identification of the eligible at risk population and conduct of CVDRA every 5 years. | • Achievement of 90% target for eligible population having had a CVDRA within the last 5 years. | • By 1 January 2017 |
| **HQMNZ Library references:** http://www.hqmnz.org.nz/library/PHO_enrolled_people_within_the_eligible_population_who_have_had_a_CVD_risk_recorded_within_the_last_five_years | | | |
| Justification<br>• High Rate of "Frequent Flier" Emergency Department Presentations<br>• COPD 45-64 ASH rates Higher than the National Average: Total population – 309 (National average – 253); Maori population – 961; Other population 166<br>• ALOS rates Higher than the National Average ALOS for Acute CWD in 2015/16 (excl. maternity and neonatal): 3.98; ALOS for elective surgical CWD in 2015/16: 2.88<br>•<br>• 47% of Presentations from 7% of Population<br>• High Rates for: Bronchiolitis, COPD, Acute URTI, Respiratory Viral Infections, Chest Pain and Asthma. | | | |

**PATIENT EXPERIENCE OF CARE:**
**BASELINE:** A BASELINE DOES NOT CURRENTLY EXIST AGAINST THIS SYSTEM LEVEL MEASURE.
**MILESTONE**: 25% OF THE ENROLLED POPULATION THAT HAS BEEN TRANSITIONED TO THE NATIONAL ENROLMENT SERVICE HAVE PARTICIPATED OR ARE AVAILABLE TO PARTICIPATE IN THE INDEPENDENT PEC SURVEY. (NB: This Milestone remains dependent on effective PMS alignment to the NES and the national survey system being fully implemented.)

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| Access to Patient Portals | • Enhanced rollout out of Patient Portals across General Practice to improve the interface between patients and their Primary Care Health Team. | • 50% of eligible patients will have access to a Patient Portals within General Practices currently offering this facility.<br>• 50% of all General Practices will be offering Patient Portals to eligible patients. | • By 1 January 2017<br>• By 1 April2017 |
| **HQMNZ Library references:** http://www.hqmnz.org.nz/library/Patients_registered_to_use_general_practice_portals | | | |
| Improved management of DNA rates for Specialist Appointments | • Develop a range of effective methodologies to enable General Practice to better support patients engaging with secondary care services – particularly in respect to reducing DNAs for specialist service appointments for Maori and Pacific Island people; e.g. automated texting for appointments. | • A baseline is developed to better understand the percentage DNA reduction achieved and the most effective interventions deployed. | • By 30 June 2017 |
| Effective transition to the National Enrolment Service (NES). | • Continued support to all Practices to transition to the NES as and when respective Practice Management Systems are compatible. | • All General Practices have transitioned to the NES.<br>• All patients within individual Practice registers have been validated against the NHI. | • By 1 October 2017<br>• By 1 July 2019 |
| **HQMNZ Library references:** http://www.hqmnz.org.nz/library/GP_practices_using_the_National_Enrolment_Service | | | |
| Specialist response to General Practice referrals. | • Create visibility, by specialty, of the number of referrals received; | • General Practice remains fully informed of progress and outcome of referrals made into | • By 1 January 2017 |

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| | those that are seen for an appointment have direct access to a procedure, have advice provided through a non-contact appointment, or where the referral is declined with no advice given. | specialist services.<br>• General Practice is fully informed of reasons for referral decline and ongoing management advice is provided within the decline letter. This to be measure by a reduction in the number of decline letters issued without ongoing management advice.<br>• Encourage secondary care to use e-referrals and electronic documentation for transference of care. | • By 1 April 2017 |
| <u>Justification</u><br>• Patient Portal Utilisation – variable<br>• Sentinel Event Management – variable<br>• Use of Technologies – variable<br>• High Rates of DNA<br>• Access to FSA and Specialist Advice – variable<br>• Access to Diagnostics – variable | | | |

## System Level Measures Endorsement Bay of Plenty District Health Board

Simon Everitt
**General Manager, Planning & Funding**
Bay of Plenty District Health Board

Date:October 2016

Janet McLean, **General Manager**
**Maori Health Planning & Funding**
Bay of Plenty District Health Board

Date: October 2016

Michelle Murray
**Chief Executive Officer**
Eastern Bay Primary Health Alliance

Date: October 2016

Janice Kuka
**Chief Executive Officer**
Ngā Mataapuna Oranga

Date: October 2016

Roger Taylor
**Chief Executive Officer**
Western Bay of Plenty Primary Health Organisation

Date: October 2016