Capital & Coast District Health Board
ŪPOKO KI TE URU HAUORA

Ora Toa PHO

Cosine Primary Care Network

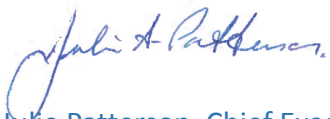
Tū Ora COMPASS HEALTH

System Level Measures Improvement Plan 2019/20

HCC

Submission 1 July 2019

Signatories for the 2019/20 CCDHB SLM Plan



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The Capital and Coast Health System Plan 2030 outlines our strategy to improve the performance of the region's healthcare system. CCDHB aims to improve health outcomes, prevent avoidable demand for healthcare, and improve the use of healthcare services.

CCDHB is responsible for improving, promoting and protecting the health of the people, whānau and communities of our region. This requires CCDHB to collaborate with relevant organisations to plan and coordinate at local, regional and national levels to ensure the effective and efficient delivery of health services.

The Integrated Care Collaborative (ICC) Alliance is a key mechanism through which the CCDHB HSP will be realised. The ICC alliance includes primary care, hospital services, planning and funding, ICT leads, pharmacy, ambulance, consumers and other key partners. The associated programme of work has included the implementation of the Health Care Home model and the integration of community services. The ICC has also introduced acute care services, diabetes consultant's collaborative case conferencing and new primary care packages of care. Enablers such as Health Pathways, patient portal, access to patient records across the sector have also been part of the ICC focus. The benefits of these developments are monitored through a number of process, quality and impact measures that include some of the national System Level Measures (SLMs).

The SLMs Framework is another lever to support improvements aligned with the CCDHB Health System Plan. The ICC ALT agreed that the milestones for the SLMs should take into consideration the strategic priorities across the sector and focus on equity. All measures within the plan are stratified for Māori, Pacific and non-Māori/Pacific. This is in line with the ICC focus on progressing the pro-equity approach.

The CCDHB SLM Plan has been developed with the following principles:

- Linked to current strategic priorities
- Relevant to family & whanau; clinicians; managers
- Focus that improves equity
- Relevant to vulnerable populations including but not limited to older people and children
- Impact on a reasonable population size
- Evidence based interventions
- Balancing a mix of outcomes and outputs
- Performance can be influenced through stakeholders and partners
- Return on investment

CCDHB SLM Plan compiled by Astuti Balram.
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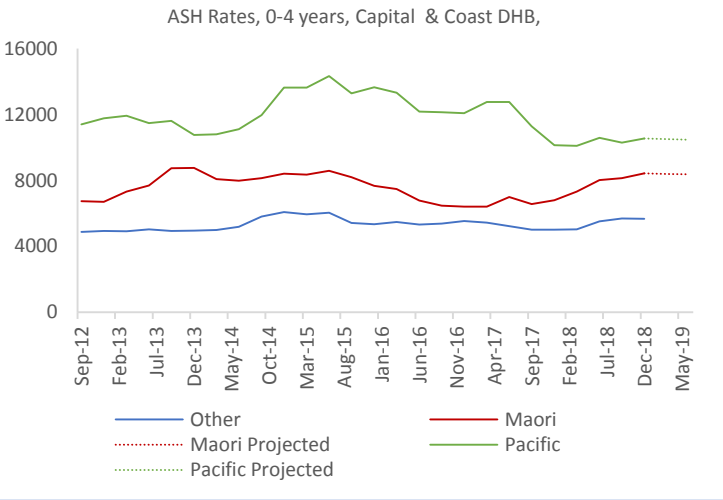
on behalf of the CCDHB Integrated Care Collaborative (ICC) Alliance.

Ambulatory Sensitive Hospitalisations 0-4 Years

One of CCDHB's strategic goals is to improve child health and child health services. Our system will empower all families to maximise their children's health and future potential.

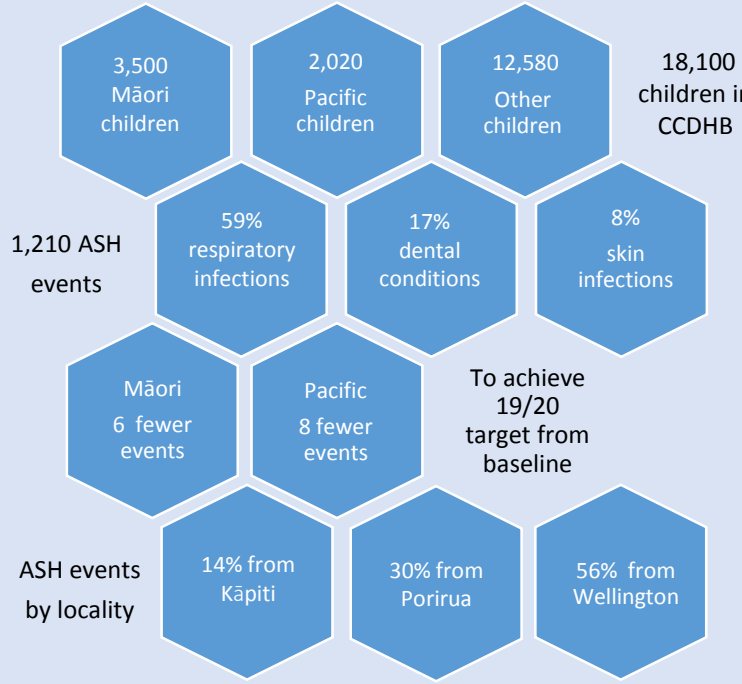


Ambulatory Sensitive Hospitalisation (ASH) 0-4yo 2019/20 milestone: 2% reduction in ASH events for Māori and Pacific.

CCDHB's ASH rate for 0-4yo is 3% lower than the national average; however, nationally there has been an increase in the childhood ASH rate. Of the seven DHB's monitored for Pacific ASH rates, CCDHB has the lowest rate nationally. For Māori children, CCDHB has the 10th lowest ASH rate nationally.

To reduce the equity gap and reduce ASH events, across all populations, will require health & cross sector services to work together. The DHB, PHOs, WCTO providers, dental services, public health, immunization services and hospital teams are partners in the ICC Child & Maternal Network and will oversee SLM plan initiatives.

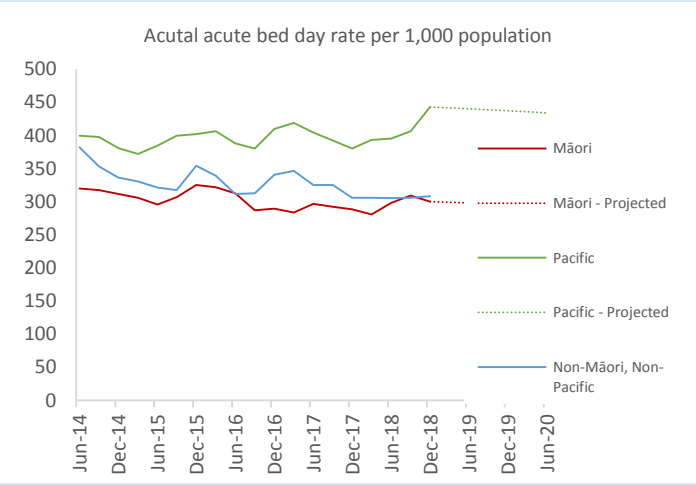
The longer term aim is to ensure that ASH rates for these populations reduce to at least the rates of the non-Maori & non-Pacific population group.



Opportunity	Actions	Contributory Measures
Whanau enrolled in VLCA practices are more likely to experience ASH events and/or present to ED and A&M. Improved access to primary care, particularly for Māori and Pacific children and families, is central to achieving equity in childhood ASH.	• Implement an integrated Mātua, Pepi, Tamariki service for Porirua mothers, babies, children and families, to provide culturally responsive primary care for Māori and Pacific families in Porirua. • DHB, PHOs and LMCs will identify barriers for newborn enrolment via questionnaire targeted to key stakeholders and implement improvement processes accordingly. • Facilitating enrolment for Māori people who are not enrolled and present to Kenepuru A&M. They will be provided with enrolment information and asked for consent to allow PHOs to proactively follow them up.	Newborn enrolment rate
Respiratory conditions contribute the majority of ASH conditions in CCDHB, particularly repeat ASH events. Prevention, effective treatment plans and support during acute episodes will support these children in the community.	• Increase the uptake of influenza vaccination of 0-4 year olds in practices. PHO will generate eligible lists for all practices prioritised by ethnicity and provide regular feedback on immunisation performance to practices. • ICC Flu Group review the 2019 influenza immunisation campaign and impact, and develop the 2020 approach. • Review immunisation precall, recall and decline practices and protocols, with a focus on improving process and access for Māori and Pacific through the Immunisation Network. • Improve asthma management for Māori and Pacific families through an initiative that includes training for staff, ECE based initiatives, and referral pathways through the Child ICC Network.	ASH rate for asthma & wheeze 0-4 year olds Childhood influenza rate Immunisation rates (8 months, 2 years)
Partnering with ECEs presents an opportunity to provide practical support for children who would otherwise not seek treatment/prevention on a range of conditions or behaviours.	• Working with Regional Public Health and East Porirua Pacific ECEs and Kohangas, to identify opportunities to 'intensify' health promotion in East Porirua, with a focus on skin care, asthma and general child wellbeing. • Continue the skin packs in Porirua schools initiative through the Child ICC Network.	ASH rate for skin infections 0-4 year olds

Acute Bed Days

Better health and independence for people, families and communities is the CCDHB vision. We want our population to be well in the community and supported to receive appropriate care when they are not well.



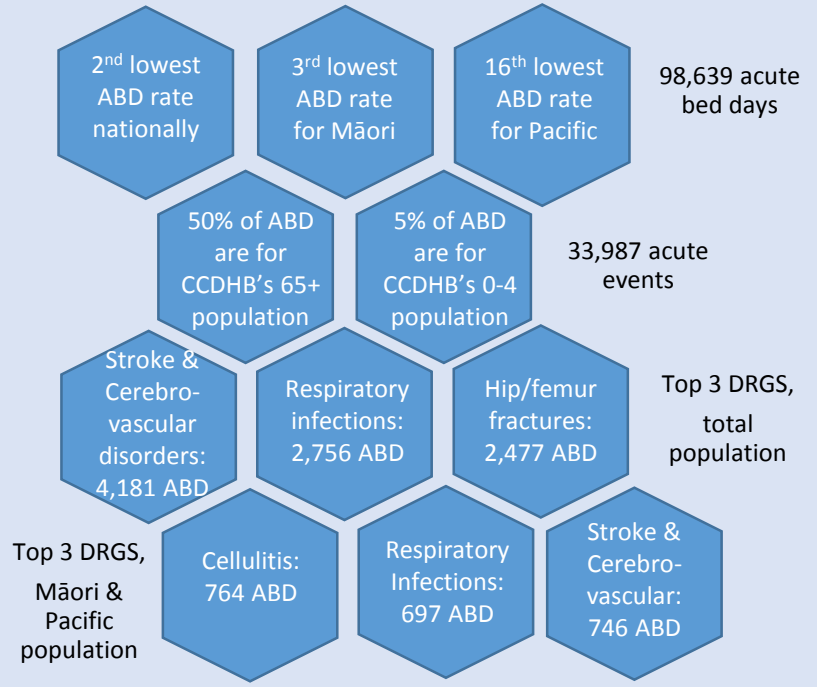
Note the age standardised rate for Māori is higher than Other ethnicities. We use the actual rate per 1,000 to model actual reductions in events and bed days. A reduction in actual acute bed days will also result in a reduction in the standardised rate for Māori.

Acute Bed Day (ABD) 2019/20 milestone: 2% reduction in actual acute bed day rate for Māori and Pacific. This equates to a reduction of 407 acute bed days or 156 fewer acute events.

The number of acute bed days is complex and attributable to many factors. Improvements to acute demand and patient flow will enable services to be smarter about acute responses and improve patient flow in hospital. Access to and timely diagnostics, comprehensive patient care coordination and logistics with a well equipped workforce will enable people to receive acute care in primary and community settings.

An Acute Demand and Bed Capacity Steering Group is providing oversight of a range of initiatives to improve bed occupancy across the system. The focus is to focus on winter peaks and ongoing pressures.

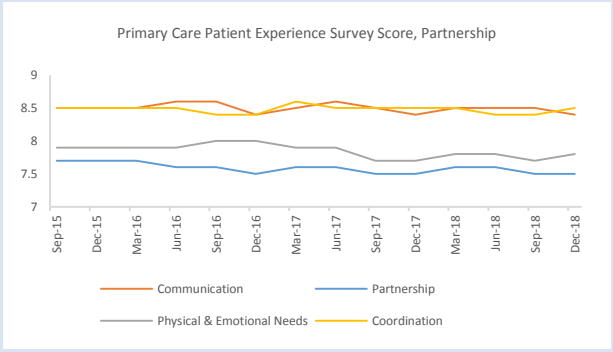
The long-term aim is to ensure that ABD rates for Māori and Pacific populations reduce to at least the same rates of the non-Maori & non-Pacific population groups.

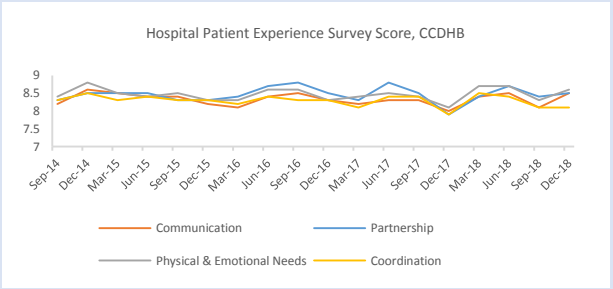


Opportunity	Actions	Contributory measure
There is increased demand on bed capacity. Similar to 2018, an increase in demand is being experienced prior to winter. Current standardised acute bed days per 1,000 population are 433.3 for Māori, 615.5 for Pacific, and 289.6 for other ethnicities.	• Implement new Patient Care Coordinators and allied health roles on the medical and rehabilitation wards to intervene early in the admission in order to support early discharge for complex patients. • Improve discharge processes for long-stay patients in general medical wards and introduce improved acute flow tools across selected wards • Introduction of Influenza POCT to influence bed management in Influenza season	Acute ALOS for CCDHB-domiciled population
Growth in ED presentation numbers continue and have exceeded capacity. Enhancing the management of people in primary care via community based acute response services will support people to receive care in the community. Current age-standardised ED presentation rates to sub-regional hospitals are 198 for Māori, 243 for Pacific and 152 for other ethnicities.	• Increased investment in packages of care and increase the range of care packages available to Health Care Homes and VCLA practices. The focus will be initially in Kapiti where a higher proportion of older people reside. • Introduce packages of care to enable ambulance diversion back to primary care in partnership with the local ambulance service • Introduce packages of care to support ED and assessment units to discharge people back to primary care early. This will be supported with warm handovers to support people returning safely to primary care.	Age-standardised ED presentation rates in sub-regional hospitals for CCDHB-domiciled population
Frail older people contribute to a significant volume of bed occupancy due to their complex health and social circumstances. Current age-standardised acute events in sub-regional hospitals for CCDHB-domiciled people aged >65 years are 309 Māori, 392 Pacific and 203 for other ethnicities.	• Implement the Community Health of Older People Initiative that will provide acute and proactive care support for people. This involves a Geriatrician and Nurse Practitioners who will partner with Health Care Homes and Allied Health teams to support care in the community. The service will participate in multidisciplinary proactive care planning, take acute calls from the community and complete comprehensive older people assessments. • Implement additional pharmacist facilitation roles in Health Care Homes practices where there are larger numbers of older people. The pharmacists will focus on polypharmacy and participate in the year of care planning multidisciplinary meetings.	Age-standardised acute admission rates in sub-regional hospitals for CCDHB-domiciled people aged >65 years

Patient Experience of Care

It is vital that patients are involved and partnered with in their care.





Patient Experience of Care – 2019/20 milestone: Improve lowest scoring domains Primary Care PES Partnership domain ≥ 7 for Pacific and Māori. Improve inpatient PES scores to: coordination ≥ 8.2, communication ≥ 8.6, Physical & emotional needs ≥ 8.7, and partnership ≥ 8.6.

The number of respondents to the Primary Care survey has increased over time, while the number of respondents to the Hospital survey has fluctuated in the recent data. The response rates for Māori and Pacific in both surveys remain lower than for the 'Other' population. Feedback from CCDHB partners identify that the length and complexity of the survey limits responses, particularly from Māori and Pacific people. This remains a challenge in making improvements from an equity perspective.

CCDHB's scores in the Primary Care survey for the total population are at or above the national average for the 4 domains: Communication, Coordination, Partnership, Physical & Emotional needs. CCDHB is below the national average for 3 domains for Māori, and all domains for Pacific. The hospital survey scores for the total population are at or above the national average for the 4 domains: Communication, Coordination, Partnership, Physical & Emotional needs. There is an insufficient sample for analysis by ethnicity.

▲ Above National Average ▼ Below National Average ▬ Same as National Average

28,979 people invited to Primary Care Survey

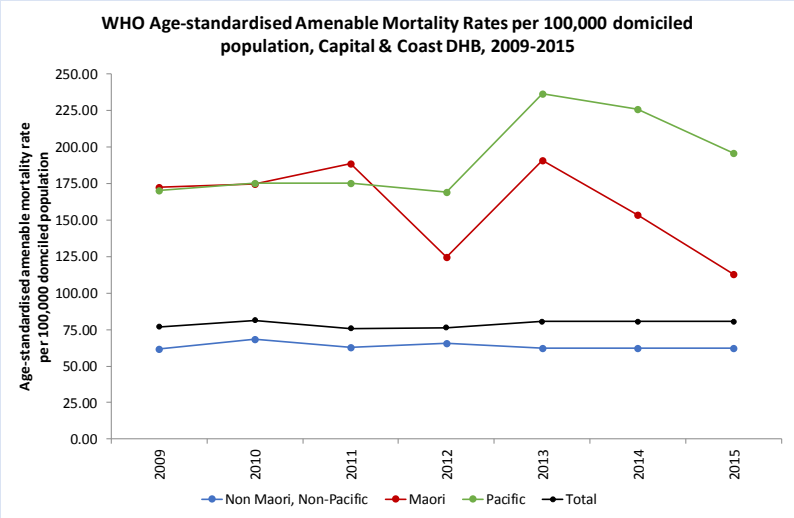
- 25% response rate; 7,093 respondents
- 24% response rate; 402 Māori respondents
- 22% response rate; 129 Pacific respondents
- 66% of respondents are female
- 10% of respondents are 15-24 years
- 32% of respondents are 65+ years
- 24% of people invited via email complete the survey
- 0.6% of people invited via SMS complete the survey

		Communication	Partner-ship	Physical & Emotional Needs	Coordination
Primary Care	Māori	8.4 ▬	7.3 ▼	7.5 ▼	7.9 ▼
	Pacific	8.3 ▼	7.0 ▼	7.5 ▼	8.3 ▼
	Other	8.5 ▲	7.6 ▬	7.8 ▲	8.5 ▬
Inpatient	Total	8.5 ▲	8.5 ▼	8.6 ▼	8.1 ▼

Opportunity	Actions	Contributory measure
Primary care will focus on the partnership domain, with a focus on improving the quality and patient focused approach to long term conditions planning.	• Patient centred care plan training will be rolled out across the Health Care Homes teams including the primary care teams, District Nurses and Community Allied Health teams. • Health Care Homes will introduce shared medical appointments with groups of people with particular long term conditions. • Expansion of the Health Care Home multidisciplinary care planning across the final tranche of practices	Number of cases discussed at HCH multidisciplinary team meetings.
There is an opportunity to increase scores across all domains in the hospital patient experience survey by improving the patient safety culture. This will improve our response to patients and families especially when things don't go as planned.	• Implement planned activities to support patient safety culture. These include improving the serious adverse events process, strengthen the speaking up for safety programme , introduce restorative practice, updating the open communication training, implementing the Korero Mai - Whānau led escalation of deteriorating patient. • Work with Māori and Pacific Health teams to initiate an improvement project to improve the response rate for Māori and Pacific. Initial activity to include understanding what is driving the current response rate. Solutions may include alternative feedback methods.	Hospital PES - All domains
Simplifying access to health care options for people with technology solutions, where appropriate, is a key strategy for Health Care Homes. The increased use of the patient portal and accessibility of patient notes via the portal; supports patient care and creates efficiencies within practices.	• Patient portal activation in Health Care Homes and VCLA practices will be increased in line with annual improvement goals agreed to through the Health Care Home change programme. • All Health Care Homes in their second year in the programme are incentivised to open their clinical notes to patients via the portal • Obtain patient portal activation data by ethnicity through ongoing negotiation with the portal vendor	Percentage patient portal activation

Amenable Mortality

The CCDHB HSP outlines that supporting population interventions to create healthier communities and preventing the onset of long term conditions is a priority in reducing amenable mortality.

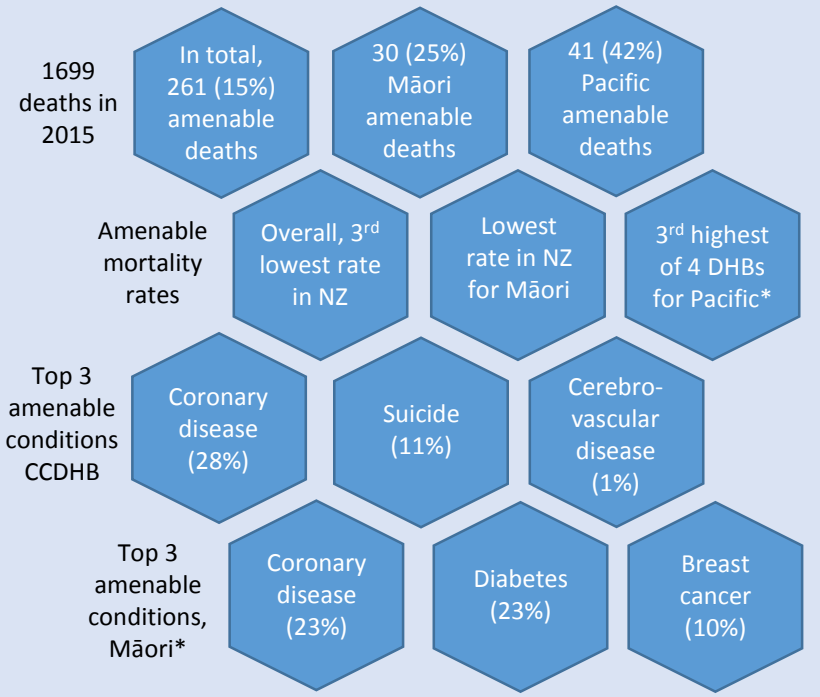


Amenable Mortality (AM) 2019/20 milestone: At the end of 2025, will achieve AM rates for all ethnicities lower than the 2015 baseline: Māori ≤ 112 and Pacific ≤ 196..

In 2014 and 2015, AM rates improved for Māori and Pacific. However, rates have fluctuated due to the relatively small population size and data for 2016 is yet to be available.

A reduction in Amenable Mortality (AM) rates requires across sector preventative and pro active care approach so long term conditions are managed well and people have the care they need in their community. The CCDHB has taken a long term approach to reduce AM rates. This reflects that changes today will impact on the rates of AM in the future.

The long-term aim is to ensure that the AM rates for Māori and Pacific populations reduce to at least the rates of the other population groups.

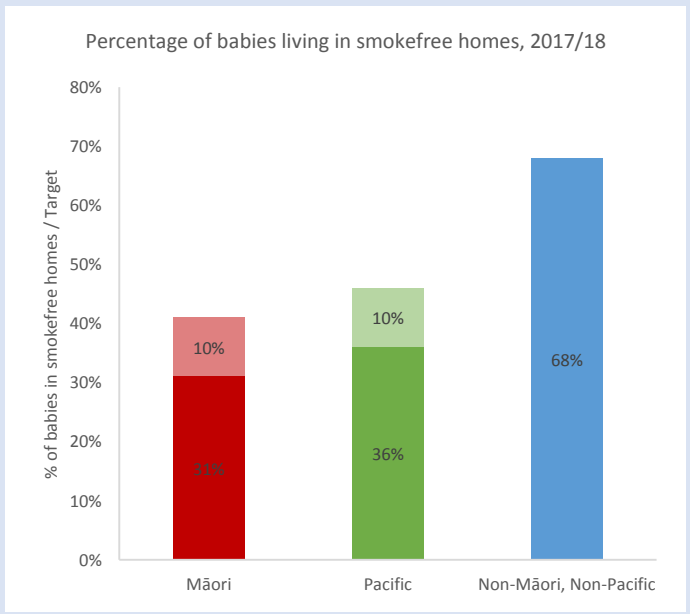


*Rates suppressed due to low numbers; Conditions for Pacific population not published by MOH

Opportunity	Actions	Contributory measure
Effective long term condition management requires a wide range of approaches and increasingly requires an approach that supports a range of co-existing long term conditions. Through the Health Care Home model a number of interventions to support long term conditions that are linked to higher rates of amenable mortality will be implemented.	• Health Care Homes will pilot Health Coaches as part of their teams to work with people with long term conditions to improve outcomes that are important to their health. • Health Care Homes will work towards agreed targets in Year of Care Planning for those people identified as higher risk as per the risk stratification tools. • The ICC Diabetes Clinical Network will apply its maturity matrix tool to priority practices and redirect specialist support across the community to broaden their reach and impact • Pilot role of the health Improvement Practitioner and health coach roles in four health centres	Percentage of year of care plans completed of those identified as high risk admission in Health Care Homes Percentage HbA1c<64 mmol/L
Improving CCDHB smoking quit rates will significantly reduce the risk related to a number of long term conditions, the related morbidity and future mortality. Supporting smokers and their families to quit continues to be a focus across the CCDHB system. Smoking quit rates are 8% for Māori, 8% for Pacific and 14% for other ethnicities.	• Refresh and implement the DHB Tobacco Control Plan for 2019-2021 focusing on integration of services and support for hāpu wāhine, Māori, and Pacific peoples. • Expand the Hāpu Mama incentives programme to support 100 Māori and Pacific mothers of children aged 0-4 years to quit smoking. • The achievement of the smoking health target by practices remains a requirement to attain Health Care Home funding	Smoking quit rate
Cardiovascular disorders and diabetes continue to be the largest causes of amenable mortality for the total population and Māori. Implementing the new screening guidelines that recommend expanded target age bands will activate earlier care for people at higher risk of these conditions.	• PHOs will work with practices with large volumes of people who require screening with a range of activities such as establishing targeted clinics, funding Māori and Pacific men's breakfast event and facilitating men's health groups • Cardiovascular screening practice level data to be included in the Diabetes Clinical Network. The Network will drive cyclical improvement activities to improve screening, including the identification of three key healthy heart messages that can be promoted across the DHB.	Percentage of PHO enrolled population identified as high risk of CVD and not on statin

Babies Living in Smokefree Homes

Supporting our whanau and their children, giving them the best start in life, is a CCDHB priority and linked to the national SUDI prevention programme.

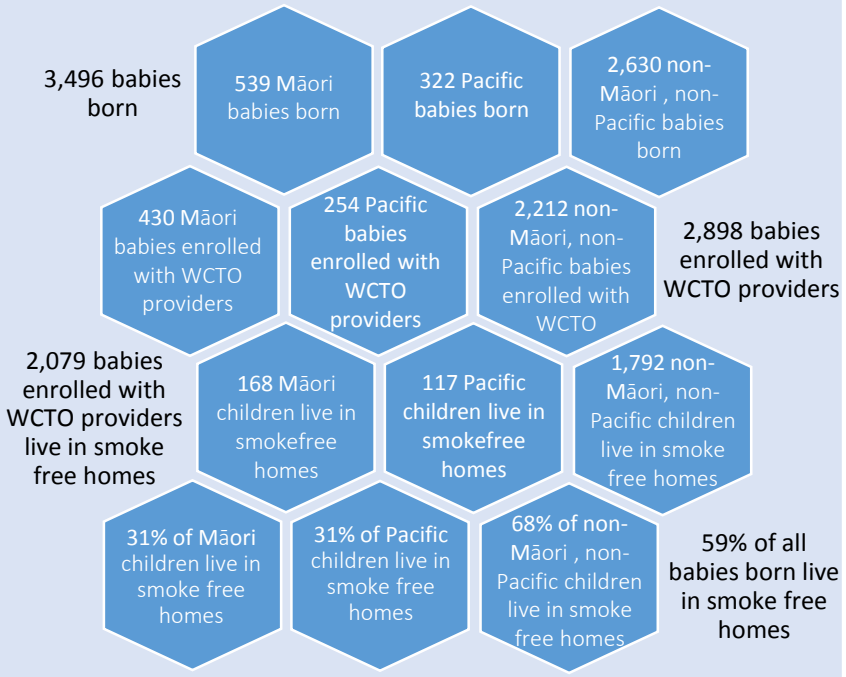


Babies Living in a Smokefree Home 2019/20 milestone: 10% improvement in percentage of Māori and Pacific babies live in smokefree homes. This will result in an additional 53 Māori babies and 31 Pacific babies living in smokefree homes.

As the HSP 2030 is implemented, it is expected that all services that support women and children to live well will be connected within a defined locality and linked with their primary health care team. A focus on the first 1000 days for our mātua, pepi and tamariki aligns with the focus early in the population life course approach.

Reducing babies' exposure to tobacco smoke through collaboration between the services focussed on child health and smoking cessation is a key aspect of wellness. The DHB, PHOs, WCTO providers, dental services, public health, immunization services and hospital teams are partners in the ICC Child & Maternal Network and will oversee SLM plan initiatives.

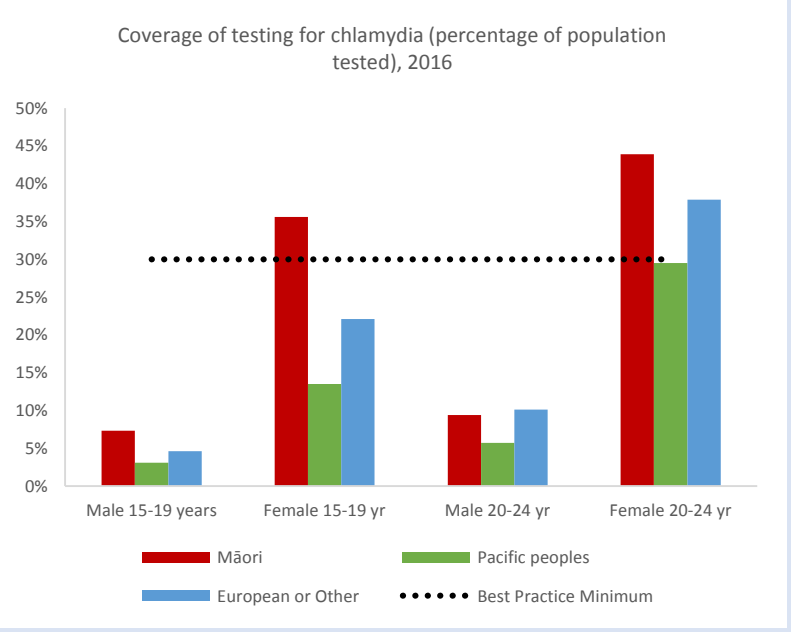
Through National SUDI prevention programme, CCDHB will focus on smoking cessation during the antenatal and postnatal periods. Primary care and the hospital are key vehicles for the implementation of the programme to support vulnerable babies in this early stages and as they grow.



Opportunity	Actions	Contributory measure
Whānau focused stop smoking support and resources will provide a healthy start for babies life and has the potential to impact on more than the individual.	• Implement wahakura wānanga programmes to vulnerable hāpu mama and whānau, including focused messages around safe sleep, immunisation, breastfeeding and smoking cessation.	Mothers who are smokefree at two weeks post-natal
Primary health care providers have an opportunity to support whanau in their smoking cessation journey as part of their overall health care needs.	• PHOs will initiate quarterly data matching processes within practices to identify new born babies and cross reference with those who identify as smokers who live in the same household. This will be the first step to identify at a practice and PHO level the rate of babies in a household with/without smokers.	PHO rate of babies in households with smokers
Porirua has the highest number and percentage of smokers compared to Wellington and Kāpiti. In 2017, 23% of women from Porirua who gave birth identified as a smoker.	• Implement and monitor a smoking cessation incentives program in Porirua, focused on hāpu mama and their whanau. This may include petrol or supermarket vouchers provided by the Hāpu mama smoking cessation service.	Uptake of cessation service by hapu mama and their whanau

Youth access to & utilisation of youth appropriate services

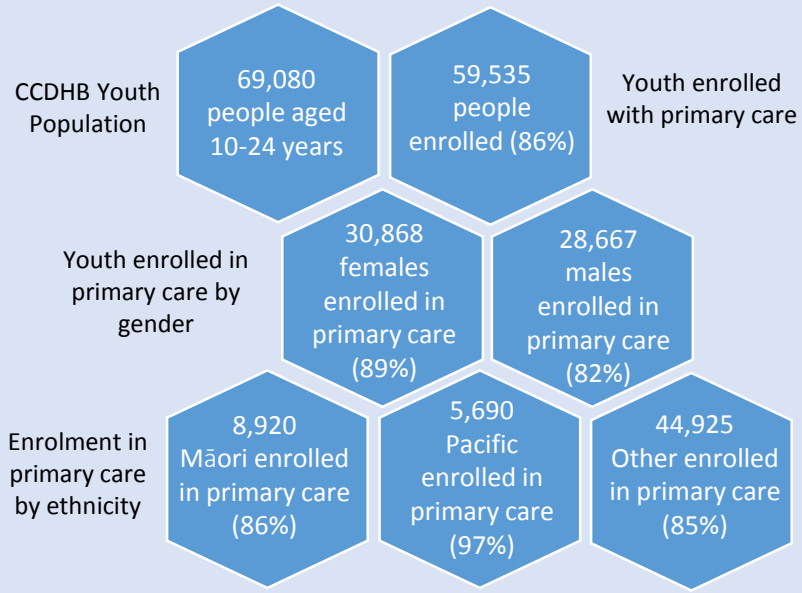
Supporting our youth to build healthy and safe lives is a focus in the CCDHB HSP. Young people are not high users of the health system, but the choices they make now impact on their future health needs.



In 2019/20, CCDHB will focus on the sexual health domain of the Youth SLM and aim to support young people to manage their sexual and reproductive health safely and receive youth friendly care. The 2019 milestone is to improve male coverage of testing to 15%, across all ethnic groups and maintain 30% coverage of testing for females. This will result in an estimated 2,200 males and 10,300 females tested for chlamydia.

Chlamydia is the most commonly reported STI and coverage screening rates vary considerably between gender and ethnicity. Through increasing coverage of chlamydia testing we aim to improve youth primary care enrolment and utilisation and also positively impact on risk of associated health conditions such as pregnancy rates and mental health conditions. Improvement projects are underway focused on youth in high needs areas to ensure youth health needs are met.

Connecting youth with health providers and strengthening links with primary care; youth can access what they need, when and where they need it.



Opportunity	Actions	Contributory measure
Youth engage with a variety of health services, outside of primary care. To ensure youth receive access and care into adulthood, enrolment with a primary provider is beneficial. Through better integration between all youth providers, youth will have a continuation of health service access. .	• Increase Sexual and Reproductive Health Education in low decile schools through MOH funded services • To complete data matching with YOSS and School Based Health Services to improve youth enrolments in Primary Care • Connect with sports clubs and PHOs to discuss and implement ways of encouraging young Māori men to enrol in primary care through the ICC Youth Steering Group.	Youth enrolment in primary care by ethnicity
Youth utilisation of health services will provide youth with access to community services, supporting positive health care decisions. There is greater risk for youth living in low social economic areas and addressing factors .	• Activate primary care recall process to recall young males who have not been vaccinated for HPV • Implement standardised process with primary care practices to enable nurses to order blood tests that accompany swap to complete the full STI screen.	Utilisation of Primary Health Services by Youth