MINISTRY OF HEALTH
MANATU HAUORA

Planned Care

2020/21 Measurement Suite

Technical Specifications

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1. Overview of Planned Care Measures

This document:

- defines the Planned Care measures and how they are calculated, and;
- describes the
  - data sources and,
  - extract criteria (inclusions and exclusions).

Rationale

Planned Care encompasses medical and surgical care traditionally known as Elective or Arranged services that are delivered in hospitals. It also includes a range of treatments funded by district health boards (DHBs) delivered in primary or community settings, and all appointments and support people need during their health care journeys.

Delivering Planned Care will require close partnerships between the Ministry of Health (the Ministry), DHBs, Primary Health Organisations (PHOs), general practice and other primary care providers, individuals and whānau, to adopt innovative and evidence-based approaches.

The Planned Care suite of performance measures is designed to evaluate how well DHBs provide access to services, the level of timeliness, quality and equity in the way services are delivered, and an evaluation of the patient's experience during their health care journey.

Key Concepts

DHB of domicile:	DHB of domicile refers to the geographical area in which the patient usually lives. Refer to the Operational Policy Framework for more information. DHB of domicile is used to report the Planned Care Interventions.
DHB of service:	DHB of service refers to the DHB that provides treatment and care to the patient. Refer to the Operational Policy Framework for more information. DHB of service is used to report waiting times, prioritisation processes, quality, and patient experience.

Summary

There are five overarching principles that guide Planned Care which determines the measures that DHBs will be evaluated against. These are summarised in the table below:

Principle	Definition	Measures
Access	Patients can access the care they need in the right place, with the right health provider.	• **Interventions** - The number of Planned Care Interventions compared to plan • **ESPI 3** - the proportion of patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT) • **ESPI 8** - the proportion of patients who were prioritised using approved nationally recognised processes or tools.
Timeliness	Patients receive care at the most appropriate time to support improved health.	• **ESPI 1** - DHB services that appropriately acknowledge and process more than 90 percent of referrals within 15 calendar days • **ESPI 2** - the proportion of patients waiting longer than four months for their first specialist assessment (FSA)

		• **ESPI 5** – the proportion of patients given a commitment to treatment but not treated within four months • **diagnostic waiting times** - the proportion of patients waiting longer than expected for coronary angiography, computed tomography (CT) and magnetic resonance imaging (MRI) • **ophthalmology follow-up waiting times** – the proportion of patients seen for ophthalmology follow-up within clinically intended timeframes • **cardiac wait times** – the proportion of patients seen within clinical urgency timeframes for cardiac surgery • **Faster Cancer Treatment (FCT)** – the proportion of patients who wait no more than 31 days between a treatment plan being agreed between them and their doctor, and the start of treatment. *Please note: although FCT is included in the Planned Care suite of measures, accountability and support for this measure remains with the Ministry's Cancer Programme. Refer to the Ministry's website and accountability documents for more information on this measure.*
Quality	Services are safe, effective, efficient, appropriate and respectful and support improved health outcomes.	• **Acute readmissions – OS8** – reducing acute readmissions to hospital (**refer to the NSFL website for more information and a technical definition of this measure).**
Experience	People and their families / whānau work in partnership with healthcare providers to make informed choices about Planned Care, which responds to their needs, rights and preferences.	• **Inpatient experience survey** – provided by the Health Quality and Safety Commission (HQSC) • **primary care experience survey** – provided by HQSC, with the focus on specialist care and hospital service questions *(Refer to the HQSC website and the System Level Measures documentation for more information about these surveys).*
Equity	People get the healthcare that safely meets their needs and preferences, regardless of who they are, or where they are.	• **Variation by key equity variables** – (age, gender, ethnicity and deprivation) where applicable for all the above measures • **developmental measure - Did Not Attends (DNAs) for FSA**

2. Planned Care measures - Access measures

PLANNED CARE INTERVENTIONS

Planned Care interventions is the new 'count' of interventions to support increased access to care required within the Planned Care programme. This replaced the 'Elective Surgical Discharges' (previous Electives Health Target), the 'Electives Initiative', and the 'Ambulatory Initiative' in the 2019/20 year. Results are available each month from the Elective Services Quickr website.

Data Sources

Data for the Planned Care interventions results is extracted a month in arrears, on the first Monday of each month from the following national collections:

- National Minimum Data Set (NMDS) and;
- National Non Admitted Patient Collection (NNPAC).

DHB view

Planned Care intervention results are coded by DHB of domicile as per the table below:

DHB of domicile code	DHB of domicile name	DHB of domicile code	DHB of domicile name
011	Northland	081	MidCentral
021	Waitemata	082	Whanganui
022	Auckland	091	Capital and Coast
023	Counties Manukau	092	Hutt Valley
031	Waikato	093	Wairarapa
042	Lakes	101	Nelson Marlborough
047	Bay of Plenty	111	West Coast
051	Tairawhiti	121	Canterbury
061	Hawkes Bay	123	South Canterbury
071	Taranaki	160	Southern

Extract criteria for 2020/21

The following criteria apply to the extraction of Planned Care intervention data:

- publicly funded interventions only – purchaser code of 13,20,34,35
- the intervention date (date of discharge for NMDS interventions, or date of service for NNPAC interventions) is between 01 July 2020 - 30 June 2021
- excludes maternity purchase units (W%%%%%)
- NMDS admission type codes are 'Elective' (WN, AP) or 'Arranged' (AA) admissions
- NNPAC attendance code is ATT – 'Attended'
- component type is included in Table one.

Table one: Planned Care interventions components

Component	Definition
Inpatient Surgical Discharges	Elective surgical discharges (see Table two) **excluding:** skin lesion procedures and intraocular injections coded to NMDS.
Minor Procedures Inpatient	Minor operations completed in an inpatient setting and coded to NMDS. See Table three for the eligible purchase units.

Component	Definition
Minor Procedures Outpatient	Minor operations completed in an outpatient setting and coded to NNPAC. See Table three for the eligible purchase units and Table four for the eligible location codes.
Minor Procedures Community	Minor operations completed in a community setting and coded to NNPAC. See Table three for the eligible purchase units and Table four for the eligible location codes.
Non-Surgical Intervention	Non-surgical intervention programme completed and coded to NNPAC, which meet the requirements of purchase unit MS02025 - Musculoskeletal Early Intervention programme. In the 2020/21 year alternative models of care are limited to early intervention programmes to assist in the prevention of musculoskeletal conditions based on the Mobility Action Programme (MAP) pilot programmes. Further information about the requirements for early intervention programmes is available from the restricted Quickr website.

Table two: eligible inpatient surgical discharges

Casemix included surgical discharges with an admission type = WN *or* AP *or* AA

Description (purchase units/ DRG groups)
S00.01 General Surgery – Inpatient Services (DRGs)
S05.01 Anaesthesia Services (inpatient)
S15.01 Cardiothoracic – Inpatient Services (DRGs)
S25.01 Ear Nose and Throat – Inpatient Services (DRGs)
S30.01 Gynaecology – Inpatient Services (DRGs)
S35.01 Neurosurgery – Inpatient Services (DRGs)
S40.01 Ophthalmology – Inpatient Services (DRGs)
S45.01 Orthopaedics – Inpatient Services (DRGs)
S55.01 Paediatric Surgical Services (DRGs)
S60.01 Plastic & Burns – Inpatient Services (DRGs)
S70.01 Urology – Inpatient Services (DRGs)
S75.01 Vascular Surgery – Inpatient Services (DRGs)
Casemix included, non surgical, purchase units (excluding Maternity), which are reported to NMDS **AND** where the DRG Code matches pattern - %0%%; %1%%; %2%%; %3%%

Table three: eligible minor procedure codes (inpatient, outpatient and community)

Non casemix interventions, reported under the following codes, where:

- The intervention is reported to NMDS, **AND** the Admission Type is WN, AP, or AA **OR;**
- The intervention is reported to NNPAC, **AND** the Attendance Code is ATT.

PUC	Purchase Unit Description
MS02016	Skin lesion removal
S00008	Minor operations
S25006	ENT minor operations
S30008	Gynaecology minor procedure - high cost
S30012	Hysteroscopy
S40005	Eye - argon laser
S40007	Intraocular injections
S40008	Eye procedures
S60007	Plastics surgery minor procedures
S70006	Urology – lithotripsy
S70007	Urodynamics
S70008	Prostate Biopsy

Table four: location codes for outpatient and community minor operations

Assigned Group	Location code	Location description
Outpatient/ DHB	1	Public hospital - a DHB owned and operated general hospital facility (includes day hospitals and the surgical bus)
	2	Private hospitals - non DHB owned general hospital facility
	3	Psychiatric hospitals - dedicated psychiatric hospital
	4*	Other Institution - not for use in phase 1A
	6	Other
	9	Default value
Community	5	Private residence - a private dwelling includes independent retirement village units and supported independent living units
	10	Residential care - residential care facilities including rest homes and residential care hospitals for under and over 65
	11	Marae
	12	Primary care - PHO or GP owned/operated facilities (includes special medical area GP facilities)
	13*	Other community - not for use in phase 1A

** Note: to be retired in NCAMP19*

Included admission types – NMDS interventions

Admission Type Group	Admission Type	Admission Type Description
Elective	AP	Private hospital elective admission
	WN	Admitted from waiting list - Normal

Arranged	AA	Arranged Admission

Included attendance codes – NNPAC interventions

Attendance code	Attendance code description
ATT	Attended

ELECTIVE SERVICE PATIENT FLOW INDICATORS (ESPI 3 & ESPI 8)

DHBs must manage patient flow processes effectively, in line with the principles of Planned Care.

Patient flow processes are measured by a suite of performance indicators referred to as Elective Services Patient Flow Indicators (ESPIs). ESPI 3 and ESPI 8 measure effectiveness and fairness to access to services.

Please note that ESPIs 1, 2, 3, 5 and 8 are included in the Planned Care suite of measures. ESPIs 4, 6 and 7 have been retired.

Data source

Data for ESPI 3 and ESPI 8 is sourced from the National Booking Reporting System (NBRS). DHBs are required to report data at least monthly, in line with the Operational Policy Framework (OPF).

DHB view

ESPI 3 and ESPI 8 are reported by DHB of service.

Extract criteria

The following criteria apply for the extraction of data:

- For ESPIs 3 and 8:
  - publicly funded NBRS records only
  - normal procedures only (ie. staged, planned and surveillance flag = 1)

ESPI 3

Measure description: patients waiting without a commitment to treatment whose priorities are higher than the actual treatment threshold (aTT). The aTT is the priority score at which 90% of all patients treated in the previous 12 months had that priority score or a higher score.

Measure calculation:

numerator: number of patients with a booking status of active review (04) who have a priority score above the aTT

denominator: total number of patients exited treatment in the last 12 months.

Expectations:

green status: percentage is 0% - zero patients in active review with a priority score above the aTT

yellow status: percentage is greater than 0% (1 patient or more), but less than 5% or 10 patients or less

red status: percentage is greater than or equal to 5%, and more than 10 patients.

ESPI 8

Measure description: the proportion of patients who were prioritised using approved nationally recognised processes or tools.

Measure calculation:

numerator: the number of patients prioritised in the month who were prioritised using an approved national or nationally recognised tool

denominator: total number of patients prioritised during the month.

Expectations:

green status:	percentage is 100% - all patients were prioritised using an approved national or nationally recognised prioritisation tool
yellow status:	percentage is greater than 90%, but less than 100%
Red status:	percentage is less than, or equal to, 90%

Please contact elective_prioritisation@moh.govt.nz if you have any questions regarding prioritisation tools.

3. Planned Care measures - Timeliness measures

ELECTIVE SERVICE PATIENT FLOW INDICATORS (ESPIS 1, 2 & 5)

The following ESPIs measure timeliness and clarity of access to services.

Data sources

ESPIs 1 and 2 – data is reported via a standard excel template and submitted monthly to the operations team at Ministry. Please refer to the Outpatient Returns Guide for more information about ESPI 1 and ESPI 2.

ESPI 5 - data is sourced from NBRS. DHBs are required to report data at least monthly, in line with the OPF.

DHB view

ESPIs 1, 2 and 5 are reported by DHB of service.

ESPI 1

Measure description: DHB services that appropriately acknowledge and process more than 90% of referrals in 15 calendar days or less.

Measure calculation

numerator: the number of services answering 'Yes' in a DHB

***denominator*:** the total number of services reported to NBRS

Expectation:

green status: percentage is 100% (all) services report 'Yes' - that more than 90% of referrals within the service are processed in 15 calendar days or less

yellow status: percentage is less than 100% of services

red status: *ESPI 1 has been temporarily removed.*

ESPI 2

Measure description: patients waiting longer than four months for their FSA

Measure calculation

numerator: the number of patients waiting longer than four calendar months for FSA

denominator: total number of patients waiting at month end for FSA

Expectation:

green status: percentage is 0% – no patients are waiting over four months for FSA

yellow status: percentage is greater than 0% (1 patient or more), but less than 0.4% OR status percentage is greater than or equal to 0.4% BUT 10 patients or less are waiting over 4 months

red status: percentage is greater than or equal to 0.4% AND 11 patients or more are waiting over 4 months

ESPI 5

Measure description: patients given a commitment to treatment but not treated within four months

Extract criteria

The following criteria apply for the extraction of ESPI 5 data:

- publicly funded NBRS events only
- normal procedures only (ie. staged, planned and surveillance flag = 1)
- the patient's booking status is assured (ie. booked (01), given certainty (02), deferred (05) or rebooked (06))

Measure calculation

numerator: the number of patients with an assured status waiting longer than 120 days

denominator: total number of patients waiting with an assured status

Expectation:

green status: percentage is 0% - zero assured patients are waiting over 120 days for treatment

yellow status: percentage is greater than 0% (1 patient or more), but less than 1% OR % is greater than or equal to 1% BUT 10 patients or less are waiting over 120 days

red status: percentage is greater than or equal to 1% AND 11 patients or more are waiting over 120 days

CORONARY ANGIOGRAPHY

Measure description:

The percentage of patients who receive their coronary angiography procedure in 90 days or less.

Data source

Angiography waiting time data is sourced from NBRS. DHBs are required to report data at least monthly, in line with the OPF.

Extract criteria

The following criteria apply for the extraction of angiography waiting time data:

- specialty name is “Cardiology”
- the clinical code for the expected procedure is in Table five
- publicly funded NBRS events only
- normal procedures only (ie. staged, planned and surveillance flag = 1)
- the patient’s current booking status is Assured **OR;**
  the patient’s current booking status is Exited (20) **and;**
  - the exit category code is 11 (patient received publicly funded elective treatment) **or** 12 (patient received publicly funded acute treatment).

Table five: Angiography codes

Clinical Code	Clinical code Description
3820000	Right heart catheterisation
3820300	Left heart catheterisation
3820600	Right and left heart catheterisation
3821500	Coronary angiography
3821800	Coronary angiography with left heart catheterisation
3821801	Coronary angiography with right heart catheterisation
3821802	Coronary angiography with left and right heart catheterisation

DHB view

Waiting times for angiography are reported by DHB of service.

Measure calculation

numerator:	patients waiting 90 calendar days or less from the date of ?certainty given who have not yet had their procedure, **and** patients who received their coronary angiography procedure during the month 90 calendar days or less after the date certainty was given.

denominator:	the total number of patients waiting for a coronary angiography procedure at the end of the reporting month, **and** the total number of patients who received their coronary angiography procedure during the reporting month.

COMPUTED TOMOGRAPHY (CT)

Measure description:

The percent of patients with an accepted referral for a CT scan, who receive their scan and the scan results are reported in 42 days or less (within 6 weeks).

Data source

Data is reported via a standard excel template and submitted monthly to the operations team at Ministry.

Please refer to the Indicator Template supporting document for more information about CT and MRI reporting.

DHB view

Waiting times for CT are reported by DHB of service.

Measure calculation

numerator:	total number of people with accepted referrals for CT waiting 42 days or less for a scan at the end of a calendar month, **PLUS** the total number of people with accepted referrals for CT who were scanned and the results reported on in 42 days or less during the calendar month.
denominator:	total number of people with accepted referrals for CT waiting for a scan at end of calendar month, **PLUS** the total number of people with accepted referrals for CT who were scanned and the results reported on during the calendar month.

Template KPI measure calculation: (KPI 502 + KPI 522) / (KPI 501 + KPI 521).

MAGNETIC RESONANCE IMAGING (MRI)

Measure description:

The percent of patients with an accepted referral for an MRI scan, who receive their scan and the scan results are reported in 42 days or less (within 6 weeks).

Data source

Data is reported via a standard excel template and submitted monthly to the operations team at Ministry.

Please refer to the Indicator Template supporting document for more information about CT and MRI reporting.

DHB view

Waiting times for MRI are measured at the DHB of service.

Measure calculation

numerator:	total number of people with accepted referrals for MRI waiting 42 days or less for a scan at the end of a calendar month, **PLUS** the

total number of people with accepted referrals for MRI who were scanned and the results reported on in 42 days or less during the calendar month.

denominator: total number of people with accepted referrals for MRI waiting for a scan at end of calendar month, **PLUS** the total number of people with accepted referrals for MRI who were scanned and the results reported on during the calendar month.

Template KPI measure calculation: (KPI 502 + KPI 522) / (KPI 501 + KPI 521).

OPHTHALMOLOGY FOLLOW-UP WAITING TIMES

Measure description: the number of patients waiting for follow up appointments with the service who have been waiting longer than the intended time for their appointment.

The 'intended time for their appointment' is the recommendation made by the responsible clinician and is the timeframe in which the patient should next be reviewed by the service.

Data source

From July 2019, data is reported via the Outpatient Monthly Template, and is submitted monthly to the operations team at the Ministry. Please refer to the Outpatient Returns Guide for more information about outpatient follow-ups.

DHB view

Waiting times for outpatient follow-ups are reported by DHB of service.

Measure calculations

Primary measure

Patients waiting 50% longer than intended for their follow-up

numerator: the number of patients waiting for follow-up appointments with the service who have been waiting greater than or equal to 50% longer than the intended time for their appointment.

denominator: total number of patients in the service at month end, waiting for a follow-up.

Example of a patient story: a patient was intended to be seen for their follow-up within 90 days of their previous appointment, but had waited greater than or equal to 135 days without having their appointment, then they would be counted in this indicator. ie. 135 days is 50% more than 90 days.

Supplementary measure

Patients waiting 100% longer than intended for their follow-up

numerator: the number of patients waiting for follow-up appointments with the service who have been waiting greater than or equal to 100% longer than the intended time for their appointment

denominator: total number of patients in the service at month end, waiting for a follow-up.

Example of a patient story: a patient was intended to be seen for their follow-up within 90 days of their previous appointment, but had waited greater than or equal to 180 days without having their appointment, then they would be counted in this indicator. ie. 180 days is 100% more than 90 days.

CARDIAC WAIT TIMES

Measure description: proportion of patients seen within clinical urgency timeframes for cardiac surgery.

Cardiac surgery should be undertaken within the appropriate timeframes based on the urgency timeframes identified by their 'Cardiac Prioritisation Score' outlined in Table six:

Table six: cardiac surgery urgency timeframes

Urgency Score	Clinically appropriate timeframe
50 – 100	Less than or equal to 72 hours
40 – 49	73 hours – 10 days
25 – 39	11 days – 30 days
0 – 24	31 days – 90 days

Data source

Data is taken from the cardiac surgery reporting template submitted to the Ministry by 12pm Tuesday each week.

Measure calculation

numerator: number of patients waiting for cardiac surgery within the clinical urgency timeframes.

denominator: total number of patients waiting for cardiac surgery

4. Planned Care measures - Equity measures

4.1 DID NOT ATTEND RATES (DNA) FOR FIRST SPECIALIST ASSESSMENT (FSA) BY ETHNICITY (DEVELOPMENTAL)

Measure description:

There will not be a Target Rate identified for this measure. It will be developmental for establishing baseline rates in the 2020/21 year.

DHBs will be required to identify actions underway to:

1. Ensure that the data used is complete and accurate,
2. Address the differences in DNA Rates of the respective populations.

National Patient Flow (NPF) 'Attendance Type' Codes will be grouped into two Attendance groups.

- '**ATT - Attended, service delivered**' and '**AND - Attended, service not delivered or incomplete**' are considered **Attendances** (ATT/AND) and
- '**DNA - Did not attend**' and '**DNW - Did not wait'** will be considered **Non-Attendances** (DNA/DNW).

The total number and percentage of referrals for each DHB that are reported broken down by Maori, Pacific Island and Non Maori/Non Pacific and Attendance groups will be displayed in the data. The Prioritised Ethnicity recorded with the event in NPF will be used. Encounter activities with no Encounter Outcome will be included in this measure. The reporting of all Attendances and Non Attendances are Mandatory in the collection; therefore all reported attendances will be counted – i.e. a patient who DNAs twice and then Attends an FSA will be counted 3 times in this measure.

All Health Specialties and Purchaser Codes with an Encounter Service Type of FSA reported to NPF will be included in the measure.

Data source

Data will be extracted from the NPF Collection and be provided through the Quarterly Reporting database each quarter. For consistency with other NPF measures in Quarterly Reporting data will be for FSA Encounters scheduled for the previous 12 months ending one quarter in arrears. i.e Quarter 1 2020/21 will be for all FSAs with an 'Encounter End Date' between 01 July 2019 and 30 June 2020.

DHB view

In the first year this measure will use the Submitting DHB as the Reporting DHB.

Measure calculation

numerator:	FSA Encounters with an Attendance Type of 'DNA - Did not attend' or 'DNW - Did not wait' for the period
denominator:	Total FSA Encounters for the period