# System Level Measures Improvement Plan
# Taranaki District Health Board
# and
# Midlands Regional Health Network

## 1. Ambulatory Sensitive Hospitalisations (ASH)

*ASH Rates per 100,000 population for 0-4 year olds*
All baseline data is at March 2016

The contributory measures chosen make up the current top six ASH conditions for Taranaki for 0-4 Year olds. Taranaki DHB and Pinnacle Midlands Health Network believe improving outcomes for pre-schoolers affected by these conditions will provide the best opportunity to reduce ASH Rates per 100,000 population for 0-4 year olds in Taranaki. Measuring the milestones by ethnicity is an acknowledgement of the need to reduce the current disparities between Māori and other ethnicities.

Reduction by 4% for Maori and 2.5% for 'other' non-Maori in order to reduce inequality has been agreed for the 2016-2017 milestone. Note the 'total row has been removed as it is not possible to estimate with any accuracy.

| | Taranaki DHB | | |
|---|---|---|---|
| **Baseline** | | **Baseline 15/16** | **Milestones 16/17** |
| | **Māori** | 7,559 | 7,257 |
| | **Non-Māori** | 5,310 | 5,177 |
| **Contributory Measures** | Hospital admissions for 0-4 years old with a primary diagnosis of a respiratory condition<br>Measured by:<br>Referrals to smoking cessation services for parents who are not in smoke free homes.<br>• Asthma management plans in place for all diagnosed Asthmatics aged 0-4 years[1] | | |
| | Full enrolment with a PHO by **three months**[2]<br>• With improvement on the baseline numbers fully enrolled by 6 weeks | | |
| | Immunisation 2 years[3]<br>As a measure of engagement with the system rather than as a provider of significant protection against admission. | | |
| | Children with a Lift the Lift score of 2-6 are referred to an oral health provider<br>• Children will have at least an annual lift the lips assessment by a practitioner in the General Practice[4] | | |

[1] Asthma management plans are particularly important for all parents/caregivers of children 0-4 who have had a life-threatening episode, required hospitalisation or frequently require out-of-hours urgent care for their asthma. Adherence to the plan can significantly reduce readmissions and emergency presentations.
[2] PHO enrolment is an indicator of engagement with the health system – critical to address a range of health issues in this age group
[3] Immunisation at 2 years is an indicator of engagement with the health system
[4] The risk of dental caries starts from the time teeth begin to erupt into the mouth (at approximately six months of age). There is a significant opportunity for different primary health care and public health programmes and health professionals to work together to prevent early childhood caries and provide early intervention if disease is identified.

## 2. Acute Bed Days

*Number of bed days for acute hospital stays per 1000 population domiciled within Taranaki DHB per year (standardised)*

Acute hospital bed days per capita is a measure of the use of acute services in secondary care that could be improved by effective management in primary care, transition between the community and hospital settings, discharge planning, community support services and good communication between healthcare providers. This includes access to diagnostics services.

The measure will be used to manage the demand for acute inpatient services on the health system. The intent of the measure is to reflect integration between community, primary, and secondary care and it supports the strategic goal of maximising the use of health resources for planned care rather than acute care.

The measure aligns well with the New Zealand Health Strategy's five themes, in particular - value and high performance.

A reduction of 2.5% has been agreed as the 2016-2017 milestone. During 2016-2017 Taranaki DHB will work with our primary care partner to understand the factors that influence this measure and understand why Māori have less bed days than other ethnicities.

| | Taranaki DHB | | |
|---|---|---|---|
| **Baseline** | | **Baseline 15/16** | **Milestones 16/17** |
| | **Māori** | 325.8 | 318 |
| | **Non-Māori** | 384 | 374 |
| | **Pacifica** | 562 | 548 |
| | **Total** | 375.2 | 366 |
| **Contributory Measures** | ED Presentation Rates | | |
| | The number of influenza vaccinations for people over the age of 65 years[5] | | |
| | Hospitalisation rates of people with COPD conditions[6] | | |
| | People aged 65 years and older dispensed 8 or more unique long term medications[7] | | |

[5] The complications of influenza in the elderly can be serious or life threatening. As a result the government funds the cost of influenza vaccines and their administration for persons 65 years and over, and persons of any age with certain chronic conditions.

[6] Exacerbations of COPD are sensitive to primary care management and smoke free households and self management plans

[7] There is strong international and New Zealand based evidence that polypharmacy is a major risk factor for poor outcomes for the elderly. It increases the risk of drug interactions and side effects, and results in avoidable hospital admissions.

## 3. Patient Experience of Care

90% of general practices uptake the primary care patient experience survey by 30 June 2017

a) The percentage of GP practices using the primary care patient experience survey to inform quality improvement measured by the uptake of the primary care survey developed by the Health Quality & Safety Commission (HQSC)
b) An increase in the percentage of General Practices offering patient e-portal
c) An increase in the percentage of patients using the patients e- portal

The purpose of these measures is to ensure patients in New Zealand are receiving quality, effective and integrated health services. Evidence suggests that if patients experience good care, they are more engaged with the health system and therefore likely to have better health outcomes. Having General Practices using the patient care survey is a first step to identifying the patient perception of the quality of their health care in the community.

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. Improved patient experience of care will reflect better integration of heath care at the service level, better access to information and more timely access to care.

| | Taranaki DHB | | |
|---|---|---|---|
| **Baseline** | | **Baseline 15/16** | **Milestones Q4 16/17** |
| | **Māori** | | 90% |
| | **Non-Māori** | | 90% |
| | **Total** | | 90% |
| **Milestone** | 90% of general practices uptake the primary care patient experience survey by 30 June 2017 | | |

| | Taranaki DHB | | |
|---|---|---|---|
| **Baseline** | | **Baseline 15/16** | **Milestones Q4 16/17** |
| | **Total General Practices** | 70% | |
| **Contributory Measures** | An increase in the percentage of General Practices offering patient e-portal by June 2017<br>• Baseline data will be available by Q2 2016-2017 | | |

| | Taranaki DHB | | |
|---|---|---|---|
| **Baseline** | | **Baseline 15/16** | **Milestones Q4 16/17** |
| | **Māori** | | |
| | **Non-Māori** | | |
| | **Total** | 3.77% | |
| **Contributory Measures** | An increase in the percentage of patients using patient e-portal by June 2017<br>• Baseline data will be available by Q2 2016-2017 | | |

## 4. Amenable Mortality Rates

Untimely, Unnecessary deaths from causes amenable to health care (per 100,000)

About half the deaths under 75 years of age in New Zealand are classified as amenable according to the current code list. That is, they are 'untimely, unnecessary' deaths from causes amenable to health care.

Reduction for the milestones is set at 4% for Maori and 2.5% for non-Maori categories in order to reduce the gap between Maori and non-Maori. The 'total' row values have been removed as it is difficult to calculate with varying rates of reduction.

| | Taranaki DHB | | |
|---|---|---|---|
| **Baseline** | | **Baseline 15/16** | **Milestones 16/17** |
| | **Māori** | 218.9 | 210.1 |
| | **Non-Māori** | 100.7 | 98.2 |
| **Contributory Measures** | Percentage of enrolled people in the PHO within the eligible population with a record of a Diabetes Annual Review during the reporting period whose HbA1c test result is 8% or less or 64mmol/mol or less[8] | | |
| | Percentage of PHO enrolled people within the eligible population who have had a CVD risk recorded within the last five years and/or measure showing good management of CVD risk[9] | | |
| | Percentage of PHO enrolled women aged 25 to 69 years who have had a cervical sample taken in the past three years[10] | | |
| | Percentage of registered smokers who have been referred to a smoking cessation service[11] | | |

[8] People living with diabetes are regarded as leading partners in their own care within systems that ensure they can manage their own condition effectively with appropriate support.

[9] Cardiovascular disease, including heart attacks and strokes, are substantially preventable with lifestyle advice and treatment for those at moderate or higher risk.

[10] Early detection and treatment of cervical cancer and other abnormalities lowers the rate of premature death for women

[11] At present, tobacco smoking places a significant burden on the health of New Zealanders and on the New Zealand health system. Tobacco smoking is related to a number of life-threatening diseases, including cardiovascular disease, chronic obstructive pulmonary disease and lung cancer. It also increases pregnant smokers' risk of miscarriage, premature birth and low birth weight, as well as their children's risk of Asthma and Sudden Unexplained Death in Infants (SUDI).