West Coast Health System

IMPROVEMENT PLAN

System Level Measures Framework 2016-2017

To be read in conjunction with the West Coast DHB Annual Plan

Contents

Introduction

The System Level Measures Framework (SLMF) has been introduced by the Ministry of Health in the 2016/17 year to extend the Integrated Performance and Incentive Framework (IPIF). As part of this framework there is a requirement to develop a set of local contributory measures aligned with each of the four national outcomes. This provides the Coast with both an opportunity and challenges. The opportunity is to determine some key measures that reflect the local needs and priorities of the Coast. The challenges come from identifying measures that reflect those needs and priorities while ensuring they are useful in understanding the progress of any actions. The key issues around this "usefulness" come from:

ISSUE OF SMALL NUMBERS

While there are a number of measures that would be aligned with the local needs and direction of the Coast many of these involve dealing with small numbers that would not be able to provide useful information on the effect of any improvement actions. This is particularly the case when we wish to look at trends month on month and/or including ethnicity as a component of the data.

ISSUE OF TIMELINESS OF DATA

In looking at the contributory measures one of the key requirements was the timeliness of data and the ability to update information on a regular basis, preferably monthly. This would support and enable the performance improvement plans developed to address specific areas. Many of the current measures only have data available on a quarterly or annual basis and would not support the ability of teams to have regular feedback on the actions they were undertaking and their impact on the measures.

APPROPRIATENESS OF FOCUS FOR THE COAST

In identifying contributory measures for the Coast the SLMF provides an opportunity to focus on some key issues the Coast is facing in improving the health of our communities. When reviewing the pool of measures available there was therefore a focus on those where improvements would make the greatest impact on the overall wellbeing of our communities.

USING EXISTING MEASURES

For the first year of the SLMF only current measures and data already being captured were considered for possible measures. Having a good baseline of information available to us, and some assurance that the data was being captured consistently and accurately, were regarded as very important. A number of possible future measures were also considered and work will be done over the next year to investigate the possibility of using these in future years.

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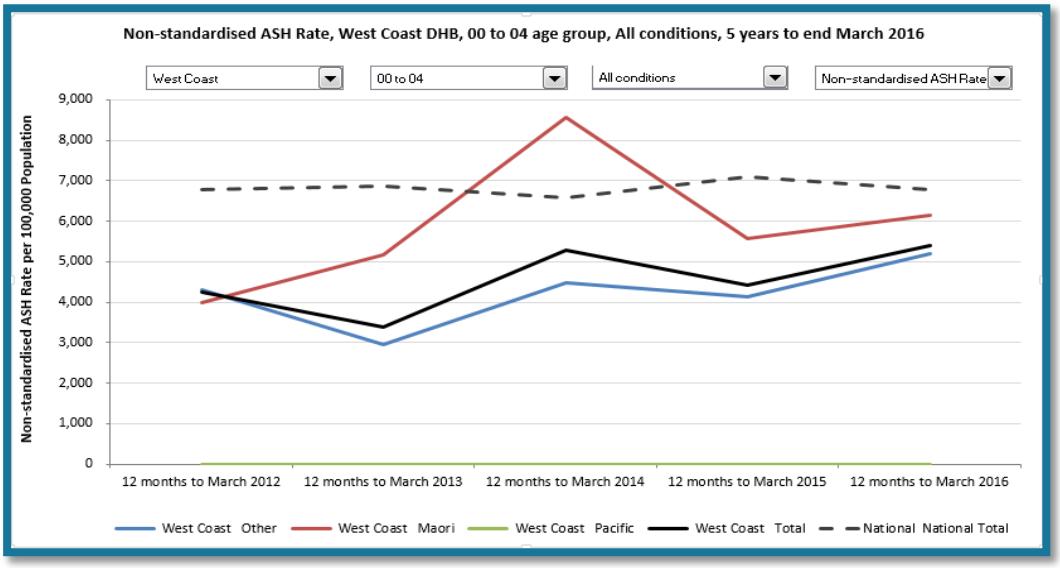
National Outcome Measures

Ambulatory Sensitive Hospitalisations (0 – 4 year olds)

'Keeping children out of the hospital'

Ambulatory Sensitive Hospitalisations (ASH) highlights the burden of disease in childhood with a strong emphasis on health equity. There is high variance among priority populations and also according to social gradient. Reducing ASH rates requires well integrated, preventive, diagnostic and management systems and a well-skilled and resourced workforce.



MILESTONE

The West Coast Health Systems agreed milestone is to maintain the current ASH rate for 0-4 year olds while further analysis is undertaken.

Acute Hospital Bed Days Per Capita

'Using health resources effectively'

A measure of acute demand on secondary care that is amenable to good upstream primary care, discharge planning and transition requiring good communication between primary and secondary care.

The DHB Aged Standardised Acute Bed Days per 1,000 population for the West Coast DHB for the year ending June 2016 was 377.7

MILESTONE

The West Coast Health Systems agreed milestone is to maintain an Aged Standardised Bed Day Rate per 1,000 population as the impact of initiatives in this plan are not expected to show an effect by June 2017.

Patient Experience of Care

'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.

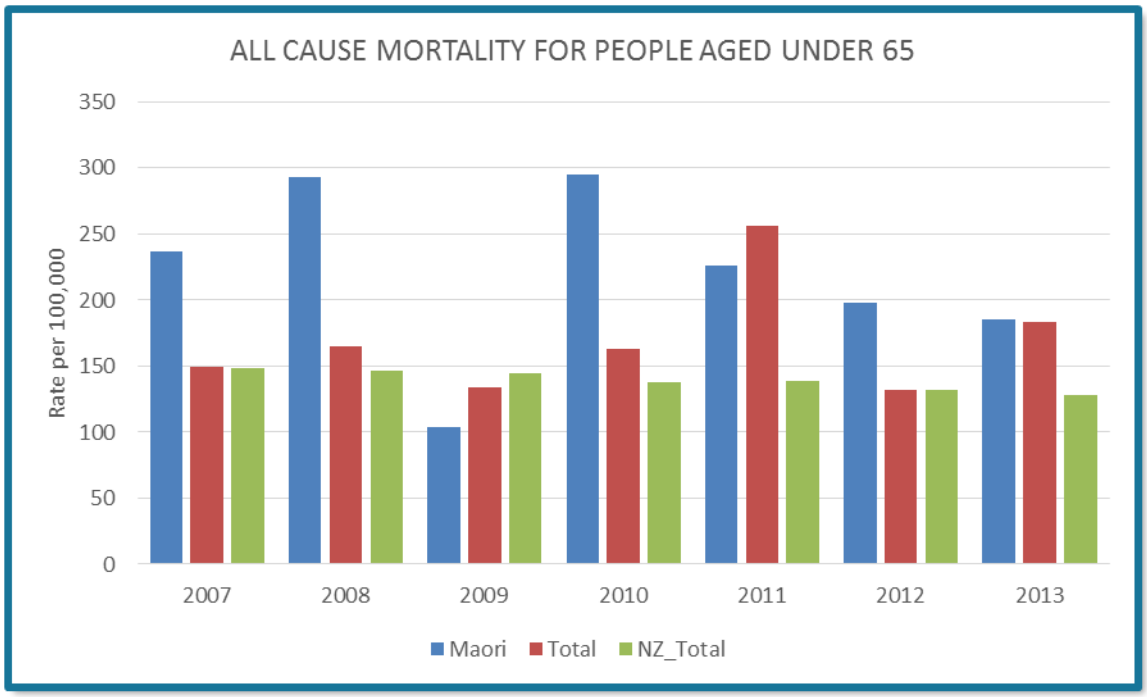
MILESTONE

The West Coast Health Systems agreed milestone is that 50% of practices uptake the primary care patient experience survey.

Amenable Mortality

'Prevention and early detection'

Deaths under age 75 years ('premature' deaths) from causes classified as amenable to health care (currently a list of 35 causes).



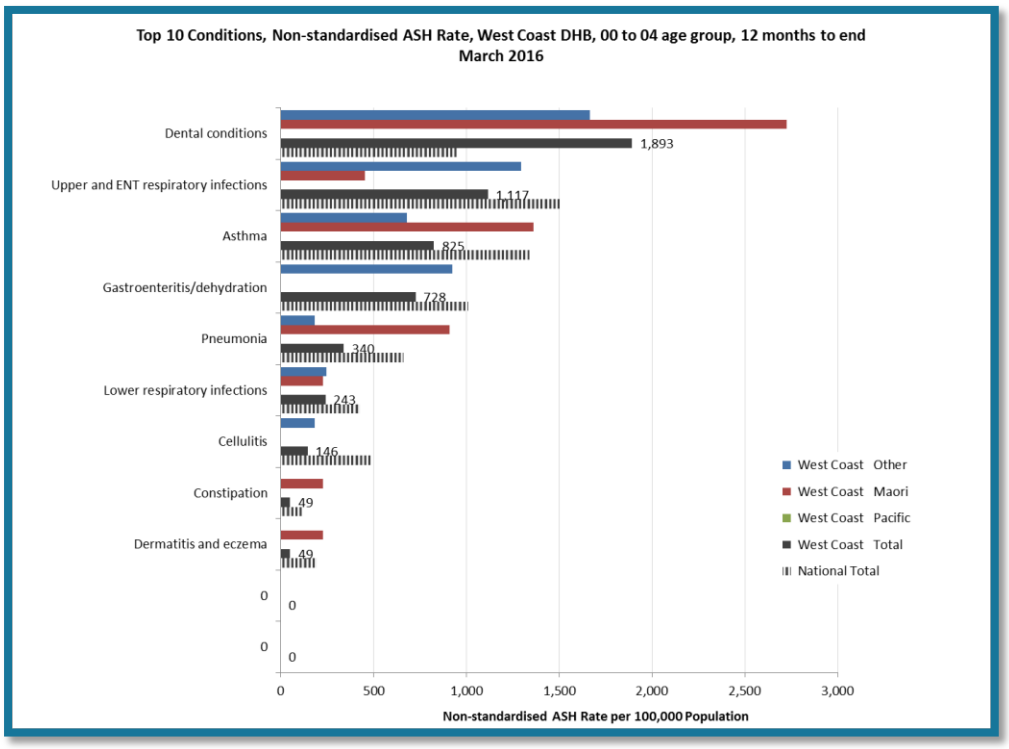
MILESTONE

The West Coast Health Systems agreed milestone for June 2017 is to maintain the current overall Amenable Mortality Rate. The timeframe involved in influencing change and the delay in reporting on the data would be a barrier to a more targeted milestone.

Local Contributory Measures

1. Ambulatory Sensitive Hospitalisation (0 – 4 year olds)

A number of admissions into hospital are for conditions which are preventable through lifestyle change, early intervention and the effective management of long-term conditions. For preventable admissions into hospital for those aged 0 to 4 the single largest category relates to dental conditions (see graph below). This area will be the focus for the West Coast Health system in improving ASH rates for the 0 - 4 year olds.



1.1. Oral Health

CATEGORY	AMBULATORY SENSITIVE HOSPITALISATIONS
Performance improvement area	**Oral health**
Proposed measures	Number of pre-school children overdue for an annual dental oral check
Rationale for choosing	Oral health is poor on the West Coast and one of our key objectives under the annual plan for disease prevention is: ***"Improve the quality and consistency of oral health service across the West Coast to increase engagement and access"*** As a key contributor to ASH rates for under four year olds, improved access and engagement in the oral health service has potential to make a significant impact on the health of our young children.
Current baseline	Current baseline is **310** pre-schoolers in arrears for oral health checks as at August 2016.[1]
Proposed 30 Jun 17 target	A reduction in the number of preschool children in arrears of by 10% for 2016/17.
Improvement plan	• Develop and implement an Oral Health Promotion Plan in conjunction with the Transalpine Oral Health Steering Group and Healthy West Coast Workstream. • Maintain West Coast representation on the Transalpine Oral Health Steering Group to support service developments that improve access and the quality of oral health care. • Develop a plan to increase capacity of this service to reach pre-schoolers. • Promote use of the New-born Enrolment Form to support early enrolment with oral health services. • Develop and implement a risk assessment tool and referral pathway for children at risk of dental caries development.
Who's involved	WCDHB, WCPHO, C&PH, Poutini Waiora, Healthy West Coast, Transalpine Oral Health Steering Group
Who's leading	WCDHB

[1] Locally reported data

1.2. Breastfeeding

CATEGORY	AMBULATORY SENSITIVE HOSPITALISATIONS
Performance improvement area	**Breastfeeding**
Proposed measures	Infants receiving breast milk at six months of age
Rationale for choosing	Early breastfeeding rates are relatively satisfactory for the West Coast but this reduces as babies reach six months. The longevity of breastfeeding is what mitigates the risk of obesity, dental care and chronic disease later in life. One of our key objectives in our annual plan is to: ***"Enhance knowledge and understanding around breastfeeding for pregnant women and their whanau to increase breastfeeding rates"***
Current baseline	Breastfeeding rate at six months is ***65***%, but this does not include all data[2]
Proposed 30 Jun 2017 target	To rectify data issues and have a data set that provides breastfeeding rates more accurately with the inclusion of both Plunket and Poutini Waiora data by 30 June 2017 and set a target for 2017/18.
Improvement plan	• Identify all sources of breastfeeding data and how collected/accurate • Decide on most accurate data source to be used for reporting • Monthly reporting from all providers to WCDHB
Who's involved	WCPHO Breastfeeding Advocates, LMCs, Plunket, Poutini Waiora, WCTO, WCDHB, C&PH
Who's leading	WCDHB

[2] Well Child Tamariki Ora Quality Improvement Framework Indicator 14

2. Acute Hospital Bed Days

2.1. Flu Vaccinations for 65+

CATEGORY	ACUTE HOSPITAL BED DAYS
Performance improvement area	**Flu vaccinations for 65+**
Proposed measures	Number of High Need enrolled persons 65 years and over who have received an influenza vaccine during the most recent influenza campaign as at 30 June 2016
Rationale for choosing	The West Coast has not met the target of 75% of people aged 65 and over having a seasonal flu vaccination. The High Need over 65 population is a key at risk group for flu and a focus on vaccinating this particular group early would potentially reduce hospitalisation due to flu.
Current baseline	62% of those 65 and over with high needs that have received flu vaccine as at 30 September 2016[3]
Proposed 30 Jun 17 target	65% of High Need people 65 years and older have received an influenza vaccine.
Improvement plan	• Promote and provide free seasonal flu vaccinations for people that are 65 and over. • Look at opportunities that incentivise and enable primary care to provide a greater coverage of vaccinations for those who are 65 and over, specifically focusing on the high needs cohort. • Look at opportunities to utilise Public Health Nurses as extra resource for practices to run additional flu clinics. • Trial dedicated after-hours flu clinics at practices and other sites.
Who's involved	WCPHO, Practice teams, Community Pharmacies, NIR coordinator, C&PH, WC Immunisation Advisory Group
Who's leading	WCPHO

[3] Local Karo data

2.2. Better Help for Smokers to Quit

CATEGORY	ACUTE HOSPITAL BED DAYS
Performance improvement area	**Better help for smokers to quit**
Proposed measures	The offer to support quitting has been made to current smokers by a health care practitioner in the last 15 months
Rationale for choosing	The West Coast achieved its primary smoking target at the end of the 2014/15 year but has since struggled to achieve the target. One of the objectives in the annual plan is to; ***"Support sustainable delivery against the 'better help for smokers to quit' health targets."***
Current baseline	Total population 79% at August 2016, Maori 78% [4]
Proposed 30 Jun 17 target	90% of enrolled patients (including the sub target of 90% of Maori enrolled patients) who identify as a smoker are offered advice and support to quit smoking within the last 15 months.
Improvement plan	• Continue to support the use of advanced IT tools in general practice to capture and promote ABC activity. • Continue to identify and promote smokefree champions to support the health target activity. • Monthly reporting of current smokers without brief advice given to practice champions. • Utilise practice admin teams to support clinicians with identifying coding of brief advice.
Who's involved	WCPHO, Practice teams, other WC smoking cessation services
Who's leading	WC Smokefree Coordinator with oversight from Healthy West Coast

2.3. More Heart & Diabetes Checks

CATEGORY	ACUTE HOSPITAL BED DAYS
Performance improvement area	**More heart & diabetes checks**
Proposed measures	Cardio-Vascular Disease (CVD) Risk Assessments for people eligible
Rationale for choosing	The West Coast continues to work with general practice to maintain the delivery of CVD risk assessments. While the West Coast continues to meet the target of 90% a continued focus is required to maintain this. It is important to also translate this into satisfactory management of conditions such as diabetes.
Current baseline	90% total population (high needs 89%) as at August 2016[5]
Proposed 30 Jun 17 target	90% of eligible adult population have had a CVD risk assessment in the last 5 years.
Improvement plan	• Continue to provide practice-specific target performance data in the Primary Bulletin (to practices) supported by advocacy messages targeting clinicians to support the delivery of CVD risk assessments. • Continue to engage with Poutini Waiora in providing culturally appropriate training, health literacy education. • Continue to work with Poutini Waiora to encourage engagement of Maori with primary care to support delivery of CVD risk assessments.
Who's involved	WCPHO, Practice teams, Poutini Waiora, Clinical Nurse Specialists
Who's leading	WCPHO with oversight from Healthy West Coast

[4] Local Karo data

[5] Local Karo data

3. Patient Experience of Care

3.1. General Practice using the National Enrolment Service (NES)

CATEGORY	PATIENT EXPERIENCE OF CARE
Performance improvement area	**GP practices using the NES**
Proposed measures	Number of general practices on the NES
Rationale for choosing	The National Enrolment Service will allow General Practice to offer electronic Patient Experience Surveys that are consistent with other used nationally. Feedback from these surveys will be valuable to inform the system about current Patient Experiences as well as decisions about future service delivery.
Current baseline	One practice (Reefton)
Proposed 30 Jun 17 target	All eight of the general practices on the Coast, subject to issues with Profile for Mac being resolved
Improvement plan	• Three practices go on to NES in 2nd tranche (High St, Greymouth Medical Centre & Rural Academic General Practice) • Two practices go on to NES in 3rd tranche (Buller Medical & Coast Medical) • Two practices go on to NES in 4th tranche (South Westland Area Practice & Westland Medical Centre)
Who's involved	WCPHO, Practice Managers, Administration teams
Who's leading	WCPHO

3.2 Uptake of primary care patient experience survey

CATEGORY	PATIENT EXPERIENCE OF CARE
Performance improvement area	**GP practices uptake of patient experience of care survey**
Proposed measures	Percentage of general practices that uptake the primary care patient experience survey
Rationale for choosing	Patient experience of primary care and how their care is managed is used for monitoring of service quality, quality improvement and patient safety This piece of work fits well with the roll-out of practices using NES in 3.1 above.
Current baseline	Zero
Proposed 30 Jun 17 target	50% of practices uptake the primary care patient experience survey
Improvement plan	• First practice Greymouth Medical Centre • Then Rural Academic General Practice • Then High Street Medical Centre • Then Reefton Medical Centre
Who's involved	WCPHO; Practice Managers & Administrators
Who's leading	WCPHO

3.3. General Practice Offering E-Portal

CATEGORY	PATIENT EXPERIENCE OF CARE
Performance improvement area	**GP practices offering an e-portal**
Proposed measures	Number of general practices offering an e-portal
Rationale for choosing	Patient Portal will assist with wider patient access to general practice. Work on delivering a Patient Portal tool is already underway and this fits with local priorities to use Information Technology as an enabler.
Current baseline	Zero
Proposed 30 Jun 17 target	Three practices
Improvement plan	• First trial practice Greymouth Medical Centre • Then Rural Academic General Practice • Then High Street Medical Centre
Who's involved	WCPHO; Practice teams; DHB IT Project Support; Patient Portal Provider
Who's leading	WCPHO

4. Amenable Mortality

4.1. Cervical Screening (Cx)

Category	Amenable Mortality
Performance improvement area	**Cervical Screening**
Proposed measures	Eligible women who have had a cervical smear in the last three years
Rationale for choosing	Cervical screening provides an opportunity to make a difference to the lives of women and their families and there continue to be opportunities for improvement.
Current baseline	82% total population [6]
Proposed 30 Jun 17 target	84% of eligible women have had a cervical smear in the last 3 years.
Improvement plan	• Improve the mismatch of Patient Management System (PMS) data with National Screening Unit (NSU) data. • Release available funding from secondary care to practice teams to support high needs screening (free smears for this cohort if done in primary care) • Improve integration of Poutini Waiora & DHB Sexual Health Service with general practice teams
Who's involved	WCPHO, DHB Sexual Health Service, Practice Champions, Poutini Waiora, Family Planning
Who's leading	WCPHO

4.2. Long Term Conditions Management

CATEGORY	AMENABLE MORTALITY
Performance improvement area	**Long term conditions management**
Proposed measures	Improved self-management support for people with long term mental health conditions
Rationale for choosing	We have a functioning Long Term Conditions Management (LTCM) programme for established diabetes, CVD and Chronic Obstructive Pulmonary Disease. Mortality for people with long term mental health conditions is much higher at younger ages than the general population so including them as part of the LTCM programme to improve wellness for this population.
Current baseline	Zero patients with long term mental health conditions enrolled in current LTCM programme
Proposed 30 Jun 17 target	One general practice will be enrolling and managing people with long term mental health conditions in their LTCM programme
Improvement plan	• Buller Medical Centre will trial clinics for this cohort of their population • Community Mental Health staff will be aligned to work with the general practice to support this cohort of people. • Visits will be incentivised for the patients – free as part of the LTCM programme
Who's involved	WCPHO; Buller Medical Centre; DHB CMH - Buller
Who's leading	Clinical Manager WCPHO

[6] Karo reported NSU data as at August 2016