System Level Measures in a nutshell

The System Level Measures Framework aims to improve health outcomes for people by supporting DHBs to work in collaboration with health system partners (primary, community and hospital) using specific quality improvement measures.

There are six System Level Measures:

- Ambulatory Sensitive Hospitalisation (ASH) rates for 0–4 year olds (keeping children out of hospital)
- Acute hospital bed days per capita (using health resources effectively)
- Patient experience of care (person-centred care)
- Amenable mortality rates (prevention and early detection)
- Babies living in smoke-free homes (a healthy start)
- Youth access to and utilisation of youth appropriate health services (youth are healthy, safe and supported).
System Level Measures focus on children, youth and reducing equity gaps for Māori and other population groups that consistently experience poor health outcomes. System Level Measures recognise that good health outcomes require health system partners to work together. For example, ‘Ambulatory Sensitive Hospitalisation (ASH) rates for 0–4 year olds’ is about keeping children well and out of hospital. To do this, clinicians and managers from primary health organisations (PHOs), general practice teams, Well Child providers, hospitals, planning and funding units, ambulance and others work together to understand what’s driving their ASH rates. They then make changes and put in place programmes that will help avoid hospitalisation – for example, making sure children are being enrolled in the dental service.

Contributory measures are chosen locally based on the needs and priorities of communities and local health services. They measure local progress against the quality improvement activities identified to improve the System Level Measure. For example, contributory measures for ‘Acute hospital bed days per capita’ could include length of stay, acute readmissions and flu vaccinations in the elderly.

10 reasons to invest in System Level Measures

1. You will become very familiar with your population’s data so you can see where you are meeting the needs of your population, and where you need to put in extra effort.

2. People and communities are involved right from the start and design a truly patient-centred system (“nothing about us without us”).

3. You will identify the equity gaps in your district and have a plan to improve health outcomes for Māori, Pacific and other vulnerable groups.

4. You will improve the quality of your services from the feedback you receive through the patient experience surveys.

5. You can decide where to put your resource and effort, and choose to focus on things that will really make a difference to your population – for example, oral health, smokefree, immunisation.

6. You can see what improvement initiatives other alliances around the country are undertaking and learn from each other.

7. You’ll have a diverse team, which might include people and communities, colleagues from other DHBs, PHOs, midwives, Well Child Tamariki Ora providers, ambulance, pharmacy, acute medical, paediatric, surgery, analysts, planning and funding and corporate services to study the data and develop your improvement plan.

8. Every improvement plan gets easier, because you develop trust and relationships across the health system.

9. The process is locally led by clinicians and management – not from the Ministry of Health.

10. You’ll have a tangible health improvement plan for the whole district – so everyone can paddle the waka in the same direction!
Within the working groups, the public health physician and PHO lead worked closely to guide the process. They made sure we were asking the right questions and finding out the right information – it was very much a team approach.

– Kim MacRae, Practice Advisor, Alliance Health Plus PHO

The proof of the pudding is going to be delivery. So far we are on track. A lot of it is about getting systems established and then moving to accelerating the change we want to see.

– Dr Allan Moffitt, Clinical Director of Procare PHO

Dental care was not covered in the alliance plan, so we began to engage more closely with the dental service. We will work together to make sure children are being enrolled and getting to appointments. This approach is reflected in the contributory measure in our improvement plan ‘Support improvements in dental care: Preschool dental enrolment’.

– Justine Thorpe, Programme Director Tihei Wairarapa

You have to understand first, A: is there a problem, B: what is the problem, what are the underlying things, what’s modifiable, and then how do we modify it?

– Professor Les Toop, Canterbury Clinical Network Alliance Leadership Team

ASH rates for Māori children were higher, and we found that most hospitalisations were because of oral health issues, respiratory conditions or gastroenteritis. Once we had this understanding of the data, we could focus the plan on what would make the biggest difference.

– Angela Francis, Chief Executive of Nelson Bays Primary Health

A great thing about the SLMs is that really strong equity focus. For the ASH rates, it’s been quite an eye opener, with things like oral health to see just what inequalities there are and being able to put some real focus on those areas.

– Kim MacRae, Practice Advisor, Alliance Health Plus PHO

“We used the data provided by the Ministry of Health to each alliance. A lot of the performance issues, particularly equity outcome gaps, we already knew, but the data confirmed it.”

– Justine Thorpe, Programme Director Tihei Wairarapa

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Don’t just take our word for it…
How it actually works, using ASH rates as an example

System Level Measure
ASH rates in 0-4 year olds: Reduce hospital admission rates for conditions avoidable through prevention or management in primary care

Analyse your local district data and identify main contributors to ASH rates in your district

• Use Ministry of Health and Health Roundtable data to identify the percentage of avoidable hospital admissions of children 0-4 in your district alliance
• Break down by ethnicity and deprivation level to identify equity gaps
• Look at most common conditions in children: respiratory illness, gastroenteritis, dental conditions and cellulitis

Identify improvement milestone for ASH
ASH improvement milestone: ASH rates for Māori and Pacific children fall by 2% (432) by end June

Identify activities and providers that will impact the milestone
To impact the milestone with focus on Māori and Pacific families:
• Introduce healthy homes initiative through NGO or Public Health Unit
• Undertake promotion of B4 School Checks to Māori and Pacific families, with aim of 90% of children receiving a B4 School Check by end June
• Smokefree homes campaign launched, focusing on Māori and Pacific families
• Comprehensive diagnosis and treatment of asthma in primary and community care including general practice, pharmacies and ambulance

Select most relevant contributory measures
See the ASH contributory measures on the Health Quality Measures website
Most relevant include:
• Hospital admissions for children aged five years with a primary diagnosis of asthma
• Four-year-old children who have received a B4 School Check
• Four-year-old children living in smoke-free homes

Develop and submit improvement plan to Ministry with signatures of alliance partners

ASH rates in 0-4 year olds

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<tr>
<th>Improvement milestone</th>
<th>Actions/Activities</th>
<th>Contributory measures</th>
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</table>
| ASH rates for Māori and Pacific children fall 2% (432) by end of June | • Introduce healthy homes initiative through NGO or public health unit  
• Comprehensive diagnosis and treatment of asthma in primary and community care including general practice, pharmacies and ambulance | • Hospital admissions for children aged five years with a primary diagnosis of asthma |

| | | |
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You’ll be wanting to know more!
Check out the System Level Measures pages on the Ministry of Health’s website, Nationwide Service Framework Library and the Health Quality Measures NZ Library.