Achievements, opportunities and challenges in cervical screening in the wider Auckland region

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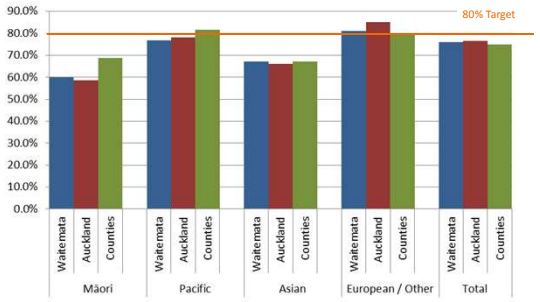
Waitemata District Health Board – Best Care for Everyone
Auckland District Health Board – Te Toka Tumai
Counties Manukau Health

Overview

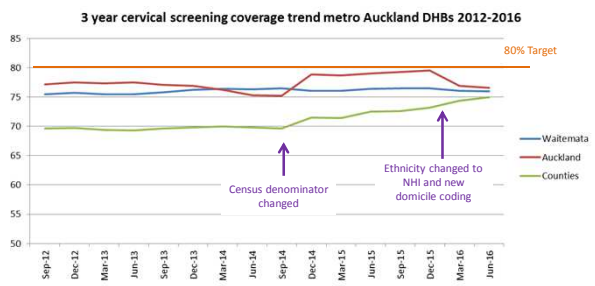
1. Auckland region data
2. Cervical screening landscape in the Auckland region
   - Work on improving coverage
3. Some reflections on reaching targets and achieving equity
   - Achievements, opportunities and challenges

1. Auckland region data

Current 3 year coverage (%) metro Auckland



Source: NCSP, June 2016



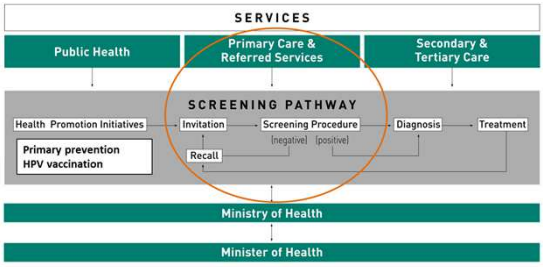
Source: NCSP, 2012-2016

2. Cervical screening landscape in the Auckland region

Cervical screening in metro Auckland

- Regional coordination service since 2012
- Metropolitan Auckland Cervical Screening Governance Group (MACSGG)
  - Regional strategy and action plans
  - Initial working groups on data issues
  - Became advisory group after evaluation 2014, and returned to a small governance group with a refocusing of effort on a larger Operational group
    - Consumer, DHBs, PHOs, ISPs, Māori and Pacific providers, coordinators, NCSP Register
  - Coordinators working at practice level
  - Whole of pathway view, but focus on improving equity in coverage

Understanding the issues across the whole of pathway, and whole of system



Improving coverage

- Diagnosis

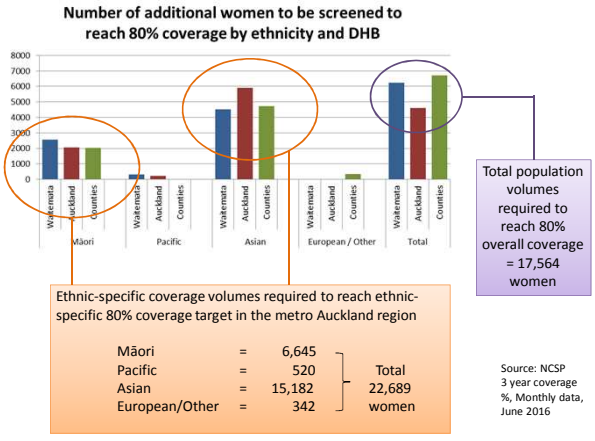
- Strategy and actions

‘Diagnosis’

- Problem:
  - Coverage is not at 80% target for any of the metro Auckland DHBs
  - There are large gaps in coverage for priority group women, with very low coverage for Māori women
- Approach the local why:
  1. Understand issues with the data
  2. Understand systems and process issues across the whole pathway

Data and systems issues

- NCSP-Register data and general practice data
  - Ethnicity data
  - Hysterectomy data
- Data available for PHOs and general practice
  - Lists from the NCSP-Register
  - Invitation and recall lists across the different Practice Management Systems and audit tools
- Lots of complexity, confusion and variability



Strategy and actions = Equity Focus

1. Systems and processes
2. Data-matching
3. What works locally

Also local research on HPV self-sampling

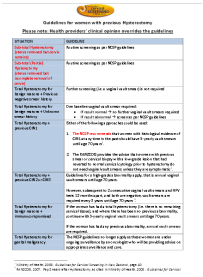
1. Systems and processes

- Own house in order
- Best practice manual
  - 'How to Guide'
  - MedTech/My Practice versions
- Education on hysterectomy and exemptions
- Support for data-matching
- Regional coordinators support practices (through PHOs) for all of the above

'How To' Guide link: http://nationalwomenshealth.adhb.govt.nz/health-professionals/auckland-regional-cervical-screening-project-

Hysterectomy

- Not consistently recorded on the NCSP-Register
- Any women with hysterectomy code in GP audit tools (eg DrInfo) is automatically exempted from recall
  - Only women with benign hysterectomy can safely be excluded



Guidelines for women with previous Hysterectomy

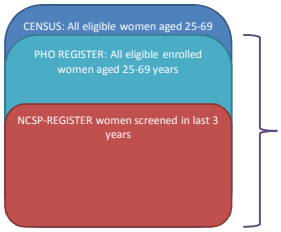
Please note: Health providers' clinical opinion overrides the guidelines

http://nationalwomenshealth.adhb.govt.nz/Portals/0/Cervical%20Screening/Guidelines%20for%20the%20management%20of%20women%20with%20a%20previous%20hysterectomy.pdf

Other 'Exempt' women

- Practice of 'archiving' women is not supported by the NCSP guidelines = lost to follow up = clinical risk
  - 'Non-responders'
    - Removing a recall if not responded eg after 3 invitations
    - Should stay on annual recall to revisit
  - 'Declined'
    - Sometimes just decline on that day
    - Respect right to choose not to have a screen, but should be periodically revisited as remain at clinical risk
    - Withdrawing from the programme is a formal process with informed consent form, all data removed from NCSP-Register
  - 'Not sexually active' or lesbian
    - Any history of sexual activity means clinical risk, should be regularly recalled as per guidelines

2. Data-matching



- Match
  - PHO Register
  - NCSP-Register
- Actual women
- Actual screening status
- Everyone overdue to recall
- Women not on the register (now able to be invited)

ProCare Pilot data-matched lists

Sunshine Medical Centre

Screening History type code	Number of women
High Grade	1
Low Grade	2
Unknown	4
Never been screened in NZ	3
Unsatisfactory	1
Normal	8
Total overdue/unscreened	19

Screening history type code	Years overdue	NHI	Ethnicity	DOB	Last smear results	Date last smear taken	Location last smear taken	Due date	Comments	Funding eligibility	Practice feedback to Regional Register
High Grade	2.3	XXX1111	Asian	1/02/1963	Negative	6/10/2011	SUNSHINE MEDICAL CENTRE	6/11/2012		DHB - Under screened	
Low Grade	9.8	XXX1112	Other	25/05/1965	Low Grade	14/10/2004	MOUNTAINVIEW SURGERY	14/05/2005		DHB - Overdue 5 years	
Low Grade	5.2	XXX1113	European	23/10/1954	Low Grade	28/10/2008	IPA NEWMARKET	28/11/2009		DHB - Overdue 5 years	
Unknown	17.5	XXX1114	Asian	23/04/1968		10/08/1994	SUNSHINE MEDICAL CENTRE	-		DHB - Overdue 5 years	
Unknown	17.3	XXX1115	Other	1/03/1977	Negative	19/10/1994	SUNSHINE MEDICAL CENTRE	-		DHB - Overdue 5 years	
Unknown	16.5	XXX1116	Asian	25/12/1980	Negative	17/08/1995	Dr John Smith – Gynaecologist	-		DHB - Overdue 5 years	
Unknown	16.3	XXX1117	European	25/12/1960	Negative	17/11/1995	Obstetrician & Gynaecologist	-	Sub Total Hysterectomy	DHB - Overdue 5 years	
Never been screened in NZ	-	XXX1118	Pacific	31/12/1995	-	-	SUNSHINE MEDICAL CENTRE	-	MIGRATION	DHB or SIA - Unscreened	
Never been screened in NZ	-	XXX1119	European	4/06/1976	-	-	SUNSHINE MEDICAL CENTRE	-		DHB - Unscreened	
Never been screened in NZ	-	XXX1120	Pacific	5/02/1963	-	-	SUNSHINE MEDICAL CENTRE	-		DHB or SIA - Unscreened	
Unsatisfactory	6.0	XXX1121	European	13/04/1977	Unsatisfactory	16/10/2008	MOUNTAINVIEW SURGERY	16/01/2009		DHB - Overdue 5 years	
Normal	5.7	XXX1122	Asian	23/04/1957	Negative	10/02/2009	IPA TAKARUNA -	10/06/2009		DHB - Overdue 5 years	
Normal	5.6	XXX1123	European	26/08/1971	Unsatisfactory	4/03/2009	IPA NEWMARKET	4/07/2009		DHB - Overdue 5 years	
Normal	5.3	XXX1124	Pacific	23/08/1954	Negative	17/08/2008	SUNSHINE MEDICAL CENTRE	17/12/2009	Total Hysterectomy	DHB or SIA - Overdue 5 years	
Normal	5.3	XXX1125	European	31/05/1959	Negative	29/08/2008	WELL WOMEN & FAMILY TRUST	29/12/2009		DHB - Overdue 5 years	
Normal	2.3	XXX1126	European	23/03/1993	Negative	31/10/2008	WELL WOMEN & FAMILY TRUST	30/11/2009		None - PATIENT PAYS (or Refer)	
Normal	5.1	XXX1127	Māori	6/08/1972	Negative	10/11/2008	SUNSHINE MEDICAL CENTRE	10/12/2009		DHB or SIA - Overdue 5 years	
Normal	5.2	XXX1128	Pacific	23/04/1966	Negative	14/11/2008	SUNSHINE MEDICAL CENTRE	14/12/2009	Withdrawn	DHB or SIA - Overdue 5 years	
Normal	5.1	XXX1129	Asian	31/07/1969	Negative	24/11/2008	WELL WOMEN & FAMILY TRUST	24/12/2009		DHB - Overdue 5 years	

- Now data-match lists available nationally to all PHOs and practices
- National and regional work on supporting PHOs and practices to optimally and routinely use the lists

3. What works locally

- Targeted free smear funding
- Local promotion (radio, Facebook)
- Sucessful Operations group sharing of ideas, rapid experimentation, testing and scaling, support
  - WorkBase health literacy training package for non-clinical and clinical staff: new model for invitation/recall
  - Support practices for screening at every opportunity eg alerts flags, having rooms and nursing staff available
  - Pop up/cluster clinics: Different venues, work with local practices and community to invite priority women and take walk-ins
  - Local initiatives led by PHO, practices or coordination service: Saturday clinics, raffles, church well woman events, nurse/ISP relationships with solo GP practices, free smear 'vouchers,' pamper evenings

Pop up / cluster clinic examples

Local venue near mall

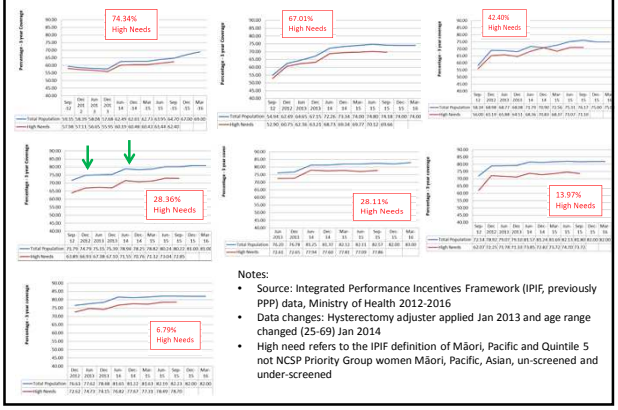
- Engage local PHOs
- Health promotor on site
- 59 women screened, check status on register
- All priority women
- 29 women (50%) had never had a smear
  - Really positive feedback from women on process
- 3 women not enrolled with a GP, offered enrolment

Primary care venue

- Group of practices
- Free clinic for overdue or unscreened women
- 66 women screened
  - 30% Māori
  - 20% Pacific
  - 20% Asian

3. Some reflections on reaching targets and achieving equity

PHO 3 year cervical screening coverage 2012-2016



Notes:

- Source: Integrated Performance Incentives Framework (IPIF, previously PPP) data, Ministry of Health 2012-2016
- Data changes: Hysterectomy adjuster applied Jan 2013 and age range changed (25-69) Jan 2014
- High need refers to the IPIF definition of Māori, Pacific and Quintile 5 not NCSP Priority Group women Māori, Pacific, Asian, un-screened and under-screened

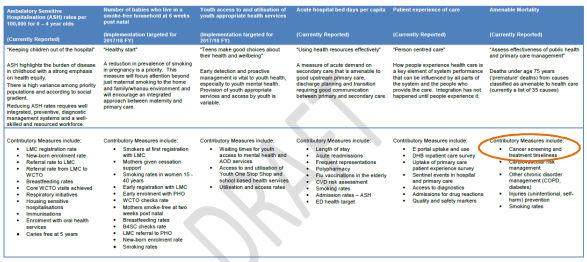
Opportunities and challenges in primary care

- Cervical screening historically and currently a primary care activity (GPs and nurse smear takers)
  - <5% of screening in metro Auckland by Family Planning Association or regional Independent Service Providers (ISPs)
  - Approximately 2,100 smear-takers metro Auckland; 1,500 GPs and 600 nurses
- Only screening programme with a cost to participate
  - Cost one of the known barriers to participation
  - Targeted free smears allocated through PHOs (priority women), but only enough funding to cover approx 25% of eligible women
  - Some PHOs fund free smears themselves
- NSU recently retendered for breast and cervical ISP services
  - Results awaited, opportunities to connect 'outreach' support better to primary care, and to systematically offer alternate locations/providers

Primary care targets

- Primary care have a financial incentivisation programme for areas the Ministry of Health wish to focus on (eg Health Targets)
- Initially Primary Care Performance Programme (PPP), currently the Integrated Performance Incentives Framework (IPIF) soon to be the Systems Level Measures Framework (SLMF)
- Cervical screening a monitored indicator in PPP, in Jan 2014 became one of 6 significantly incentivised IPIF indicators = focused efforts
- As of July 2016 no longer financially incentivised
  - But a potential contributory measure under one of the 6 SLMs (Amenable Mortality)

System Level Measures (SLMs)



Ambulatory Sensitive Hospitalisation (ASH) rates per 100,000 for 0 – 4 year olds (Currently Reported)	Number of babies who live in a smoke-free household at 6 weeks post natal (Implementation targeted for 2017/18 FY)	Youth access to and utilisation of youth appropriate health services (Implementation targeted for 2017/18 FY)	Acute hospital bed days per capita (Currently Reported)	Patient experience of care (Currently Reported)	Amenable Mortality (Currently Reported)
"Keeping children out of the hospital"	"Healthy start"	"Teens make good choices about their health and wellbeing"	"Using health resources effectively"	"Person centred care"	"Assess effectiveness of public health and primary care management"
ASH highlights the burden of disease in childhood with a strong emphasis on health equity. There is high variance among priority populations and according to social gradient. Reducing ASH rates requires well integrated, preventive, diagnostic management systems and a well-skilled and resourced workforce.	A reduction in prevalence of smoking in pregnancy is a priority. This measure will focus attention beyond just maternal smoking to the home and family/whanau environment and will encourage an integrated approach between maternity and primary care.	Early detection and proactive management is vital to youth health, especially to youth mental health. Provision of youth appropriate services and access by youth is variable.	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.	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.	Deaths under age 75 years ('premature' deaths) from causes classified as amenable to health care (currently a list of 35 causes)
Contributory Measures include: • LMC registration rate • New-born enrolment rate • Antenatal rate to LMC • Referral rate from LMC to WCTO • Breastfeeding rates • Core WCTO visits achieved • Respiratory initiatives • Housing sensitive hospitalisations • Immunisations • Enrolment with oral health services • Caries free at 5 years	Contributory Measures include: • Smokers at first registration with LMC • Maternity given cessation support • Smoking rates in women 15 - 40 years • Early registration with LMC • Early enrolment with PHO • WCTO checks rate • Mothers smoke-free at two weeks post natal • Breastfeeding rates • B4SC checks rate • LMC referral to PHO • New-born enrolment rate • Smoking rates	Contributory Measures include: • Waiting times for youth access to mental health and AOD services • Access to and utilisation of Youth One Stop Shop and school based health services • Utilisation and access rates	Contributory Measures include: • Length of stay • Acute readmissions • Potentially preventable hospitalisations • Flu vaccinations in the elderly • CVD risk assessment • Smoking rates • Admission rates – ASH • ED health target	Contributory Measures include: • EI portal uptake and use • DHB inpatient care survey • Long term conditions patient experience survey • Sentinel events in hospital and primary care • Access to diagnostics • Admissions for drug reactions • Quality and safety markers	Contributory Measures include: • Cancer screening and treatment timeliness • Cardiovascular risk management • Other chronic disorder management (COPD, diabetes) • Injuries (unintentional, self-harm) prevention • Smoking rates

Amenable mortality = Early / Premature deaths <75 years
Main causes: cancer, cardiovascular disease
Contributory measures chosen locally (DHB/PHOs)

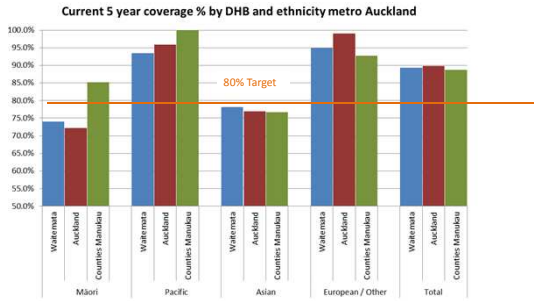
Pros of targets

- Allows focus on a limited set of priorities
- Resource into diagnosing the issues (usually data and systems issues) and strategies to address these
- To get high coverage need to know information about actual people and be able to offer them the service in a way that works for them
  - May or may not be the way we are currently delivering that service
  - May need alternative access points, alternative providers, supports to overcome barriers

Cons of targets

- Always the possibility of unintended consequences
  - Improving overall coverage at the expense of equity (taking the 'easy' wins)
    - Importance of monitoring primary care and DHB coverage by ethnicity (and/or 'high need')
  - Potential issues with patient experience (numbers-centric not people/whānau-centric)
    - Need to ensure good conversations with women, importance of informed consent, privacy and time, health literacy and understanding, guidelines (esp changes to the programme)

NCSP change to primary HPV from 2018, move to 5 year coverage



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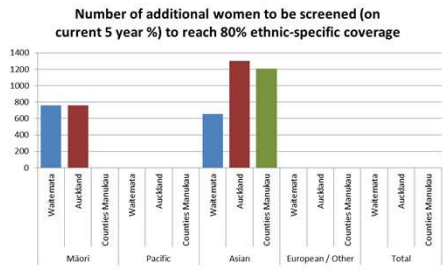

Source: NCSP, June 2016

Thank you

Feel free to email me: Karen.Bartholomew@waitematadhb.govt.nz
Coordination service: Jane.Grant@waitematadhb.govt.nz

Link to the Auckland coordination project information
or Google Auckland Cervical Screening Project
http://nationalwomenshealth.adhb.govt.nz/health-professionals/auckland-regional-cervical-screening-project-