



PHO PERFORMANCE PROGRAMME

PERFORMANCE RESULTS

For

Nelson Bays Primary Health Trust

PHO

As at 31 December 2009

Overview

The PHO Performance Programme has been developed by District Health Boards (DHBs), the Ministry of Health and the primary health care sector to support improvements in the health of people enrolled in a [Primary Health Organisation \(PHO\)](#).

The Programme aims to:

- Encourage and reward improved performance by PHOs in line with evidence-based guidelines
- Measure and reward progress in reducing health inequalities by including a focus on high need populations;

DHBs contract PHOs to deliver a range of health care services for people when they are unwell, to help people stay healthy and to reach out to groups of people in the community who have poor health or are missing out on primary health care.

The Programme has developed a number of performance indicators to measure PHO achievements over a six month period. Some performance indicators measured by the Programme look at services accessed by all PHO-enrolled patients while other indicators look at services specifically accessed by Maori or Pacific Island people or those living in lower socio-economic areas. These patients are referred to as ‘high need’ patients.

Evidence has shown that ‘high need’ patients have poorer health than non-Maori or non-Pacific Island people or people who do not live in a lower socio-economic area. One of the Programme’s main objectives is to reduce the health ‘gaps’ between high need and non-high need patients so that all New Zealanders, whatever their ethnicity or living standard, can access the health services they need in order to be healthy.

The performance indicators which are included in this report are:

- Breast cancer screening coverage
- Cervical cancer screening coverage
- Cardiovascular risk assessment
- Diabetes detection
- Diabetes follow up
- 65 years + influenza vaccinations
- Age appropriate vaccinations for 2 year olds
- GP referred laboratory expenditure
- GP referred pharmaceutical expenditure

Each indicator's performance result is structured as follows:

- **Indicator Name**
The name of the indicator that has been measured
- **Description**
A description of the indicator and why it is included
- **Target Population**
Who within the PHO population meets the requirements to be 'counted'
- **Programme Goal**
The desired overall target that all PHOs should be striving to achieve or exceed – the goal is based on what has been recommended to the Programme from evidence based analysis
- **Data Source**
Where the Programme sources the data to measure the performance indicator
- **Cautions**
The constraints or limitations encountered by the Programme when measuring the performance indicator
- **PHO Performance**
A graphical representation of the PHO-level performance results versus overall DHB and national performance
- **PHO Narrative**
An accompanying statement from the PHO explaining or commenting on its performance results

Breast Cancer Screening Coverage

Description

Early detection and treatment of breast cancer lowers the rate of death from breast cancer. The national breast screening programme ([BreastScreen Aotearoa](#)) recommends women aged 45 to 69 have 2 yearly [mammograms](#). Currently this indicator measures screening rates for women aged between 50 and 64 years. In the future the Programme will align its age band measures with the national programme.

Target Population

All women aged 50 to 64 years who are within the high need population (identified as Maori, Pacific Island and/or Decile 9 or 10).

Programme Goal

70% or more of the PHO's target population have had a mammography within 2 years.

Data Source

To measure this indicator the Programme depends on data provided by the national screening programme.

Cautions

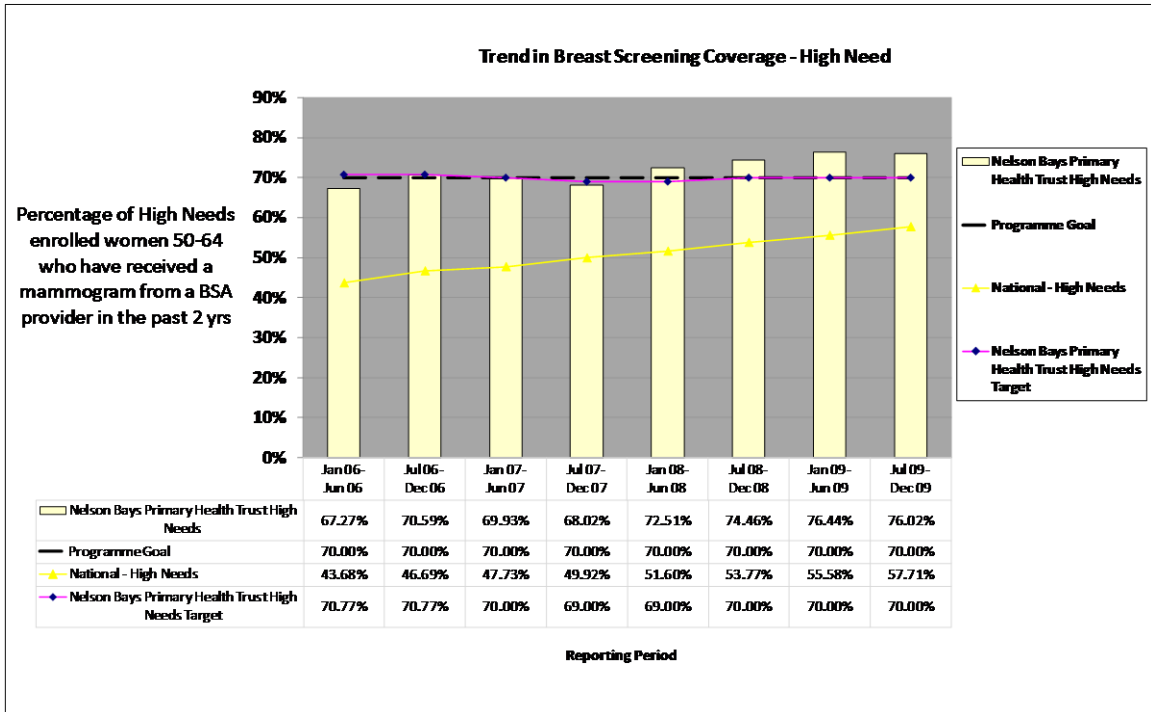
➤ National

Some regions have infrequent access to mammography screenings due to the remoteness of their location. There is also no allowance in the measurement of this indicator for women who have had mastectomies.

➤ Data

Only publicly funded mammography screenings performed by BreastScreen Aotearoa health carers are 'counted' by the Programme. Private mammography screenings are not counted.

PHO Performance



PHO Narrative

Nelson Bays Primary Health has been exceeding the national target for Breast Cancer Screening for High Needs women for the last four performance periods. Nelson Bays Primary Health acknowledges the support of its general practices in achieving the national goal with 20/26 practices exceeding the goal.

In addition, Nelson Bays Primary Health continues to work collaboratively with BreastScreen Aotearoa and Te Awhina Marae to provide mobile screening services in Motueka. The mobile screening unit also visits Golden Bay, which contributes positively to screening coverage.

Cervical Cancer Screening Coverage

Description

Early detection and treatment of cervical cancer and other abnormalities lowers the rate of death from cervical cancer. The [national cervical screening programme](#) recommends women have three yearly cervical screens from the ages 20 to 69 years. This screening interval may alter if a smear result is abnormal.

Target Population

1. All women aged 20 to 69 years
2. All women aged 20 to 69 years within the high need population (identified as Maori, Pacific Island and/or Decile 9 or 10)

Programme Goal

75% or more of a PHO's target population have had a cervical screen within 3 years.

Data Source

To measure this indicator (both total population and high need population) the Programme depends on data provided by the national cervical screening programme.

Cautions

➤ National

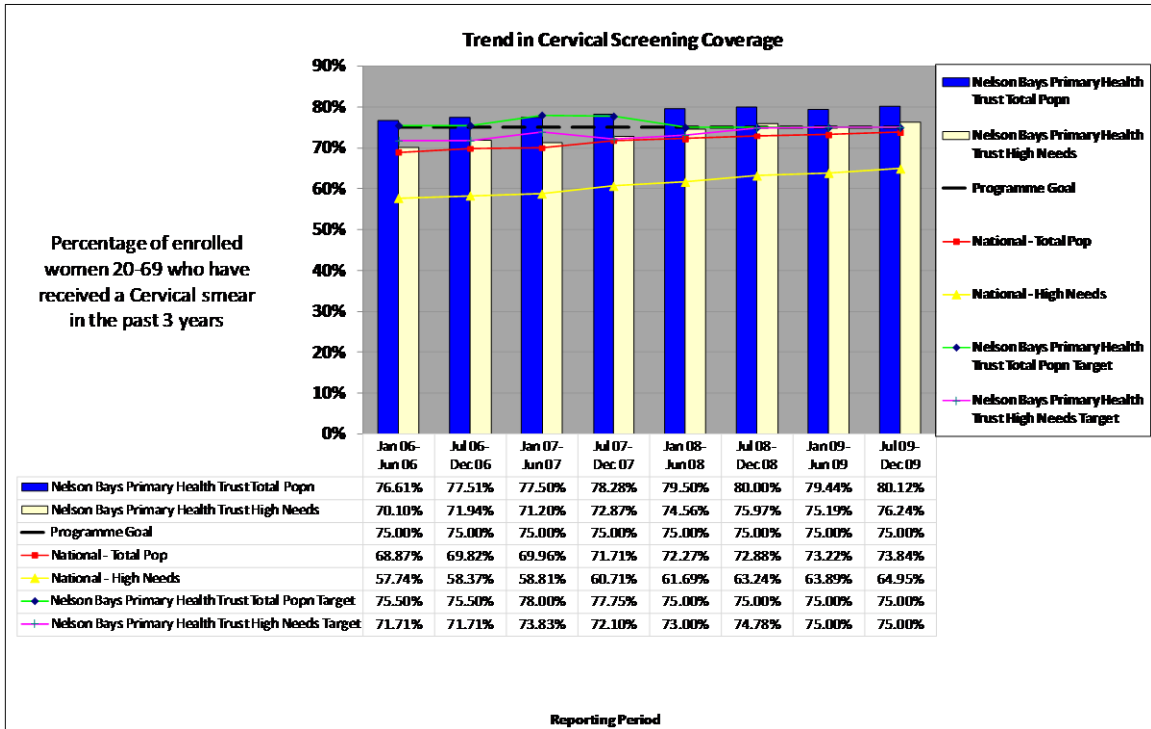
Many women who have had a hysterectomy do not need a cervical smear. The Programme does apply an adjustment calculation to allow for women with hysterectomies, based on the national rate.

However since the rate of hysterectomies within each PHO may vary, this adjustment may not always be correct at the PHO level.

➤ Data

Some patients choose to 'opt off' the national screening programme's register (which means that although they have had a cervical screen, they will not be 'counted' by the Programme).

PHO Performance



PHO Narrative

Nelson Bays Primary Health performance exceeds the national goal for both Total Population and High Needs women. A number of initiatives have contributed to the increase in cervical cancer screening coverage including encouraging practices to offer the Public Health Service subsidy for High Needs women, providing annual smearer training within the Nelson Bays region, and providing practices with audit tools to identify women who have not had a smear. In addition, in December 2009, Nelson Bays Primary Health introduced a further High Needs subsidy for those women ineligible for the Public Health Service subsidy, which has been welcomed and readily accessed by general practices. These combined strategies have increased the coverage rate for cervical cancer screening.

Cardiovascular Risk Assessment

Description

A Cardiovascular Risk Assessment (CVRA) is a tool for identifying individuals at high risk of a cardiovascular event (e.g. stroke, heart attack or angina) and enables health carers to provide appropriate patient management and support. Cardiovascular disease (CVD) is the leading cause of death in New Zealand - preventative treatment can increase life expectancy and quality of life for patients at risk of CVD

Target Population

1. Males of Maori, Pacific or Indian sub-continent ethnicity aged 35 to 74 years
2. Females of Maori, Pacific or Indian sub-continent ethnicity aged 45 to 74 years
3. Males of any other ethnicity aged 45 to 74 years
4. Females of any other ethnicity aged 55 to 74 years

Programme Goal

80% or more of a PHO's target population have been assessed for their risk of developing cardiovascular disease.

Data Source

To measure this indicator (both total population and high need population) the Programme depends on data provided through Primary Health Organisations.

Cautions

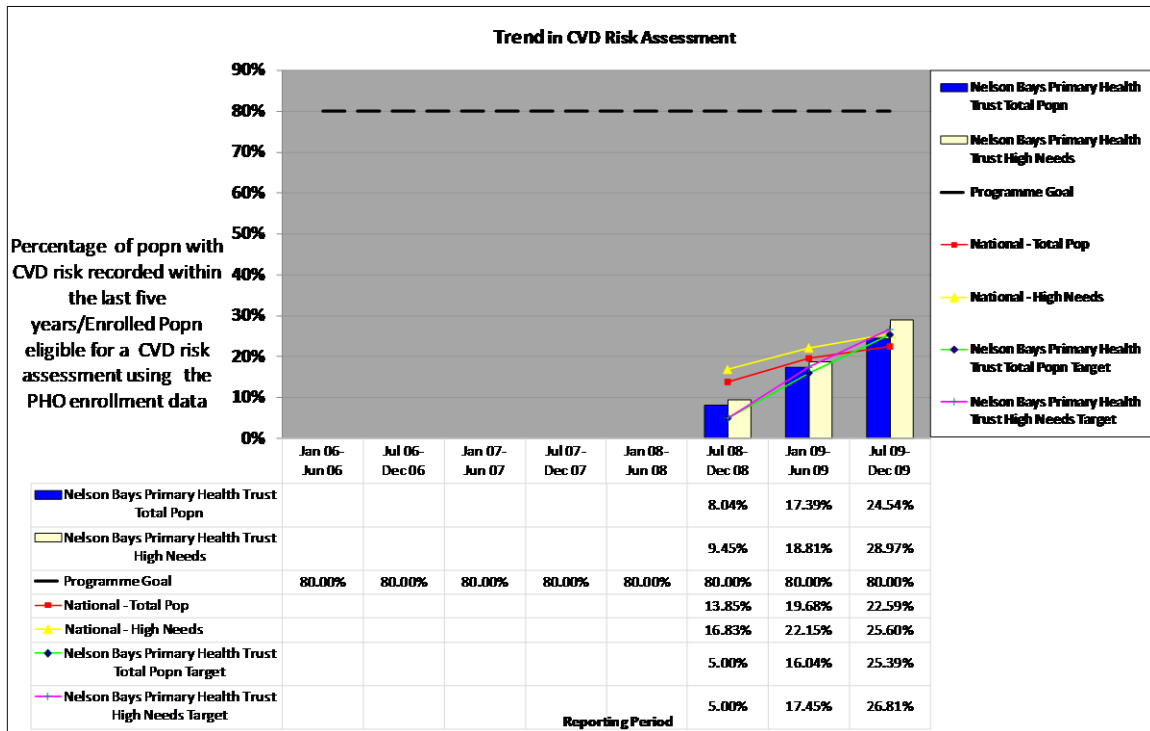
➤ National

As this indicator was only introduced by the Programme on 1 July 2008, the Programme goal has been set for PHOs to achieve over a 5 year period.

➤ Data

There are currently technical computer software difficulties in collecting this data in some regions; these are being addressed.

PHO Performance



PHO Narrative

In October 2008, Nelson Bays Primary Health introduced a comprehensive programme of Vascular Risk Assessments, with all 26 practices in the region providing the assessments. From the inception of this programme until the end of this performance period 6734 screens had been completed. Nelson Bays Primary Health exceeded the target for High Needs populations but missed the Total Population target by less than 1% (240 screens).

Strategies that have been employed to increase the number of screens performed within general practice include use of audit tools e.g. Dr Info, feedback reports to practices on performance, clinical review and audit reports, and business advice on nurse-led clinics.

Diabetes Detection

Description

[Diabetes](#) presents a serious health challenge for New Zealand. It is a significant cause of ill health and premature death. Diabetes affects about 200,000 people in New Zealand but only half of these people have been diagnosed. Identifying people with Diabetes is important to enable the regular recall and review of all people who have Diabetes. This indicator focuses on both Type 1 and Type 2 Diabetes.

Target Population

1. All people aged 15 to 79 years
2. All people aged 15 to 79 years who are within the high need population (identified as Maori, Pacific Island and/or Decile 9 or 10)

Programme Goal

90% or more of those estimated to have diabetes have been identified and coded by their general practice or primary care provider

Data Source

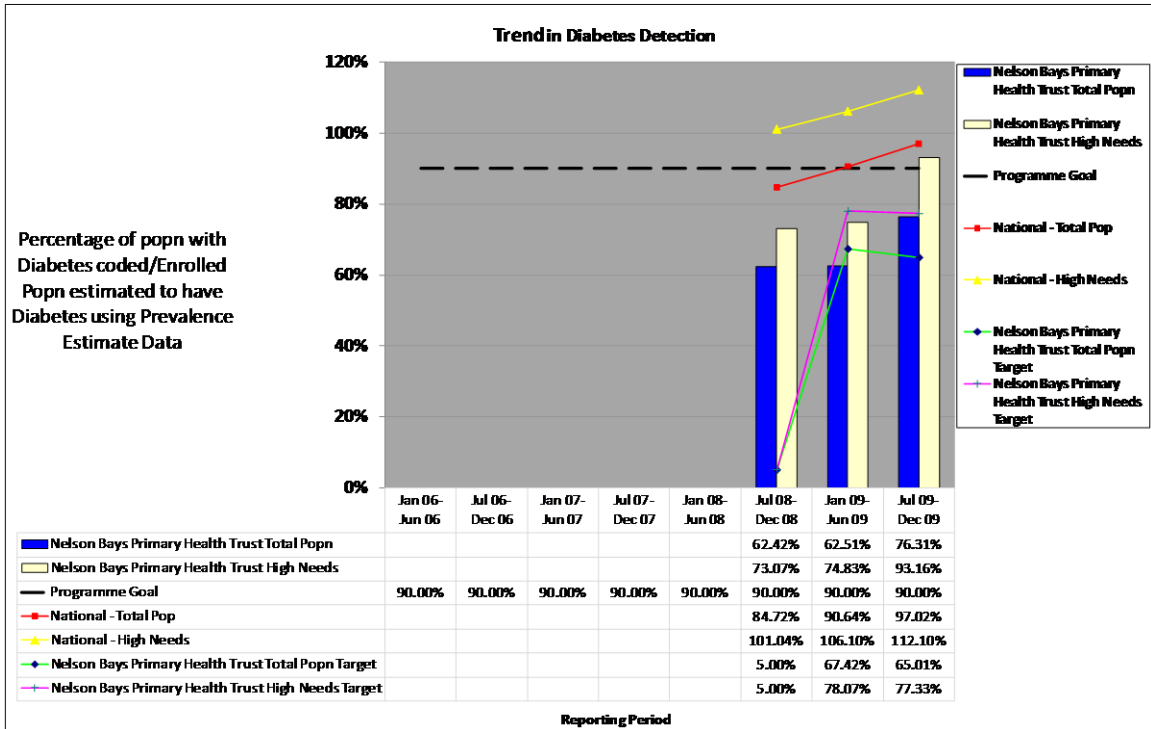
To measure this indicator (both total population and high need population) the Programme depends on data provided by Primary Health Organisations.

Cautions

➤ Data

Estimations of people expected to have Diabetes are calculated by considering the ages, genders and ethnicities of PHO populations and applying diabetes rates from the 2008 National Diabetes Prevalence Data Model. When applying this model to small populations there may be inaccuracies. Currently the National Diabetes Prevalence Data Model appears to be underestimating the number of people with diabetes in many regions, and hence some PHOs are achieving a diabetes detection rate of greater than 100%.

PHO Performance



PHO Narrative

Nelson Bays Primary Health has exceeded the targets for both Total Population and High Needs populations within the performance period. In addition, the national goal has been surpassed for the High Needs population. These improvements not only reflect the consistent efforts of general practice to increase the use of READ coding but also improvements to data capture. These results are particularly pleasing as both targets were missed in the last performance period

Diabetes Follow Up

Description

An appropriate Diabetes review (follow up) gives people with Type 1 or Type 2 Diabetes the opportunity for their GP or nurse to review their treatment and lifestyle advice, and update their care plans. The expected service requirements that constitute a diabetes review include, through the year, the measurement of certain blood and urine tests, retinal (eye) screening (every two years), review of cardiovascular risk, examination of the feet and review and updating of the patient's care plan. The care plan may include patient-specific goals related to diabetes control, exercise, diet etc. In some areas much of this service is provided at an "annual review". In other areas the service may be provided in parts at each quarterly visit.

Target Population

1. All people aged 15 to 79 years identified as having Diabetes
2. All people aged 15 to 79 years who are within the high need population (identified as Maori, Pacific Island and/or Decile 9 or 10) identified as having Diabetes

Programme Goal

80% or more of those estimated to have Diabetes have had a Diabetes review

Data Source

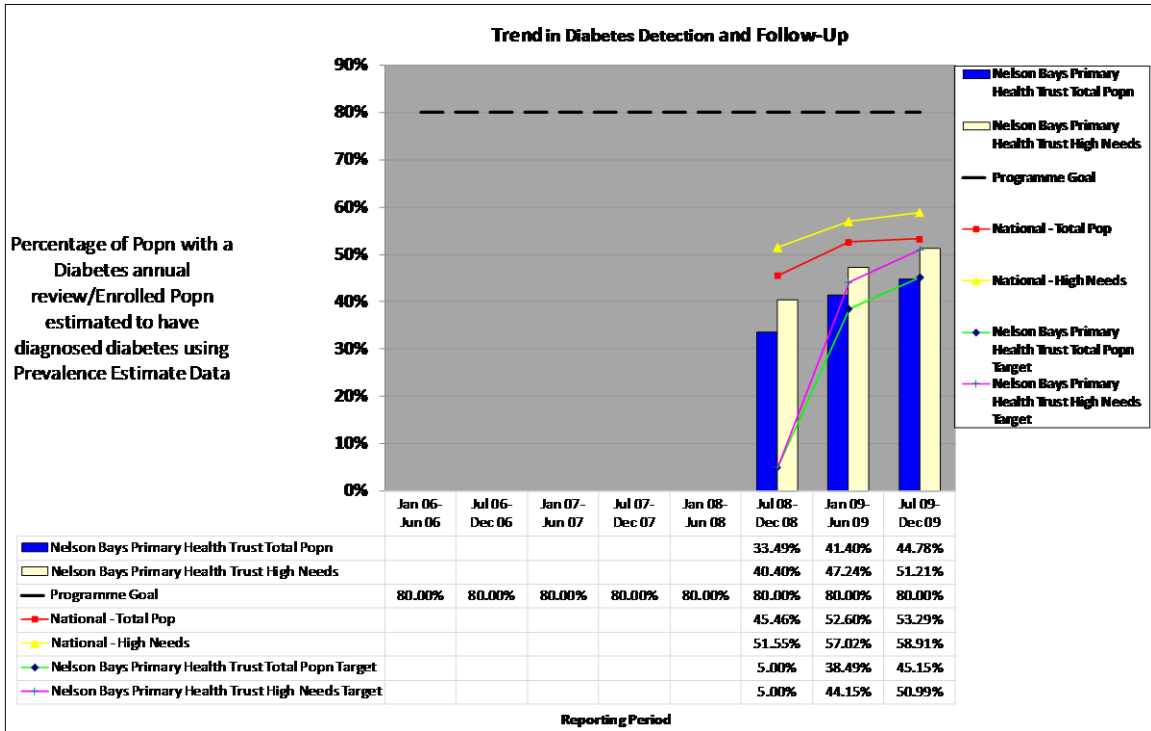
To measure this indicator (both total population and high need population) the Programme depends on data that is provided through Primary Health Organisations.

Cautions

➤ Data

Currently there are technical difficulties in collecting this data from PHOs who do not use the Get Checked Programme to provide diabetes reviews; these difficulties are being addressed by the Programme on a case by case basis. The indicator measures the percentage of people estimated to have diabetes who have had a review, rather than the percentage of those identified and recorded in general practices as having diabetes who have had a review. This may result in some regions having higher than expected diabetes review rates. Conversely if a region has not identified and recorded all their people who are estimated to have diabetes, they will not be able to achieve high diabetes review rates.

PHO Performance



PHO Narrative

All 26 Nelson Bays primary Health general practices offer Diabetes Annual Reviews to their enrolled diabetic populations. This review is optional and some patients, particularly type 1 diabetics, may have their review performed at outpatient clinics at Nelson Hospital, where their data cannot be collected for this indicator. Nelson Bays Primary Health exceeded its target for High Needs populations but missed the Total Population target by less than 1% (12 people).

Nelson Bays Primary Health has employed number of strategies to assist practices to identify people with diabetes that are eligible for a Diabetes Annual Review including the use of audit tools e.g. Dr Info and a data matching exercise with the Ministry of Health which identified diabetics that may not have a recall for Diabetes Annual Review.

65 Years + Influenza Vaccinations

Description

The complications of influenza (more commonly known as 'flu') in the elderly can be serious or life threatening. As a result, the Government funds the cost of influenza vaccines and their administration for people aged 65 and over and people of any age with certain chronic conditions. Only vaccinations provided to people aged 65 and over are counted by the Programme.

Target Population

1. All people aged 65 years and over at the end of an annual influenza vaccination season
2. All people aged 65 years and over who are within the high need population (identified as Maori, Pacific Island and/or Decile 9 or 10) at the end of an annual influenza vaccination season

An annual influenza season usually falls between 1 January and 30 June of any year.

Programme Goal

75% or more of a PHO's target population have had a flu vaccination by 30 June of any year.

Data Source

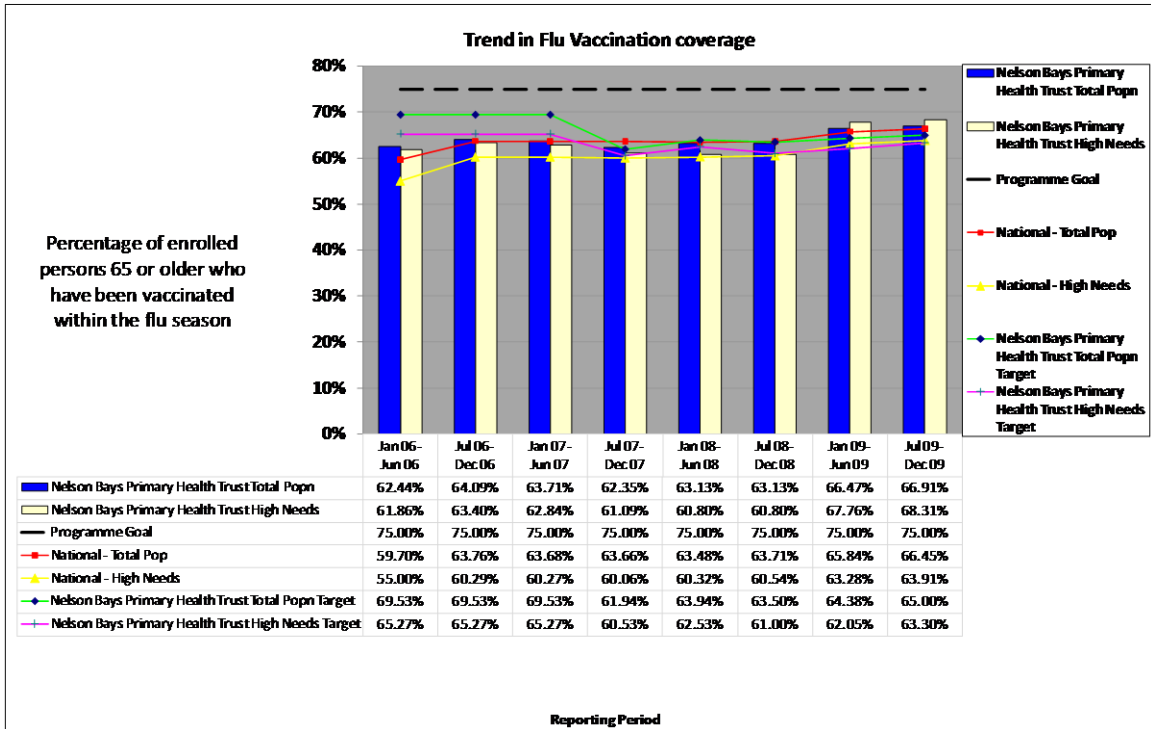
To measure this indicator (both total population and high need population) the Programme depends on data provided by the Ministry of Health.

Cautions

➤ Data

If a person within the PHO's target population chooses not to have a vaccination that person is still included as part of the PHO's target population. PHOs with a high number of declining patients will not fare well against this indicator.

PHO Performance



PHO Narrative

Nelson Bays Primary Health general practices offer seasonal influenza immunizations free of charge to people over the age of 65 years, and to those with chronic diseases. The national seasonal influenza vaccination programme begins at the end of February (as soon as vaccine is available) and runs until the end of June. Nelson Bays Primary Health has exceeded its targets for this performance period for both Total Population and High Needs populations.

Age Appropriate Vaccinations for 2 Year Olds

Description

Children who receive the complete set of age appropriate vaccinations (in this case for the 2 year old age group) are less likely to become ill from certain diseases. The vaccinations which fall within the 2 year old group are for measles, mumps, rubella, diphtheria, tetanus, whooping cough, polio, hepatitis b, pneumococcus and haemophilus. A child must receive the complete set of 2 year old vaccinations to be counted by the Programme.

Target Population

1. All children within the 2 year old age cohort (between the ages of 24 and 35 months)
2. All children within the 2 year old age cohort (between the ages of 24 and 35 months) who are within the high need population (identified as Maori or Pacific Island)

Programme Goal

85% or more of a PHO's target population have received their complete set of age appropriate vaccinations.

Data Source

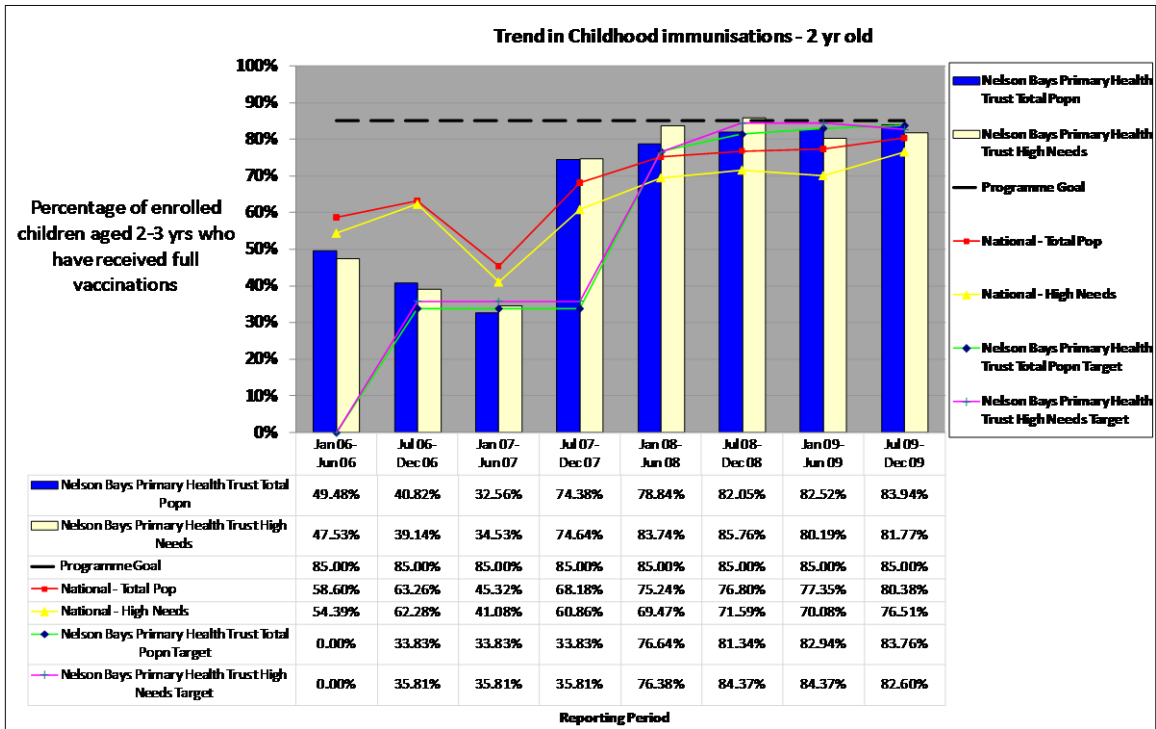
To measure this indicator (both total population and high need population) the Programme depends on data provided through Primary Health Organisations.

Cautions

➤ Data

If the parent or caregiver of a child decides that their child is not to be vaccinated the Programme still includes that child as part of the PHO's eligible population. PHOs with a high number of children declining will not fare well against this indicator. In some regions there are still technical difficulties in collecting this data from PHOs

PHO Performance



PHO Narrative

Childhood immunizations are offered by all 26 general practices within Nelson Bays Primary Health. This performance period, the target was exceeded for Total Population and although there was improvement in the High Needs performance, Nelson Bays Primary Health disappointingly missed this target by less than 1% (2 children).

The appointment of an Immunisation Facilitator to the Nelson Bays region during this performance period has contributed positively to this result.

GP Referred Laboratory Expenditure

Description

This indicator measures how actual laboratory test expenditure¹ for a PHO relates to ‘expected expenditure’ - this is based on historical utilisation and national average expenditure. One of the aims of the Programme is to promote more affordable use of resources.

Programme Goal

Actual laboratory test expenditure for a PHO matches its expected expenditure.

Data Source

To measure this indicator the Programme depends on data sourced from the National Laboratory Warehouse (managed by the Ministry of Health).

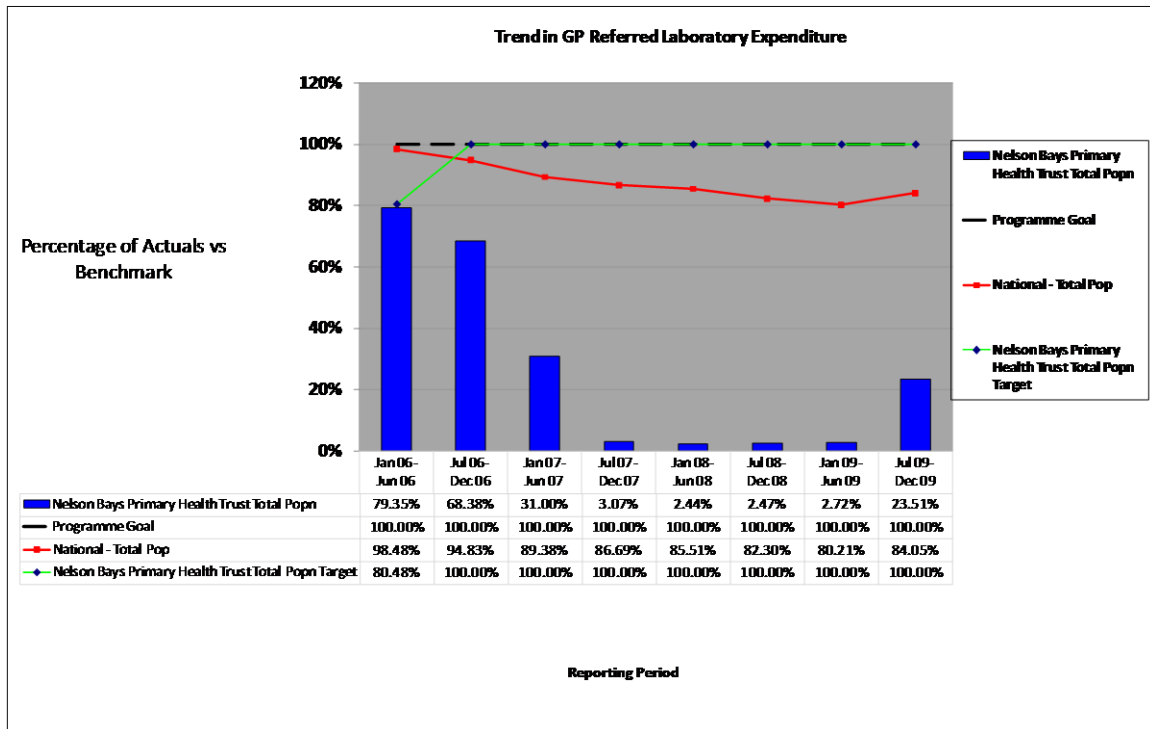
Cautions

➤ Data

There may be circumstances where laboratory tests that have been ordered are processed by a laboratory operating under a bulk funded arrangement. In these cases tests may not be recorded in the warehouse at the time the Programme is measuring the performance of a PHO, or alternatively the cost associated with these tests may not be recorded. In these instances, the Programme is unable to ‘count’ these tests or if the tests are counted, an ‘estimated’ cost is used. There may also be circumstances where laboratory test information is not submitted to the warehouse until 3 months after the test has been conducted. For this reason, the Programme waits 3 months after the period being measured, before requesting data from the warehouse.

¹ Laboratory test expenditure refers to the cost of laboratory tests ordered by health carers working within PHOs

PHO Performance



PHO Narrative

Laboratory data, which is deposited into the Labs Warehouse and used as a basis for this report, does not appear to be complete yet. This data flow is outside the control of Nelson Bays Primary Health, making it difficult to comment on the indicator or draw any conclusions from the data.

GP Referred Pharmaceutical Expenditure

Description

This indicator measures how actual pharmaceutical test expenditure² for a PHO relates to 'expected expenditure' - this is based on historical utilisation and national average expenditure. One of the aims of the Programme is to promote more affordable use of resources.

Programme Goal

Actual pharmaceutical expenditure for a PHO matches its expected expenditure

Data Source

To measure this indicator the Programme depends on data that is sourced from the National Pharmaceutical Warehouse (managed by the Ministry of Health).

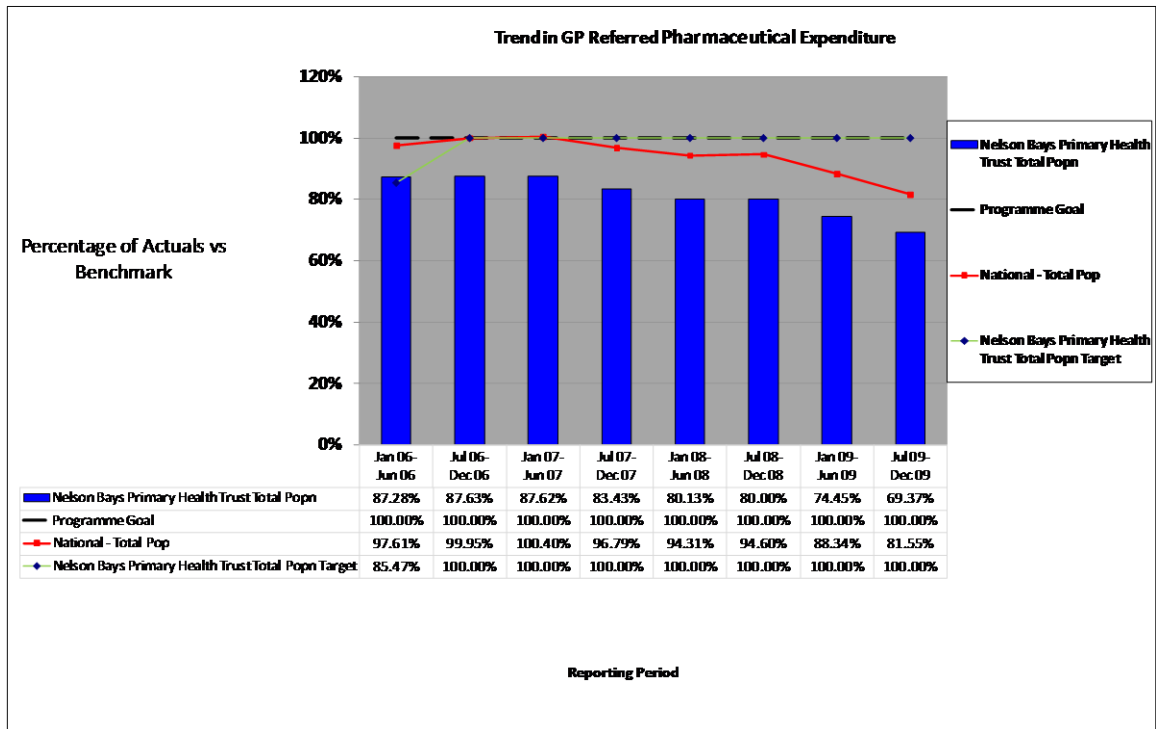
Cautions

➤ National

There may be circumstances where prescriptions that have been written by general practitioners are not submitted to the warehouse until three months or more after the prescription has been written. For this reason, the Programme waits three months after the period being measured, before requesting data from the warehouse

² Pharmaceutical expenditure refers to the cost of medicines prescribed and dispensed by health carers working within PHOs

PHO Performance



PHO Narrative

This indicator measures pharmaceutical cost from prescriptions written by general practitioners in the Nelson Bays region and dispensed in community pharmacies. Nelson Bays Primary Health-aligned general practitioners consistently score below the national benchmark for this indicator. A number of reasons contribute to this result, e.g. a district-wide authority to substitute (DWAS) agreement for generic medicines is in place with over 103 GPs signed up to the agreement, local best-practice prescribing guidelines are in place for a number of disease areas and antibiotics, GPs are well-educated and up-to-date with best practice, or some patients may not fill prescriptions.

END