



**PHO PERFORMANCE  
PROGRAMME**

**PERFORMANCE RESULTS**

**For**

**Hurunui Kaikoura PHO**

**As at 31 December 2009**

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**Overview**

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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

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### **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.

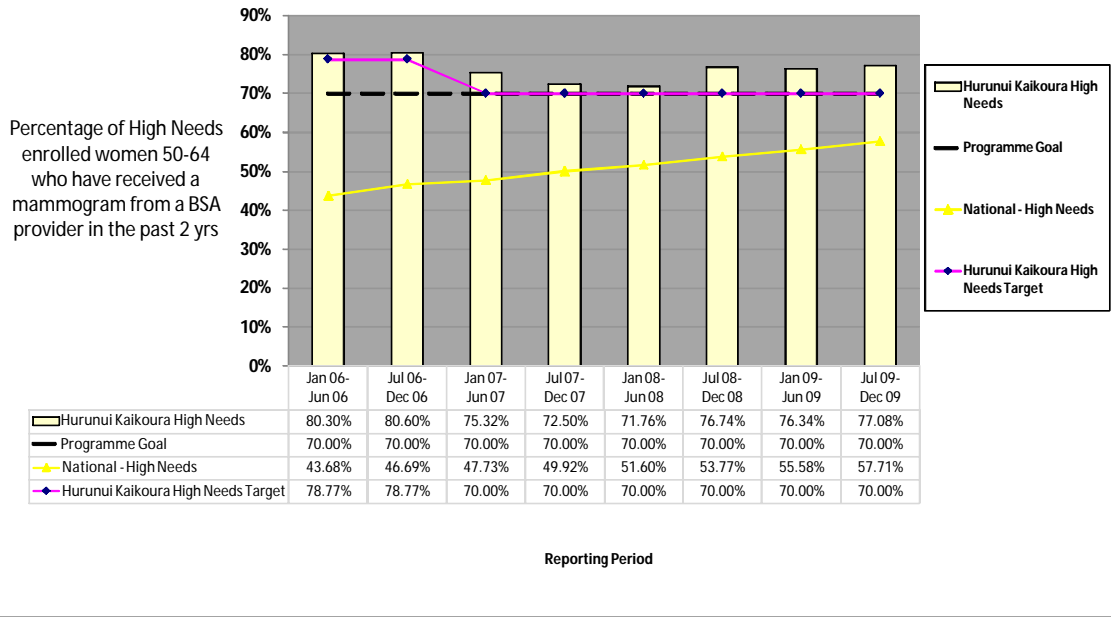
### **Data Source**

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.

**Trend in Breast Screening Coverage - High Need**



# Cervical Cancer Screening Coverage

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## 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

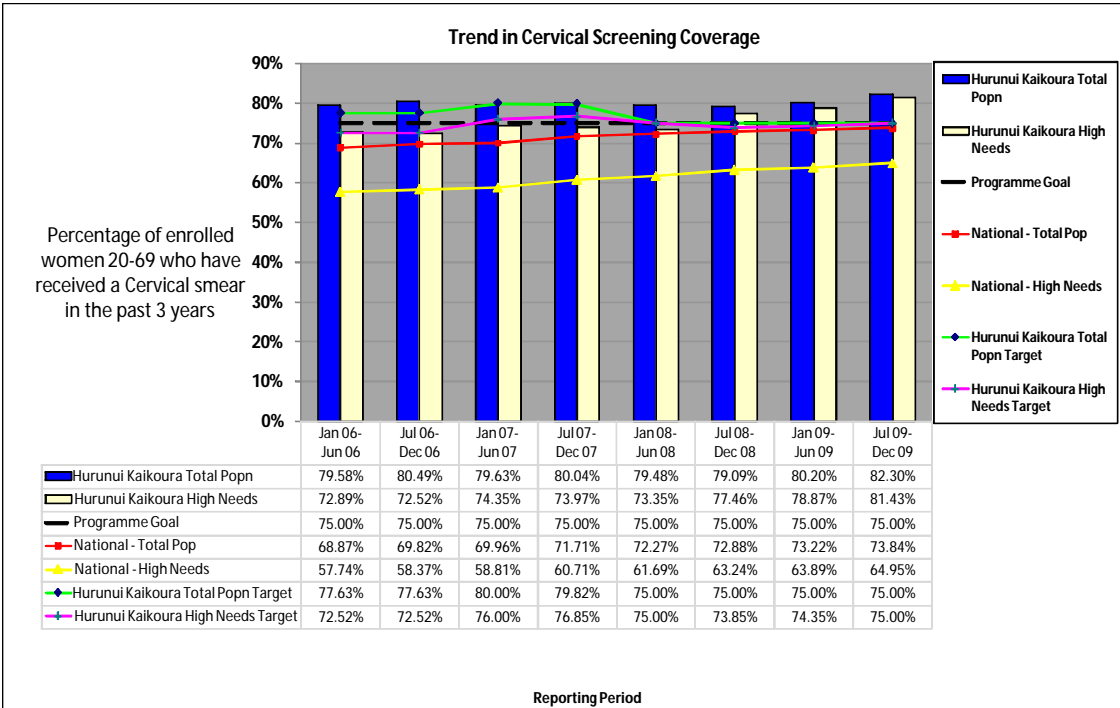
### ➤ National

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).



# Cardiovascular Risk Assessment

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## 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.

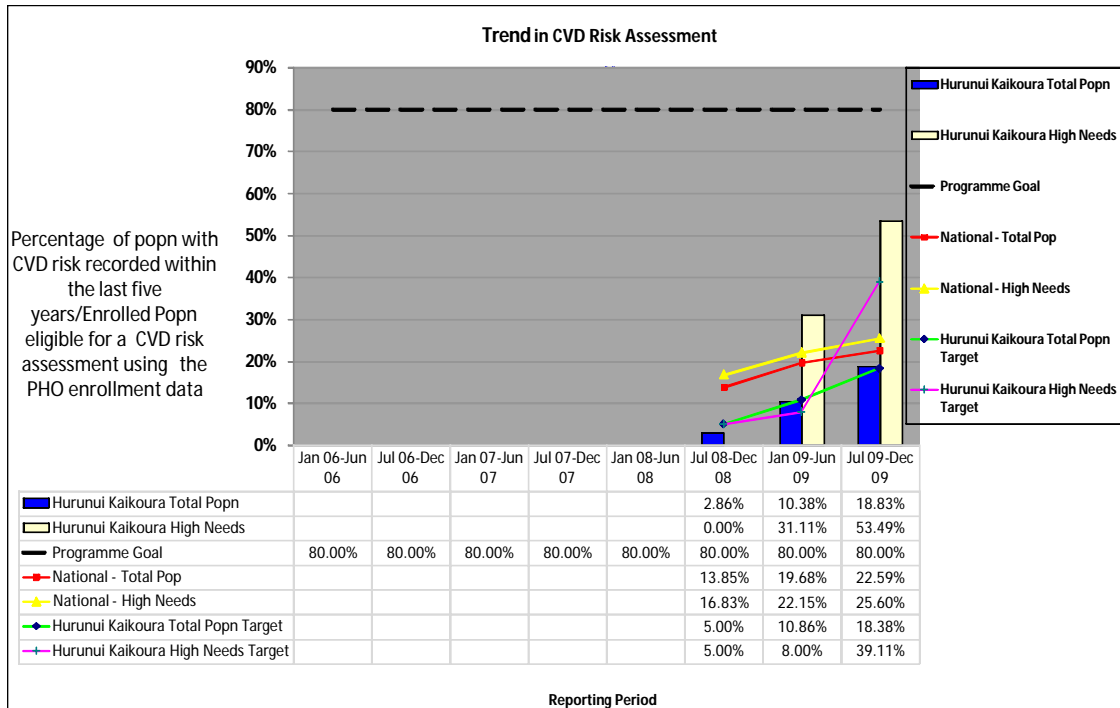
## Cautions

### ➤ 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 Narrative**

*The RCPHO has done well with this indicator. ‘One off’ special funding was used to focus on this as a pilot for the PPP.*

# Diabetes Detection

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## 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

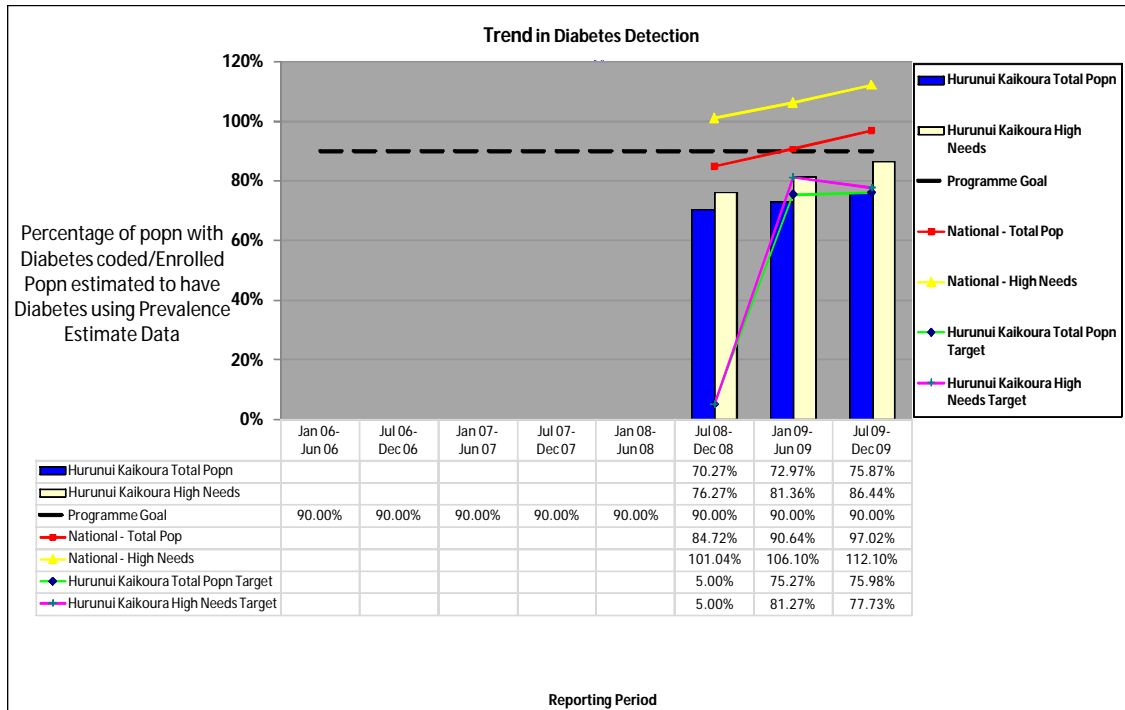
## Data Source

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%.



# Diabetes Follow Up

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## **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

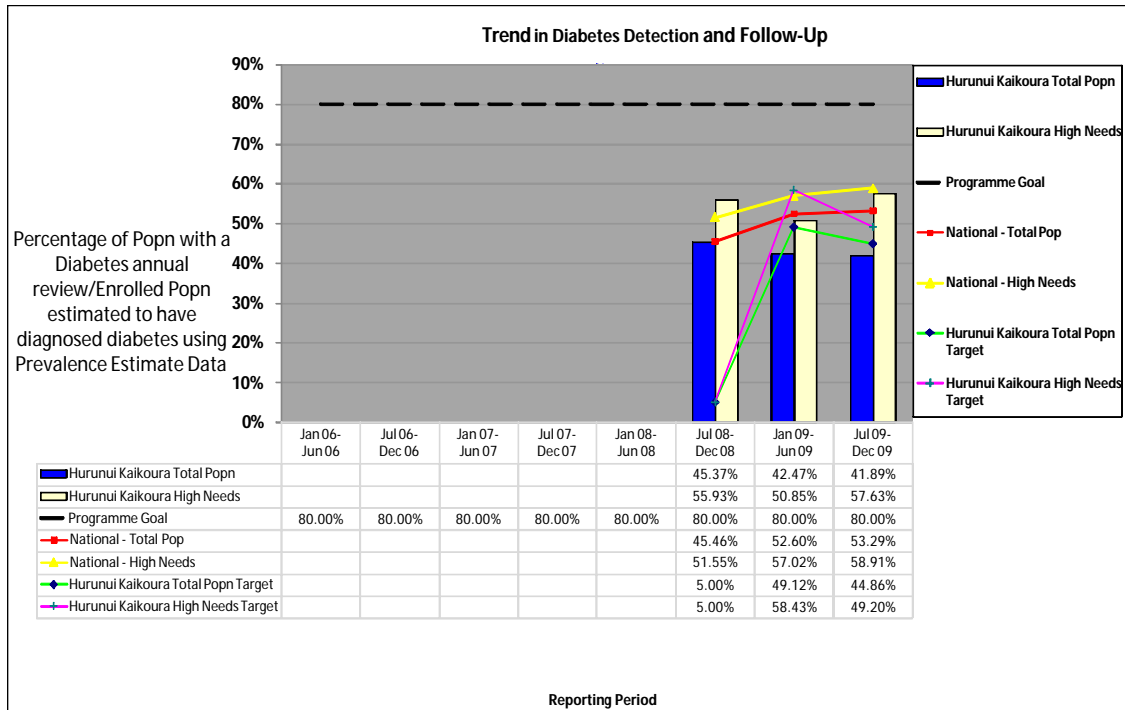
## **Data Source**

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.



## 65 Years + Influenza Vaccinations

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### **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.

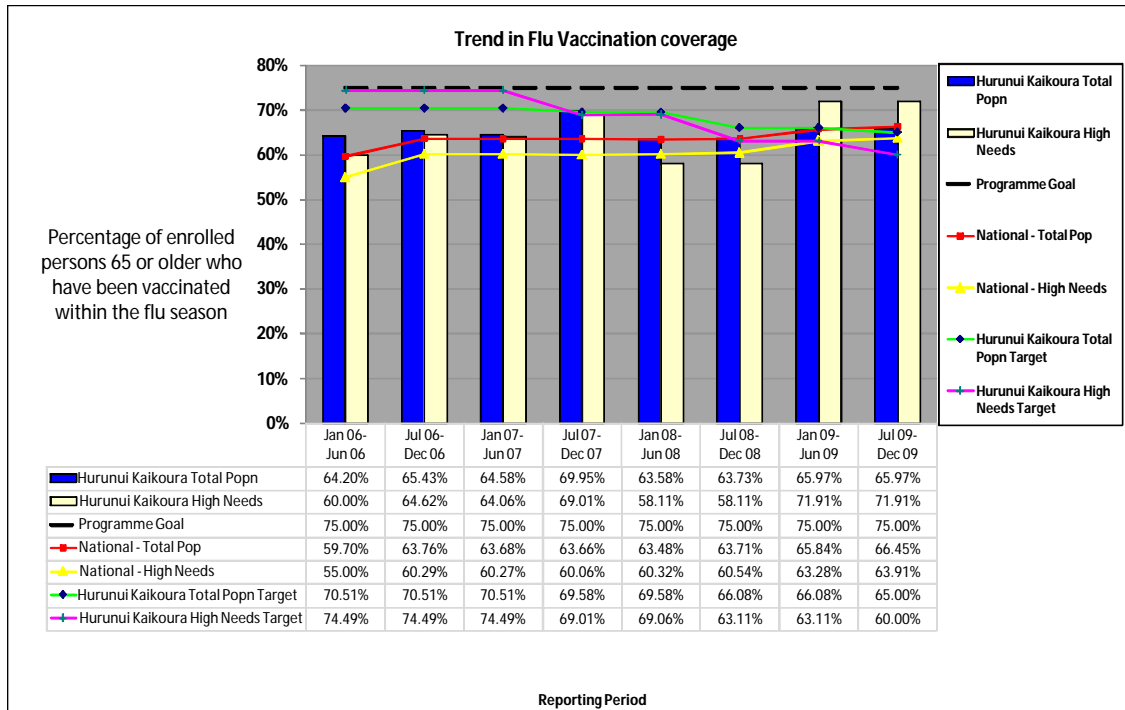
### **Data Source**

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.



## Age Appropriate Vaccinations For 2 Year Olds

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### **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.

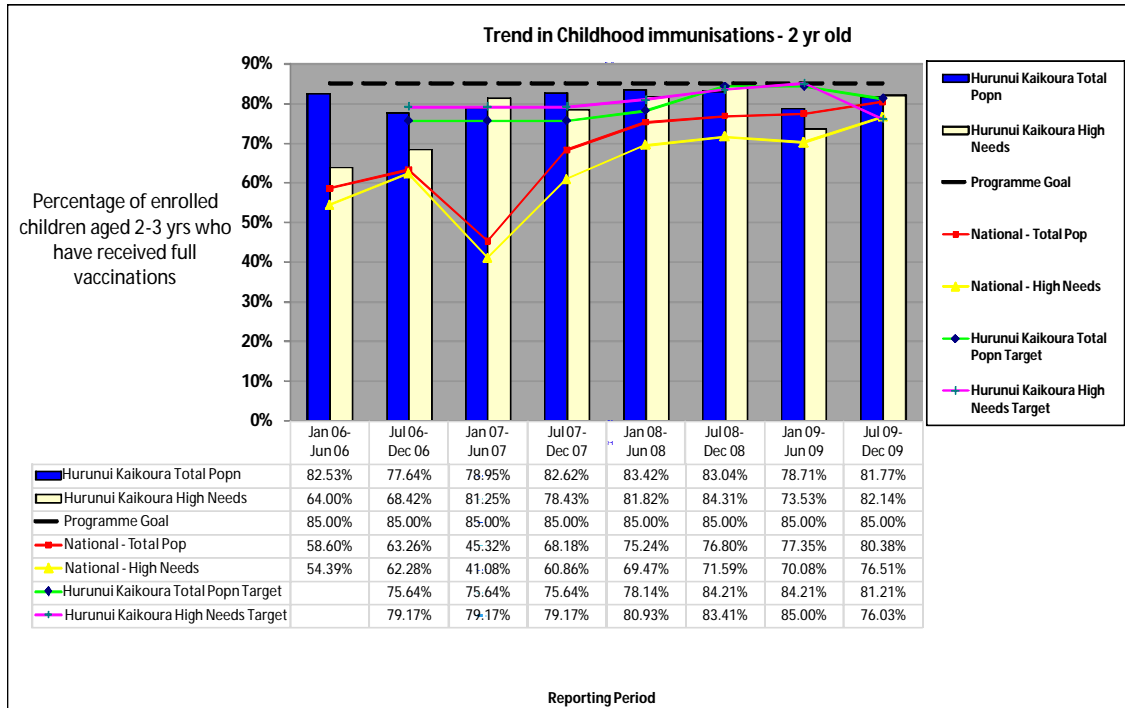
### **Data Source**

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



## GP Referred Laboratory Expenditure

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### **Description**

This indicator measures how actual laboratory test expenditure<sup>1</sup> 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).

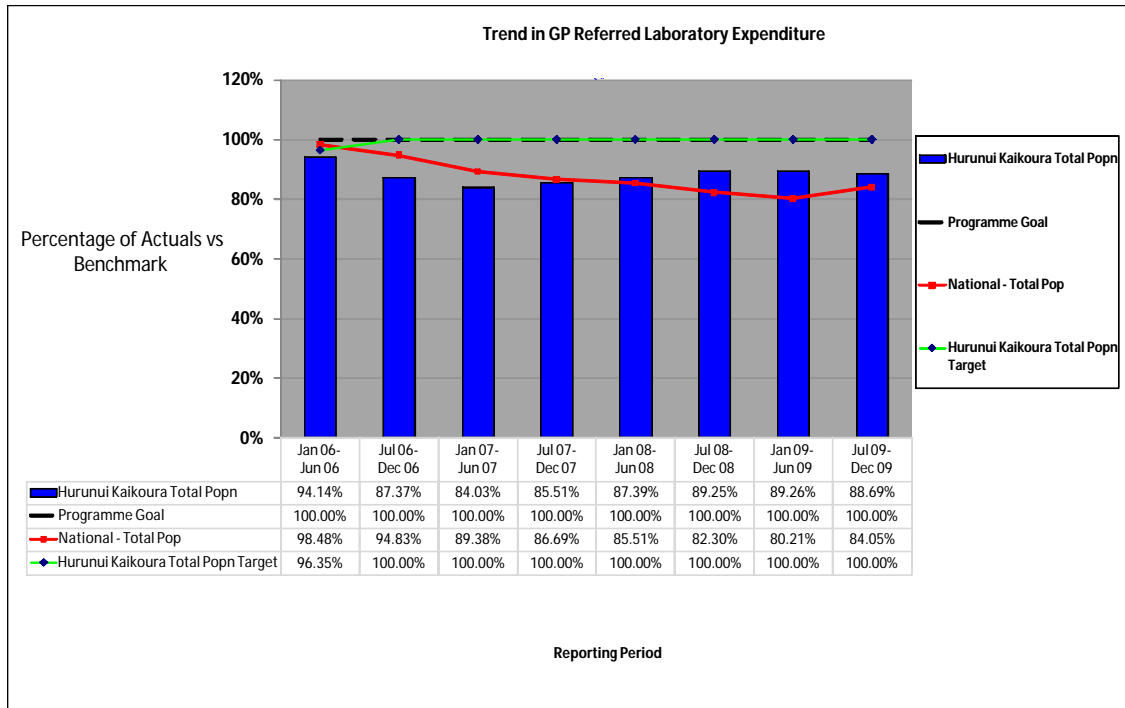
### **Cautions**

#### ➤ 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.

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



## GP Referred Pharmaceutical Expenditure

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### **Description**

This indicator measures how actual pharmaceutical test expenditure<sup>2</sup> 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).

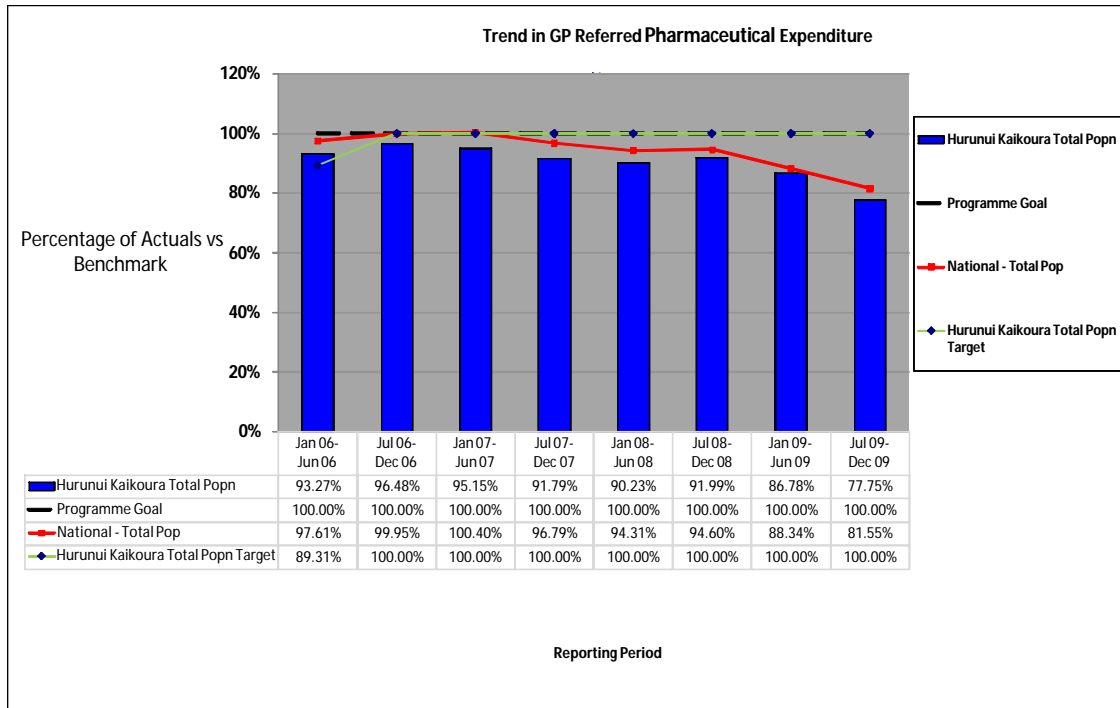
### **Cautions**

#### ➤ 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

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



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