



**PHO PERFORMANCE
PROGRAMME**

PERFORMANCE RESULTS

For

Rural Canterbury PHO

As at 30 June 2010

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 Māori 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-Māori 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
- Ischaemic cardiovascular disease detection
- Cardiovascular disease risk assessment
- Diabetes detection
- Diabetes detection and follow up
- 65 years + influenza vaccination coverage
- Age appropriate vaccinations for 2 year olds

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](#). During the reporting period this indicator measured 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 Māori, 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

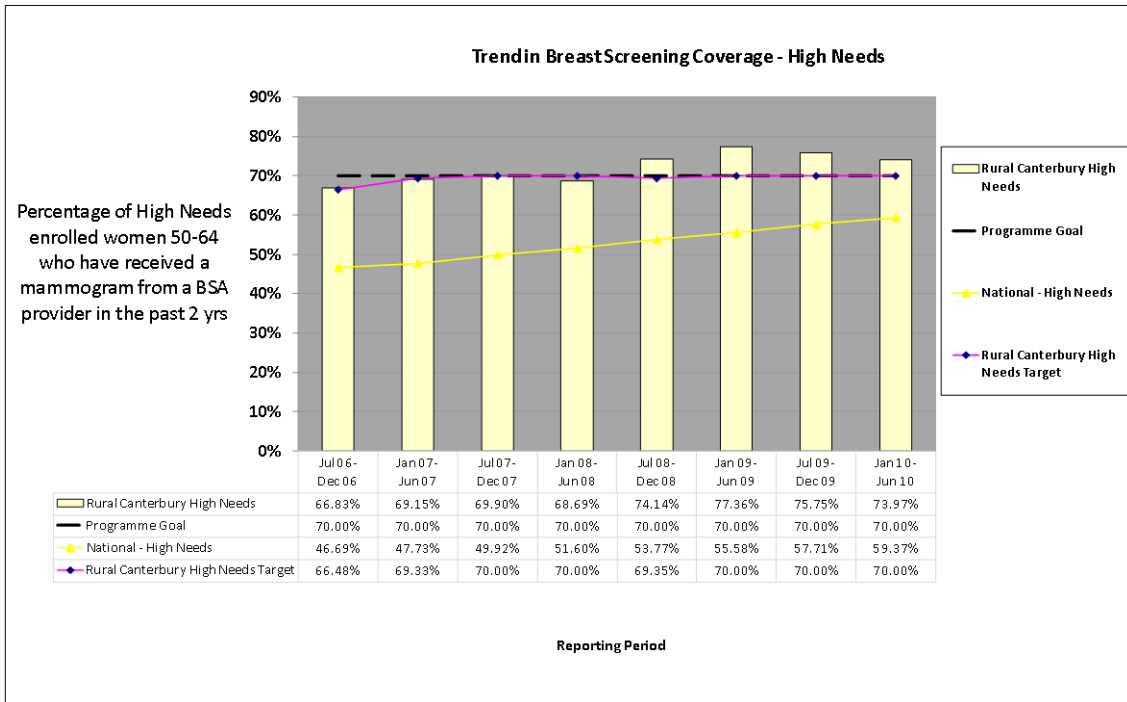
➤ National

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

Rural Canterbury PHO has provided no additional comments for this indicator.

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 Māori, 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

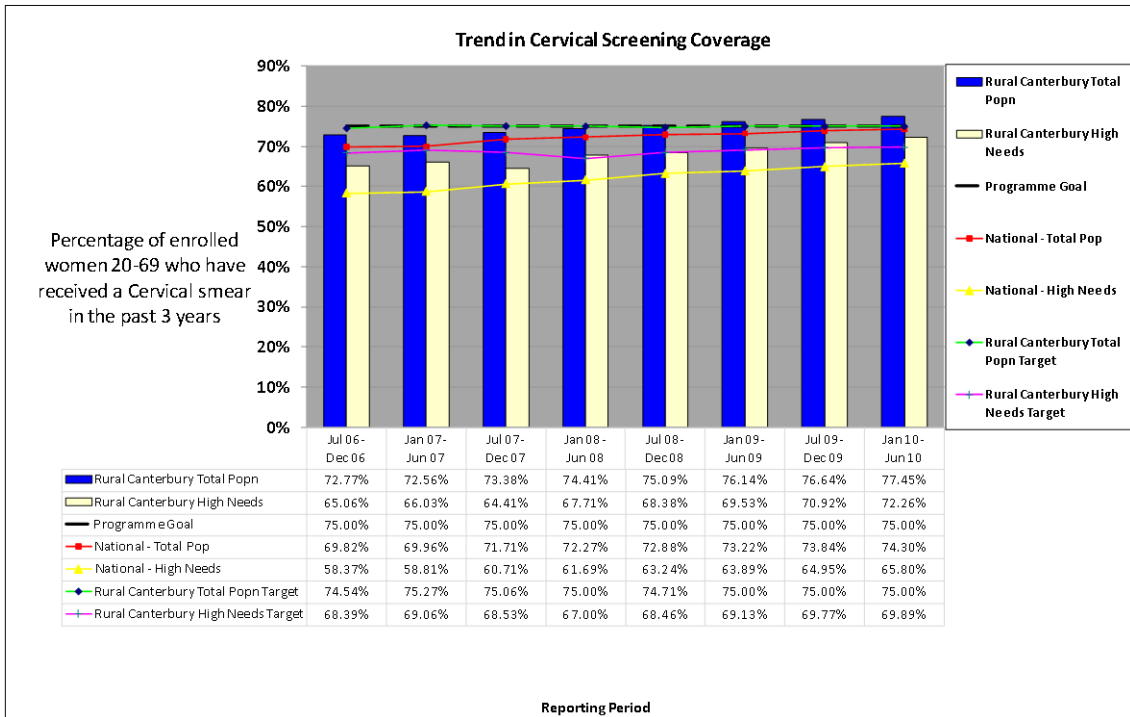
➤ National

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

The national target has been exceeded for the women in the total population.

Amongst high needs women, the RCPHO has exceeded its performance target for this period.

The RCPHO HP/SIA funded screening for high needs women has assisted this.

Ischaemic Cardiovascular Disease Detection

Description

Ischaemic heart disease (IHD) is the leading single cause of death in New Zealand. Identifying people with ischaemic cardiovascular disease is important to enable the regular recall and review of all people who have this disease.

Target Population

1. All people aged 30 to 79 years
2. All people aged 30 to 79 years who are within the high need population (identified as Māori, Pacific Island and/or Decile 9 or 10)

Programme Goal

90% or more of those estimated to have ischaemic cardiovascular disease 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 through Primary Health Organisations.

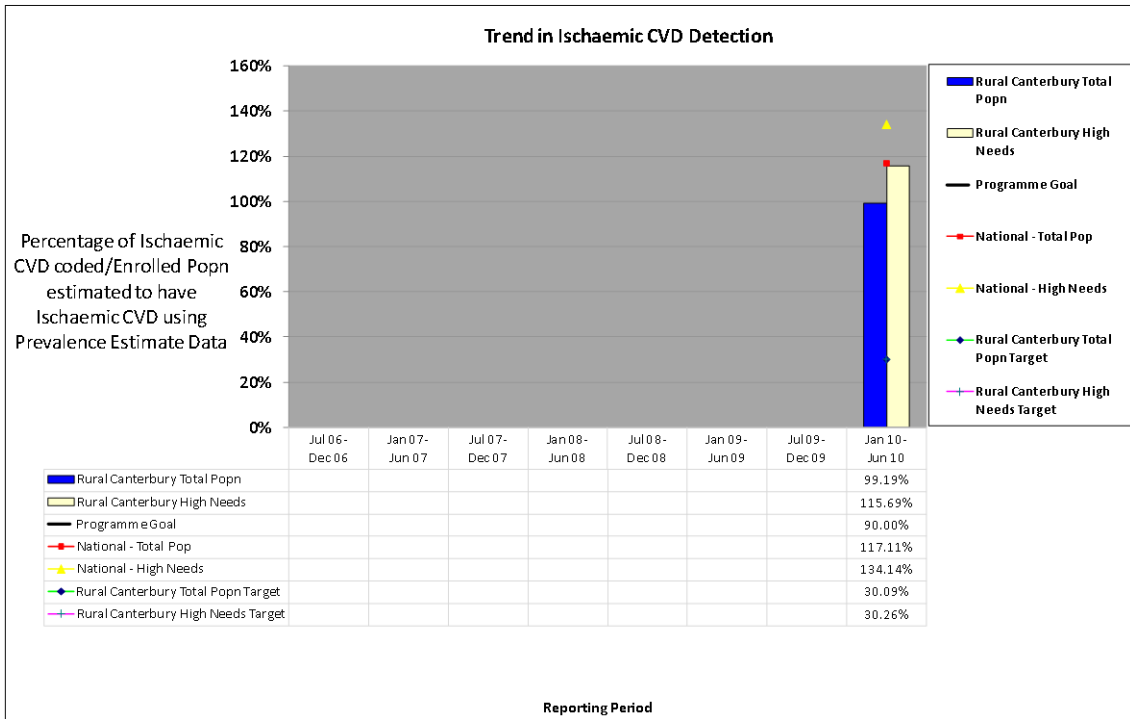
Cautions

➤ National

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

Data for previous periods were incomplete and have been excluded from the trend graphs.

PHO Performance



PHO Narrative

Current programme goals have been exceeded by the RCPHO practices.

Cardiovascular Disease 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 Māori, Pacific or Indian sub-continent ethnicity aged 35 to 74 years
2. Females of Māori, 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

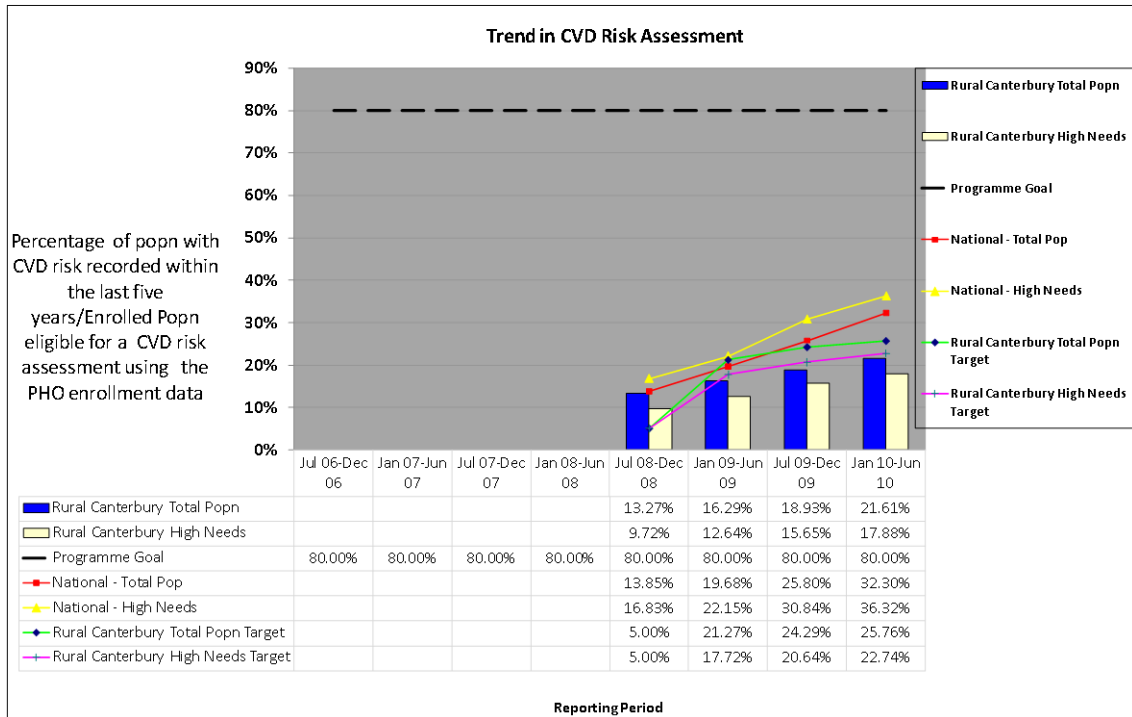
➤ National

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

There has been some progress made in this performance indicator, but more risk assessments need to be performed.

Additional education to practice staff in the use of the decision support tool and Read coding should assist with this.

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 Māori, 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.

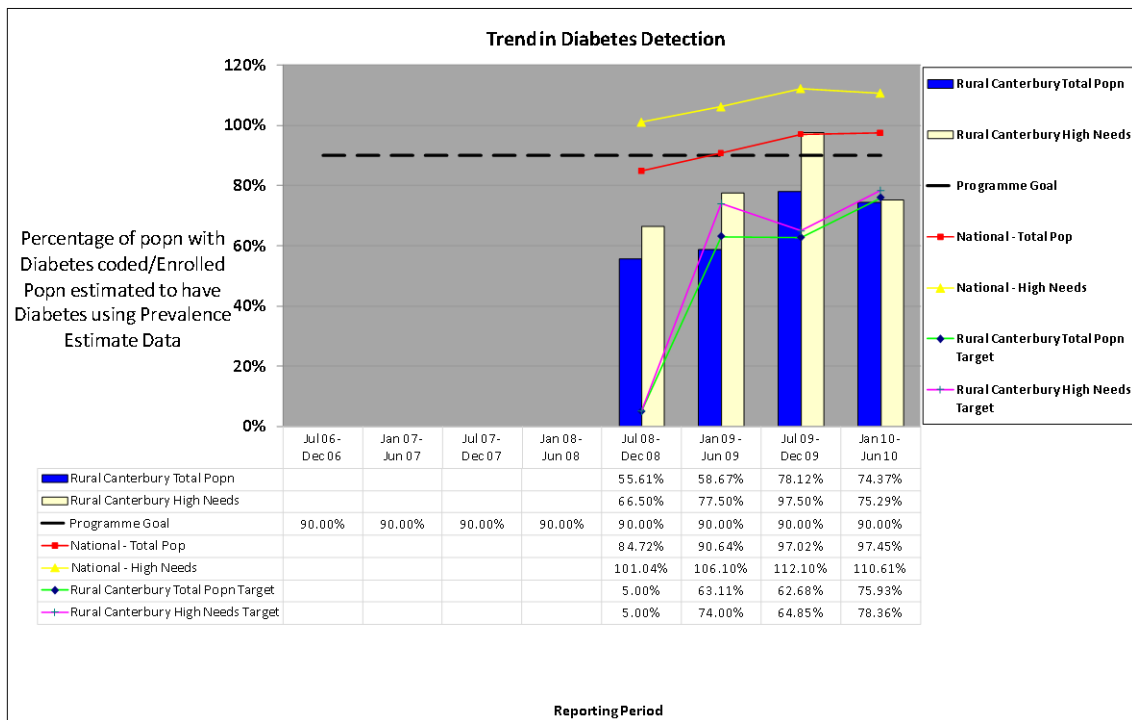
Cautions

➤ 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 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%.

Revised prevalence estimates were introduced in 2010. This makes comparison with previous periods difficult. In future, historic performance will be recalculated to reflect performance against the current prevalence estimates and provide an accurate representation of progress in improving diabetes detection.

PHO Performance



PHO Narrative

There is some debate over the validity of the estimates of prevalence of diabetes within the RCPHO population – which is regarded by some as being too high.

This is a ‘work in progress’ epidemiologically.

The RCPHO is also working to increase the detection of the number of people with diabetes amongst its population

Diabetes Detection and 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 Māori, 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.

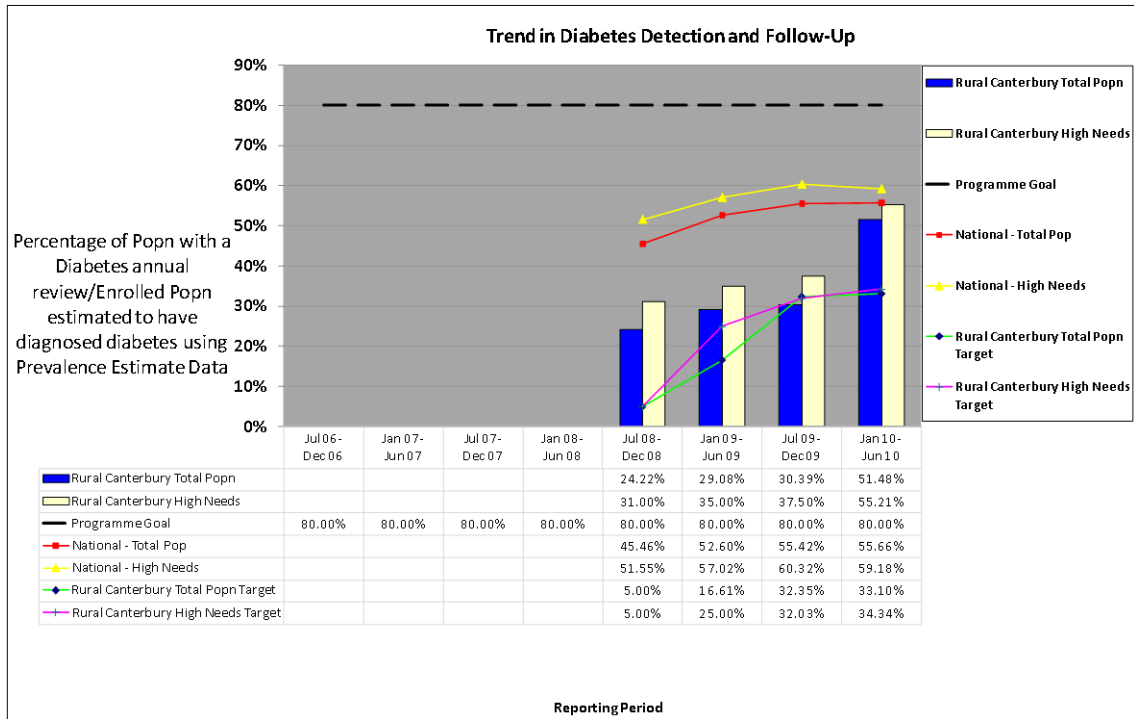
Cautions

➤ 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.

Revised prevalence estimates were introduced in 2010. This makes comparison with previous periods difficult. In future, historic performance will be recalculated to reflect performance against the current prevalence estimates and provide an accurate representation of progress in improving diabetes detection and follow-up.

PHO Performance



PHO Narrative

Performance Indicator targets achieved for this period.

65 Years + Influenza Vaccination Coverage

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 Māori, 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

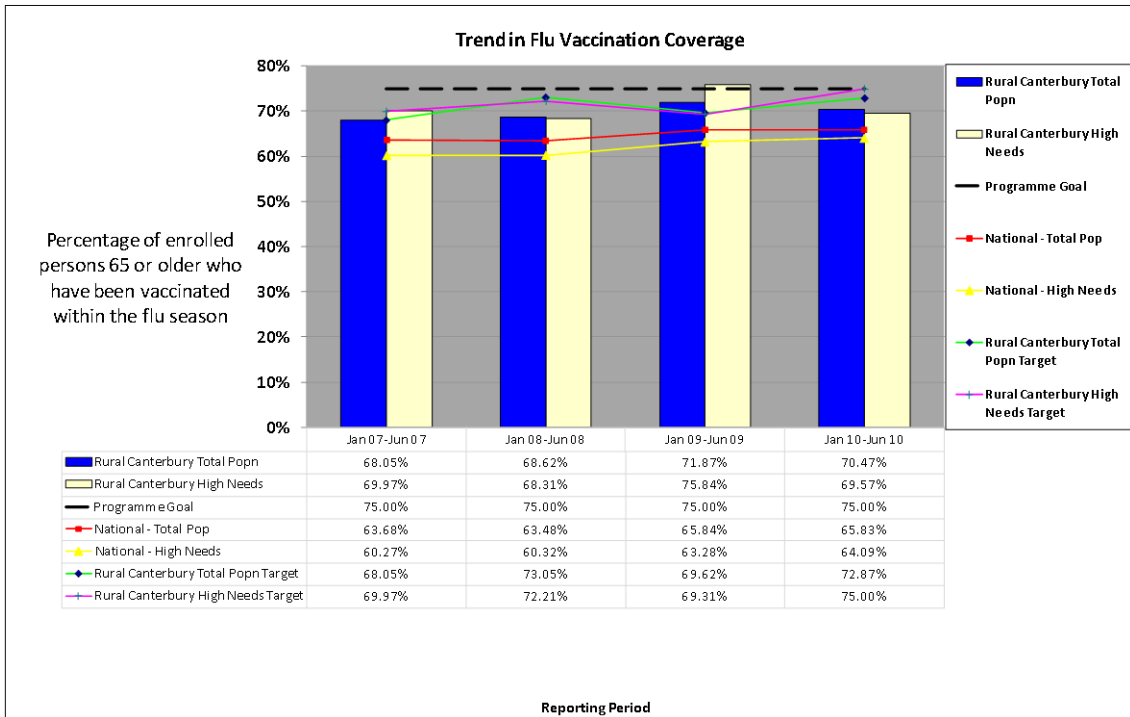
To measure this indicator (both total population and high need population) the Programme depends on data provided by the Ministry of Health.

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

There was partial achievement (94%) of the target set for the RCPHO for this performance indicator.

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 who were 2 years old during the reporting period.
2. All children who were 2 years old during the reporting period and who are within the high need population (identified as Māori or Pacific Island)

Programme Goal

85% or more of a DHBs 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 has previously depended on data provided through Primary Health Organisations. Most PHOs have now elected to be measured using data collected from the National Immunisation Register. All PHOs will be measured using data from the National Immunisation Register from 1st January 2011.

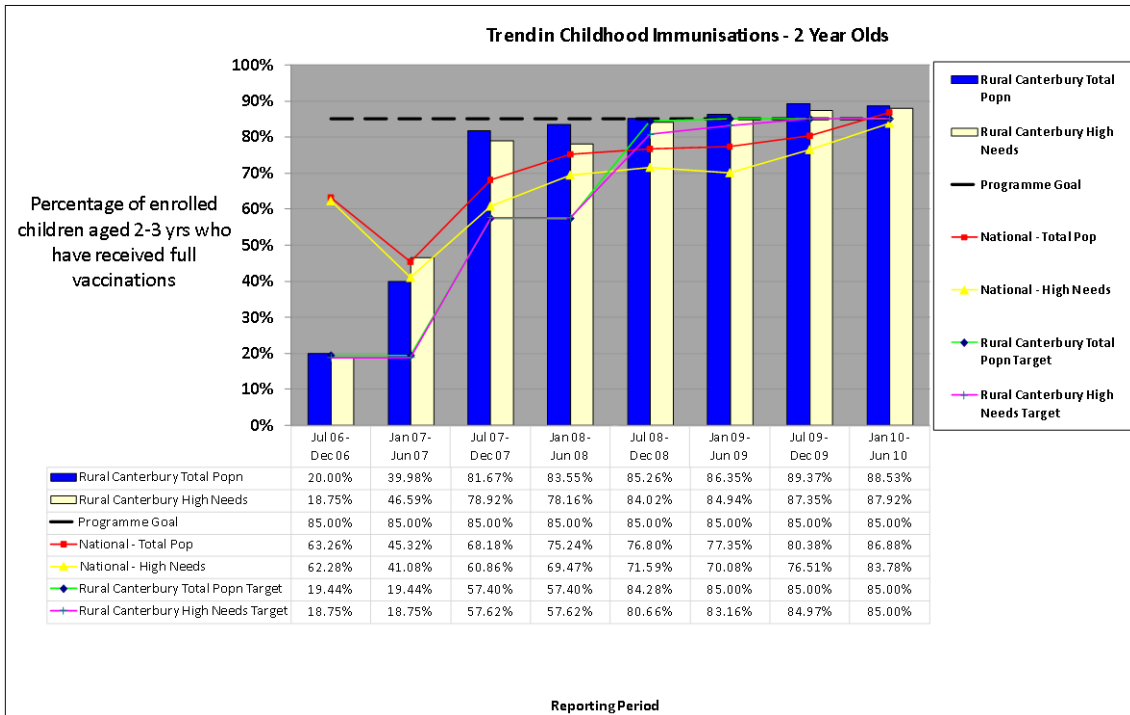
Cautions

➤ 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 DHBs eligible population. DHBs with a high number of children declining will not fare well against this indicator.

Overall the National Immunisation Register (NIR) shows slightly higher rates than those collected locally as it accounts for children who receive their vaccinations from a number of different sources. However the NIR only records children who are fully vaccinated on their second birthday. Locally sourced data measures the number of 2 year olds who are currently fully vaccinated even though they may not have been fully vaccinated on their second birthday. These differences mean that in some cases the NIR data may record lower rates of vaccination than was previously recorded locally.

PHO Performance



PHO Narrative

The current national goals for this programmes were exceeded.

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