Turanganui Primary Health Organisation

2005

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Organisational structure and governance

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AMENDMENTS TO DOCUMENTS

Turanganui PHO Ltd is a not for profit company. Please refer to www.companies.govt.nz for a copy of the online constitution. Amendments in order to transfer ownership from First Health to Pinnacle Inc and Turanga Health respectively were made with a series of documents filed electronically over the 2004-2005 financial year. No other amendments have been made.

Quality indicators and targets

Please note that there have been no national quality indicators set for the period that this annual report relates to.

Please note that there have been no TDH:TPHO quality indicators and targets set for the period that this annual report relates to.

Please note that in the 2004/2005 year TDH continued to purchase quality plans via the PHO and Pinnacle Inc based on the former general practice network quality plans. A copy of the annual quality report (QP8) has been attached to this annual report.

Performance

ORGANISATIONAL REQUIREMENTS.

Inland Revenue has issued charitable status following the amendments made to the constitution. No further amendments have been made as evidenced by referencing to the companies website.

Turanga Health is an owner of TPHO with three directors appointed to the governance board. TPHO have also appointed two community directors with full voting rights.

All major providers contracted by TPHO as outlined in our organisational structure are owners in the PHO with a strong vehicle to influence decision making.

Service provision

SERVICES PROVIDED TO IMPROVE ACCESS

The following SIA programmes were introduced, continued or completed between 01 July 2004 – 30 June 2005.

ISCHAEMIC HEART DISEASE (IHD) PROGRAMME - COMPLETED

The goal is to identify those with ischaemic heart disease who are at high risk of complications of this disease and to ensure that they are receiving the best current medical IHD disease management, based on National Heart Foundation National Evidence Based Guidelines, and to co-ordinate across all primary care providers both behavioral and medical interventions.

The evaluation concluded:
A total of 184 patients were initially enrolled in the project, and of these 170 patients completed the project. All 19 Turanganui GPs participated in the project, enrolling an average of 10 patients each in the project (range of 3 to 23 patients). Twenty-two per cent of patients were Maori, compared with 35% Maori in the general PHO population. However 97% of the IHD patients were over 50 years and of the PHO population over 50 years, 18% are Maori.

The evaluation found that the project was well structured and relatively easy to incorporate into practice activities. The programme was well managed and well implemented. Having a nurse project coordinator was fundamental to the success of the project. Turanganui PHO practices have good practice systems in place to be able to manage structured care programmes for patients with long term conditions.

There were significant improvements in patient outcomes and patient knowledge of their condition. There was a significant decrease in admission rates. There has been a greater shift in some indictors for Maori than for non Maori, thus helping decrease health inequalities.

Clinical measures - means

	Turanganui – 170 pts 2003/4	
	Pre	Post
Wt - kg	82.6	82.3
BMI	30.37	30.34
Abd circum - cm	100.5	99.4
BP - systolic	139.6	137.4
BP - diastolic	81.8	80.4
Fasting glucose	5.92	5.76
Total Cholesterol	**4.73**	**4.46***
LDL	**2.79**	**2.33***

*Statistically significant difference P<.001, t-Test. Other changes not statistically significant

Percentage of patients on Cardiac Medications

	Turanganui – 170 pts	
	Pre	Post
Aspirin	86	89
Statins	**78**	**90***
Other lipid lowering	6	7
Beta blockers	60	57
ACE Inhibitor	48	45

*Statistically significant difference P<.001, t-Test. Other changes not statistically significant

Patient self management indicators

	Turanganui	
	Pre	**Post**
Rating of general health (5 pt scale, 5 highest)	**3.28**	**3.42***
No. pts with work days missed	10	4
Total days missed	332	13
Angina > 3x/wk	11.8%	9.6%
Smokers	10%	10%
Heavy drinkers	3%	3%
Exercising 4 or more times per week for 30 minutes	37.6%	39.8%

	Turanganui	
	Pre	**Post**
Understand what medications are for	92%	99%
Take meds as instructed	88%	90%
IHD knowledge score (/15)	**11.7**	**12.7***
Flu vaccination	**66%**	**76%**
Satisfaction with care (5 pt scale)	4.77	4.79

*Statistically significant difference P<.001, t-Test. Other changes not statistically significant

Ethnicity comparisons

Indicator	Maori and Pacific			NZ European		
	Pre	**Post**	**Change**	**Pre**	**Post**	**Change**
Statins	71%	92%	21%	82%	89%	7%
LDL	3.03	2.38	-0.65	2.73	2.33	-0.40
Flu vaccination	74%	78%	4%	64%	75%	9%
BMI	33.29	33.12	-0.17	29.50	29.56	-0.40
Health score (1=excellent)	2.94	2.75	0.19	2.67	2.54	0.13

Admission data

	Patients in project 170 pts	
	One year pre enrolment date	One year post enrolment date
Number of individuals with an admission	38 (22%)	15 (9%) Highly significant difference p<0.001[1]
Number of admissions in whole group	49	18
Mean admissions per project patient (range)	0.29 (0-3)	0.11 (0-4) Highly significant difference p<0.001[1]
Median number of admissions (for pts with an admission)	1	1

Mean length of stay per admission	3.67	3.33 No significant difference[2]
Median LOS/ admission (range)	2 (1-18)	2 (1-12)
Average days in hospital per project patient	1.06	0.35
Total number of hospital days	180	60

1 = test of two proportions
2 = Two sample t test

Value of programme: $82,728 (gst exclusive)
Programme length: 01 July 2003 – 31 December 2004

CARDIAC DISEASE RISK DETECTION (CDRD) PROGRAMME - CONTINUED

To detect Maori and Polynesian men between the ages of 35 to 60 inclusive who are at increased risk of cardiovascular disease and to intervene and reduce the overall risk of detected individuals.

Status:
A part time project manager for Phase II of CDRD and will be working with each general practice to make sure that all patients identified on the lists (patients identified in Phase I as being high risk) are recalled and as many as possible complete the assessment process. It is planned that all assessments are completed by 31 October 2005. An evaluation report of the programme will be prepared early 2006.

Value of programme: $80, 376 (gst exclusive)
Programme length: 01 July 2003 – 31 December 2005

COMMUNITY DEVELOPMENT - CONTINUED

Work with an identified community in collaboration with PHO health professionals, in developing an initiative concentrating on improving access to primary care services.

Status:
A survey of the Kaiti community was undertaken in 2005. The report is currently being produced and information from that report will be contained in the 2006 annual report.

Value of Programme: $33, 462 (gst exclusive)
Programme length: 01 February 2004 – 31 December 2005

COMMUNITY ACTION-COMPLETED

Pilot the provision of free vision tests for the Maori/Pacific Peoples and/or People living in deprivation areas 9 and 10 over the age of 55, with the service to be trialed first at Kaumatua programme, with the associated follow up for the pilot to be coordinated by Turanga Health kaiawhina.

Status:

The programmes was completed late 2004 and an evaluation was prepared by Kain Sternersen Opticians who undertook the programme on our behalf. The service was delivered via the Kaumatua program.

Approximately 100 people have now had their eyes tested with the following results:

- 85% of people required their spectacles to be updated or required new spectacles.
- 60% have cataracts of varying degrees. Not all are at a stage of requiring surgery yet.
- 59% have other health problems with their eyes. This included Diabetic changes, Macula problems, and Glaucoma symptoms.
- Only 26% had been having regular eye examinations
- 17% had never had their eyes tested (or not been seen in the last 20 years.)
- Of the 100 people that we saw, when asked, approximately 90% admitted that they were having problems.

Finally, it was noted was that everyone was more relaxed and comfortable with the eye tests being undertaken on the marae.

It is planned to undertake this programme again in the 2006/2007 financial year.

Value of Programme: $21, 728 (gst exclusive)
Programme length: 01 January 2004 – 31 December 2004

ORAL HEALTH - CONTINUED

The Oral Health Facilitator programme aims to decrease the incidence of poor oral health in the children of Gisborne by:

- Improving the level of enrolment in the school dental service and the uptake of the free dental service provided under the Oral Health Service Agreement (OHSA) for adolescents
- Supporting oral health promotion activities e.g. Brush – in programmes in Kohanga reo, pre-schools, schools and like venues and in the community
- Ensuring families have information about how to access free oral health services for children and adolescents under the age of 18 years.
- Promoting oral health and hygiene to young people and their families.

Status:
Over the past 9 months, the following activities have taken place

- Oral education and implementation of the Brush In Programme with:
    - Pakowhai Te Kohanga Reo
    - Pahou Te Kohanga Reo
    - Parekereke Te Kohanga Reo (Whatatutu)
    - Muriwai Primary School
    - Te Kura O Whatatutu
- Rangatahi holiday programme: Maori Battalion – Oral Education, static display and competitions
- Supporting individual's to dental appointments (request from parents)
- Missed appointments follow-ups for clients referred by dental services
- Attending Whanau Hauora Health days: Static displays and information
- Ordering resources for programme i.e toothbrushes/toothpaste, toothpaste covers, materials for holders etc
- Cleaning and stocktaking of resources being used on a daily basis

Value of Programme: $145, 000 (gst exclusive)
Programme length: 01 October 2004 – 30 September 2006

PALLIATIVE CARE - DEVELOPED

In 2004 TDH agreed it would reconsider funding a SIA Palliative Care initiative if TPHO was to undertake an evaluation of the effective methods of delivery for our enrolled population. This evaluation is to cover areas such as cultural appropriateness, what is the current situation, what services would make best practice, what would the service look like.

Status:
The evaluation was completed September 2004 and an amended proposal was submitted in early 2005. This proposal was accepted by TDH and commenced October 2005. The proposal involves the following components:

Part One:
All patients who have been diagnosed as palliative but not end stage are able to be referred to the IMAP for care co-ordination. TPHO are aiming to cover "arms-length" care co-ordination for people for their whole last year (depending on prognosis at time of diagnosis).

Involved at this stage also will be Gisborne Palliative Care Service and the availability of Medication Review services and support to the patient from the pharmacist. The pharmacist will follow the case through and provide ongoing input on medication as needed.

Part Two:

All patients who have been diagnosed as palliative end stage again will be actively managed by the Care coordinator within the IMAP team in partnership with the General Practice. A management plan will be developed by the general practice, with IMAP and/or Gisborne Palliative Care coordinating the multi-disciplinary team approach to the non-general practice clinical and support management of the patient.

A GP palliative care end stage service will be available and will be completely subsidised for the patient.

An additional service will be available for those Maori patients who require additional social/cultural support from Turanga Health.

Also available will be a service for the pharmacists to undertake a home visit after death to collect and destroy any pharmaceuticals.

(Please note that referral to all components will be at the discretion of the general practitioner and would require discussion and agreement from the patient.)

Value of Programme: $209, 460 (gst exclusive)
Programme length: 01 October 2005 – 30 September 2007

SEXUAL HEALTH - DEVELOPED

In 2004 TDH agreed it would reconsider funding a SIA Sexual Health initiative if TPHO was to review the Sexual and Reproductive Health strategy and amend the initiative accordingly. The review was completed December 2004 and an amended proposal was submitted in early 2005. This proposal was provisionally accepted by TDH with further work required to finalise the development of the initiative. It is planned that the programme will be delivered from 01 July 2006.

Value of Programme: TBC
Programme length: 01 July 2006 – 30 June 2008

INTENSIVE MOBILE ACCESS PROGRAMME - CONTINUED

Over the development of the PHO, it has become apparent that a more managed and comprehensive primary care programme need to be offered to those individuals and whanau within our enrolled population who have high and complex needs.

In October 2004 a mobile team consisting of a social worker, specialist primary care nurse and kaiawhina was established who work closely with the general practice, the individual and their whanau, and other agencies who need to be involved with the objective of moving the individual and their whanau to a more stable management of their health as well as identifying any behaviours, health logistic or social factors that are inhibiting their ability to manage their health better.

Status:
To date 111 clients have been referred from general practices and managed within the IMAP team. This programme is ongoing with a formative evaluation planned for November 2005. Information about this evaluation will be contained in the next annual report.

Value of Programme: $456,150 (gst exclusive)
Programme length: 01 October 2004 – 30 September 2006

DIABETES MANAGEMENT – TO BE EVALUATED

1. Promotion (advertising (radio, print) and marketing (posters, pamphlets))
TPHO funded advertising and marketing opportunities to promote lifestyle messages; inform about detection opportunities, diabetes self-management, purpose of get checked, and inform about supporting services.

2. Detection
TPHO funded the general practices to identify within their systems patients that meet the agreed clinical criteria for screening and arrange contact with patient to inform of screening process and outline options for participation.

3. Management (Closer management of newly diagnosed diabetics, increased uptake in diabetes annual assessments)
TPHO funded general practices to implement a management plan and offer additional free consultations for two years for newly diagnosed diabetics.

TPHO funded Turanga Health to deliver location/transport services for those TPHO patients that practices have identified would require transport assistance or a more personal approach to assessment attendance.

4. Integration (closer aligned lifestyle programmes and ancillary services)
TPHO funded a diabetes project manager for one year who had principal responsibility to develop and deliver all the processes required in successfully implement this project.

Status:
This programme will be completed 31 December 2005. An evaluation report of the programme will be prepared in 2006.

Value of Programme: $280, 000 (gst exclusive)
Programme length: 01 July 2004 – 30 September 2005

HEALTH PROMOTION SERVICES AND ACTIVITIES

The following Health Promotion programmes were developed and introduced between 01 July 2004 – 30 June 2005.

HEI ORANGA TATOU (EVERYONE BE HEALTHY) - COMPLETED

A Lifestyle Program developed by Sport Gisborne to help women on medication for mental illness take positive steps toward improving their health and wellbeing.

Program Objectives:

1. That each of the women would be more informed about the importance of regular physical activity, the types of activity available and felt more able to participate in a variety of activities.
2. That each of the women would have a greater awareness about the role of food in their life, better food choices and greater competence in preparing healthy food options.
3. Self esteem would be enhanced through improved self image, greater autonomy and achievement of personally set goals.

Program Overview:

The Program was conducted over a 12 week period for 2 hours per week (Friday 1 – 3pm) and incorporated:

- a variety of activity options for the women to try; Walking for Fitness, Movement to Music, Aquafitness, Pilates, Chair Exercise, Stretching
- practical information and demonstrations on healthy eating and healthy cooking
- tips on skin care, make-up and dressing styles to manage figure challenges.

Each of the 10 women, with the help of their Key Workers and Program Tutors, set weekly activity and nutritional goals, recorded the activity they did each day and filled in Food Records 3 times a week. Rewards were given throughout the program in recognition of effort; recording foods, using pedometer, achieving a goal set the previous week etc.

Value of Programme: $5,000 (gst exclusive)
Programme length: 01 January 2005 – 30 April 2005

HEALTHY KIDS/ACTIVE FAMILIES: - DEVELOPED

This Service aims to improve health gain and reduce childhood obesity through delivery a service for Children with the aim of helping children and their families make healthier lifestyle choices. Access to this programme will be referral from a primary care provider.

Description of the Service
The aims of the service are:
- To assist and support Children and their whanau to make healthier lifestyle choices

The outcomes sought through this service are:
- Early identification of overweight/obese children;
- Improved access and uptake of physical activity options and nutritional advice

The service users will be
Children and their families who:
- have developed or are at risk of developing medical conditions related to inactivity and / or poor eating patterns
- are of school age
- have BMI $\geq 85^{th}$ percentile
- have a stable medical condition which would improve with a change in lifestyle
- do less than 30 minutes of moderate physical activity most days of the week
- are ready to make positive changes to their lifestyle

Value of Programme: $150,000 (gst exclusive)
Programme length: 01 January 2005 – 30 June 2007

Referred Services management activities
The core services provided by TPHO in the 2004/2005 year included:

- **Clinical Leadership** – this has been provided by individual GPs agreeing to provide clinical leadership in areas that TPHO have SIA projects in. The GPs appointed to the TPHO Board also provide wider clinical leadership to the members of Pinnacle Inc.
- Establishment and maintenance of a **peer groups** - TPHO through to April 2004 operated two peer groups who amalgamated into one peer group from May 2004.
- **Clinical support** – Marty Kennedy is the TPHO clinical facilitator with responsibility for coordinating peer group meetings and one-on-one sessions with all TPHO general practitioners. Marty is supported by the clinical team of Pinnacle Group Ltd.
- **Contracting and Administrative** support - This activity has been undertaken jointly by the TPHO CEO and staff from Pinnacle Group Ltd.
- **Information systems** – This activity has been undertaken by staff from Pinnacle Group Ltd.
- Information systems **technical support** - This activity has been undertaken by staff from Pinnacle Group Ltd.

TPHO has utilised resources from Pinnacle Group Ltd to assemble and analyse the prescribing and testing data supplied by Health PAC and from patient management systems and provides reports and feedback (both static and interactive) to the Pinnacle Inc network. In addition TPHO has continued their education program promoting best practice around a range of RSM topics which are selected dependant on the analysis of local general practice specific data.

Every general practitioner was provided with the opportunity to receive a face to face session with a pharmacist facilitator to discuss in-depth information and comparison with other general practitioners aligned with TPHO. Marty has increased his hours to take on the additional support to the former First Health GPs.

Quality improvement activities

Please note that there have been no TDH:TPHO quality indicators and targets set for the period that this annual report relates to.

Please note that in the 2004/2005 year TDH continued to purchase quality plans via the PHO and Pinnacle Inc based on the former general practice network quality plans. A copy of the annual quality report (QP8) has been attached to this annual report.

Consumer satisfaction and complaints summary

All providers contracted by TPHO are required to have consumer satisfaction and complaints processes. During the period that this report relates to, TPHO undertook no population wide consumer satisfaction processes and did not receive any formal complaints.

Issues and exceptions report

During the period that this report relates to, TPHO have no issues and exceptions to report.

Fee levels

The fee levels as notified to TDH in February 2005 remain the same:

Age Group	Up to a maximum of:
0 – 6 years	$05
6 – 18 years	$15
18 years +	$20

Evidence of how you achieve appropriate service levels

Ratio of practitioners to enrolled population is 1:1575. TPHO general practices provide first level services to the PHO enrolled population including the provision of after hours services.

Audited financial reports.

The information for the financial year relating to this report is attached.