



Māori Health Overview



**Review Period:
1 April – 30 June 2011**

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for

**NBPH Board
Nelson Marlborough District Health Board**

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Executive Summary

NBPH has funded, managed and delivered services throughout the Nelson Bays region since 2005. All of the services have Māori patients and whānau involved and they all report on the Māori health activity undertaken within each programme. This report is a summary of some of those Māori health activities.

Purpose

The purpose of this report is to collate a brief summary of the Māori health activities undertaken within the programmes and/or services funded or managed by NBPH.

Objectives

- Highlight contracts and programmes that have committed resources and specific plans to address Māori health needs and population inequalities.
- Highlight the support given by NBPH in the development of cultural safety and population health perspectives across the primary health sector.
- Summarise the initiatives delivered by NBPH to improve access to the primary health care sector.

Focus Areas

This provides you with an update on the two focus areas highlighted for improvement in NBPH for Maori Health.

Vascular Risk Assessment

Cardiovascular Disease and Diabetes are still high priority areas of concern for Māori and NBPH. The Cardiovascular Risk Assessment (VRA) target set by the Nelson Marlborough District Health Board in 2008 was 21,169 screens to be completed by March 2012. NBPH have completed 14,153 screens which is approximately 67% of the target set completed. Of the 14,153 total screens, 872 (6.2%) identified as Māori. Of the 872 who have had a VRA 232 have been identified as at risk of diabetes (29% of the total Māori population screened).

During this quarter 87 Māori patients completed VRA screens. Of these 87 screened, 30 had abnormal fasting glucose results and 1 new diabetic was identified this quarter. The VRA programme has identified that of those Maori clients screened, 29% have been identified as having risk of developing diabetes within the next 5 years.

NBPH has a commitment to reducing the risk of Māori having a heart event and/or becoming a diabetic within the next five years. NBPH has initiated a number of healthy lifestyle programmes for Maori including:

- Kaiatawhai Whanau Ora Liaison Service
- Green Prescription at Whakatū Marae Whānau Ora
- Outreach nursing from Stoke Medical Centre with Te Korowai Trust support
- Aquatic Swim programmes provided by Te Kahui Hauora o Ngāti Koata
- Green Prescription programme for Maori communities in Motueka

There is the potential to improve the numbers of Māori patients accessing the VRA and ongoing support through a number of avenues;

- NBPH Kaitakawaenga continues to raise the issue with their networks
- Link with Tane Ora Coordinator
- Kaiatawhai Service receiving more referrals for general practices and increasing the number of general practices referring to the service
- Newsletters
- Iwi Pānui
- Working together with the Māori health providers to facilitate clients to access
- Kohanga Reo and Kaumatua Pānui

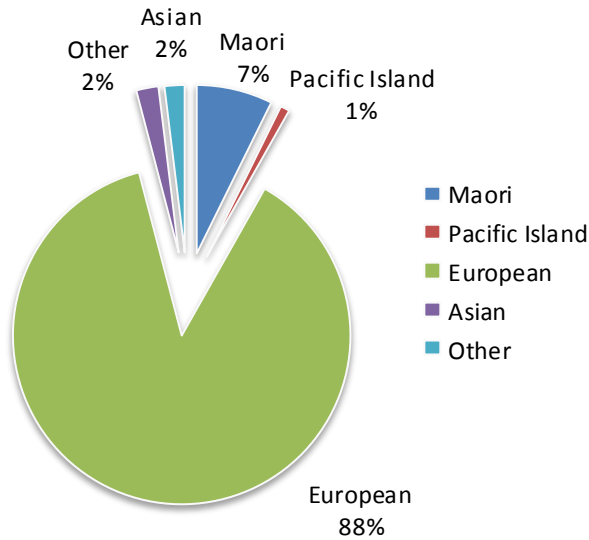
ACC Falls Prevention programme

In the last quarter Falls Prevention programmes had 1 Māori participant, in this quarter the total number of participants enrolled or participating in Falls Prevention was 890 up 158 from the last quarter. Of the 890 participants, 2 identified as Māori. Although NBPH is meeting the contractual requirements, the contract doesn't specify ethnicity as an output. NBPH have identified three Māori health providers who have expressed an interest in delivering a range of strength and balance, home safety and other modules used by Falls Prevention (Upright and Able programmes) to their Kaumatua groups. The delivery of these modules will begin in the next quarter.

Nelson Bays Enrolled Population

At the end of the January – March 2010 quarter, **93363** people were enrolled in NBPH.

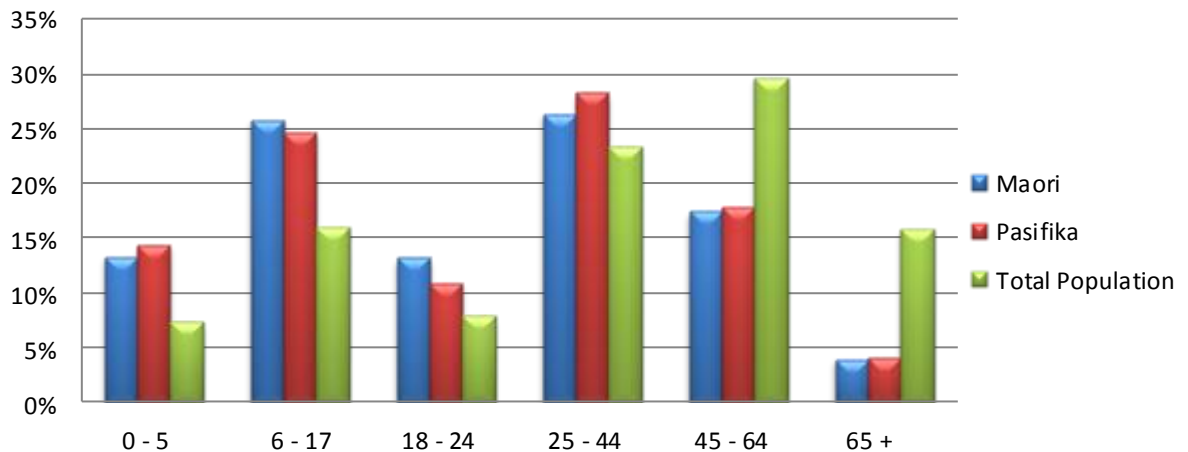
Ethnicity Breakdown



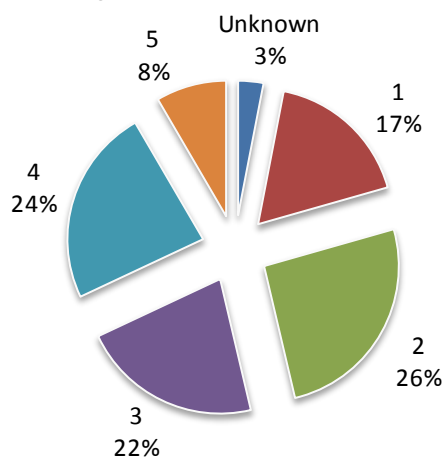
| Ethnicity Breakdown | |
|---------------------|--------------|
| Ethnicity | Number |
| Maori | 6815 |
| Pacific Island | 828 |
| European | 81914 |
| Asian | 1998 |
| Other | 1808 |
| Total | 93363 |

| Age Group | Maori | Pasifika | Total Population |
|--------------|-------------|------------|------------------|
| 0 - 5 | 909 | 119 | 6883 |
| 6 - 17 | 1756 | 204 | 14894 |
| 18 - 24 | 902 | 90 | 7388 |
| 25 - 44 | 1793 | 234 | 21811 |
| 45 - 64 | 1184 | 147 | 27658 |
| 65 + | 271 | 34 | 14729 |
| Total | 6815 | 828 | 93363 |

Age group as Percentage of total population



Deprivation by Quintile



| Quintile | Number | Percentage |
|--------------------|--------------|---------------|
| Unknown | 2832 | 3.0% |
| 1 (Least Deprived) | 16388 | 17.6% |
| 2 | 24037 | 25.7% |
| 3 | 20241 | 21.7% |
| 4 | 22022 | 23.6% |
| 5 (Most Deprived) | 7843 | 8.4% |
| Total | 93363 | 100.0% |

Māori Health Overview

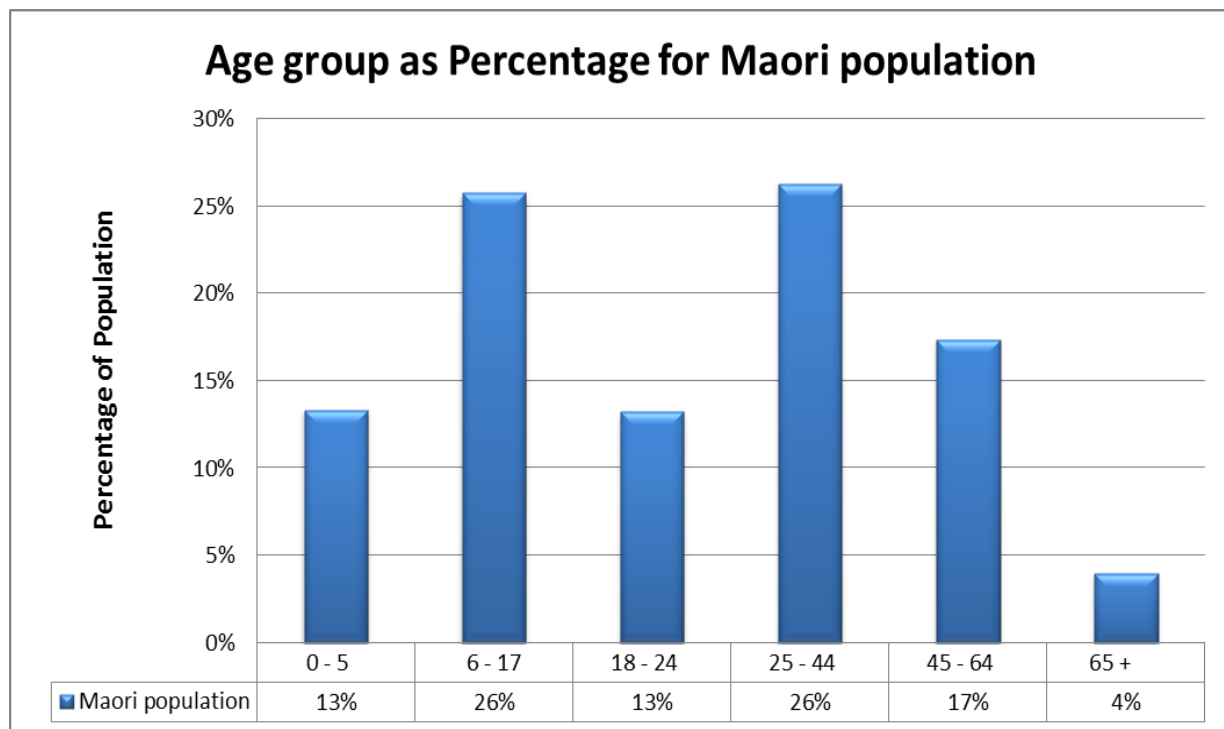
Demographic (for the quarter from 1 April – 30 June 2011)

Total registered with NBPH: 6815 Māori/93363 enrolled

Age and Gender breakdown April – June 2011

| Gender | 0-<6 | 6-17 | 18-24 | 25-44 | 45-64 | 65+ | Total |
|--------------|------------|-------------|------------|-------------|-------------|------------|-------------|
| Female | 426 | 824 | 458 | 910 | 619 | 169 | 3406 |
| Male | 483 | 932 | 444 | 883 | 565 | 102 | 3409 |
| Total | 909 | 1756 | 902 | 1793 | 1184 | 271 | 6815 |

| Quintile | Total |
|--------------|-------------|
| Quintile 0 | 255 |
| Quintile 1 | 551 |
| Quintile 2 | 1231 |
| Quintile 3 | 1446 |
| Quintile 4 | 2092 |
| Quintile 5 | 1240 |
| Total | 6815 |



Te Kahui Hauora o Ngāti Koata - Aqua Aerobics and Tāne Swim

Purpose

Te Kahui Hauora o Ngāti Koata (TKHONK) provides aqua exercise programmes for Māori patients and whānau. The aqua exercise programmes receive referrals from their own service areas, GRx, Māori health providers and other community organisations.

Objectives

- To support Māori clients and whānau to increase their physical activity through aqua exercise programmes
- To support Māori men to reduce weight and increase their physical activity through aqua exercise programmes and Whanaungatanga.

Programme Description

Te Kahui Hauora o Ngāti Koata provide three aqua sessions a week, two mixed sessions and one focusing on Māori men. In addition to the aqua classes TKHONK provide a health education and health promotion session once a month.

Performance Summary

In the past the three aqua sessions had individual contracts that came up for renegotiation towards the end of the last quarter and by mutual agreement the contracts have been merged into one contract.

This quarter the Aquatic Swim programmes had 62 participants enrolled in the Aquatic programmes. Of the 62 participants enrolled 28 were new participants to the programmes and they were all referred to these programmes by the GRx coordinator.

This quarter also saw 19 participants exit the programmes. There were a number of reasons that they left; these included transport issues, clients not attending programme regularly and consistently, Green Prescription (GRx) expired and a client exited due to the programme not being suitable for individual e.g. multiple health issues.

Education sessions included:

- Water and hydration
- Nutrition provided by the NBPH Community Nutrition Service
- Motivation and Strength.

The benefits of the programme reported by individuals and the pre and post assessments included:

- Weight loss
- Pain reduction
- Motivation to become physically active through group motivation
- An increase in physical activity levels

Participant Feedback

One of the participants, a kaumatua, remarked on the big improvements to the programmes, saying that the instructor's expertise was tūmeke and he was keen for more classes e.g. shape up exercises, more walking and weight loss programmes.

Te Reo Māori Classes

Purpose

The purpose is to provide Māori language sessions for NBPH staff to access to help improve their pronunciation and confidence to use Māori words through the Ataarangi model.

Objectives

For staff to learn basic pronunciation, greetings and Mihimihi.

Programme Description

NBPH Te Reo Maori classes are run weekly, length one session. The classes start in July 2010 and have continued into 2011. The tutor is Marleina Leota an Ataarangi-trained kaiako. Ataarangi is well-known for the use of coloured Cuisenaire rods as a learning tool. It's an effective language-learning technique that encourages people to speak.

Performance Summary

In the last six months NBPH staff have gained some of the basics of understanding Te Reo Māori, e.g. basic pronunciation, numbers, colours, greetings and mihimihi/short introductions. Staff numbers attending the sessions range from 6 – 12 staff members, this is influenced by staff workload. Feedback from staff about the lessons is very positive. At the last three mihi whakatau almost all of the staff introduced themselves in Māori. This is very good evidence to show the lessons are flowing into the workplace.

Child Birth Education Coordination

Purpose

The purpose is for the delivery of childbirth education in Motueka and for young parents in Nelson Bays. Motueka services are sub-contracted to be delivered by the local Parents Centre.

Objectives

Improved access to childbirth education programmes in particular for young parents

Raise awareness of the importance of child rearing including but not limited to; breastfeeding, immunisation and safe sleeping techniques.

Programme Description

Each course currently consists of six 2-hour sessions and is delivered in accordance with national standards.

Performance Summary

- This quarter 4 young parents took part in the young parents' antenatal course.
- 15 expectant parents took part in the Motueka childbirth education course delivered by Parents Centre NZ.
- Te Korowai Trust has expressed interest to deliver childbirth education programmes for the young parents engaged with their service with the support of Ruth Brodbeck, NBPH Childbirth Educator.

Piki Te Ora Best Practice Guidelines

Purpose

The purpose is to provide a resource for primary health care providers that support them to better meet the needs of Māori patients and their whānau.

Objectives

Piki Te Ora Best Practice Guidelines is a guideline for working with Māori patients and whānau in primary care. It is a resource that will contribute to providing primary health care services to better able to respond to Iwi/Māori rights/rites, needs and interests.

Overview

The Piki Te Ora Best Practice Guidelines final draft was accepted by the Clinical Governance Group and is waiting for the final document to be printed. A Piki Te Ora Best Practice Guidelines flipchart is also close to completion and is about to be presented to the Management Operations Group for final sign off. When the flipchart is signed off, both guidelines will be sent to the printers and a launch of the guidelines will be arranged. All primary health care providers will be able to acquire a copy of the guidelines to support their service.

Developing relationships with Iwi Māori

Purpose

The purpose is to support the NBPH Board and organisation to develop a relationship with Mana Whenua Iwi and the wider Māori community to encourage them to participate in the development of NBPH and primary health care providers.

Objectives

To support NBPH Board;

- To develop a relationship with Mana Whenua Iwi
- To develop and maintain a relationship with the NMDHB Iwi Health Board
- To develop a relationship with Mata Waka ki te Tai Ao Rere
- For the NBPH Maori Board members to have a relationship with the Iwi Health Board

Overview

In April 2011 NBPH Board meeting a paper was put to the Board making recommendations to further facilitate the development at a board level of the relationship between NBPH and the Mana Whenua Iwi in the Nelson Tasman region. The recommendations were to support the development of a relationship with;

- The NBPH Māori Board members and the Iwi Health Board
- The NBPH Board and the Iwi Health Board
- The NBPH Board and Mana Whenua Iwi and Maataa Waka ki te Tai Ao Rere.

The NBPH Iwi/Māori representatives and senior staff recently arranged a meeting to further progress discussions. As a result of this meeting a paper is to be presented to the Iwi Health Board on behalf of the NBPH Māori Board members to meet with the Iwi Health Board to discuss opportunities to give and receive feedback about NBPH Māori health issues, and also to discuss IHB expectations and opportunities to share resources such as; Governance training and communications with communities and Iwi.

Māori GRx – Whakatū Marae Whānau Ora

Purpose

The purpose is to support the delivery of a Kaupapa Māori 'Lifestyle Support Programme'; coordinated by Lifestyle Support Worker/s (LSW), based at Whakatū Marae which will meet the unique needs and desires of the Māori community they are serving.

Objectives

- Deliver a weekly programme which has a focus on entry level physical activity and wellbeing
- Ensure the programme is easily accessed by Māori whānau
- Increase participant awareness of appropriate and accessible physical activity opportunities outside of the programme
- Provide opportunities for programme participants to receive support and information about living a healthy lifestyle
- Provide opportunities for programme participants to meet with others with similar concerns and interests to support each other to maintain healthy lifestyles
- Monitor and review participants to assess programme uptake, goal achievement and physical and behavioural change

Programme Description

The Lifestyle Support Programme ideally runs for 1 -1 ½ hours with 4 key components:

1. Registration and review (including individual goal setting and support) by LSW staff
2. Group activity/Interactive learning session (introduction to a variety of physical activity options and health/wellbeing topics)
3. Provide a choice of different types of physical activity options
4. Provide social interaction time or opportunities

Performance Summary

This quarter Whakatū Marae Whānau Ora GRx service had 42 participants enrolled on their programmes. The activity programmes included Waka Ama, Kaukau (swimming) and hīkoi (walking). Patients can be referred to this service through a number of ways e.g. a general practice, the health nurse at the Marae, self-referral or through whānau. The service also provides education sessions to help whānau to understand the importance of physical activity and healthy nutrition. This quarter the education sessions included:

- benefits of drinking more water daily and when exercising
- Stretching before and after exercising
- How food gives you fuel and aids recovery
- Encouraging and supporting whānau to keep motivated

Numbers of referrals and gender

| | | | |
|--|----|---------------|----|
| Total number of participant enrolled with the programme this quarter | 44 | | |
| Number of new participants referred to the service through the Marae or whānau | 33 | | |
| Number of new participants referred to the service through the GRx coordinator | 6 | | |
| Number of participants who exited the service this quarter | 17 | | |
| Number of Tāne/men | 7 | | |
| Number of Wāhine/women | 22 | | |
| Pākēhā Male | 3 | Pākēhā Female | 12 |

Benefits of the service for participants include:

- Losing weight

- Improved joint mobility
- Reduced pain
- Taking less medication
- Improved fitness levels
- Becoming whānau role models.

Community Podiatry

Purpose

This report relates to the activities which have occurred as a result of contracting Mapua Podiatry for the Community Podiatry Service during the contract period of July 2010 – June 2011. The contract requires the delivery of podiatry services to individuals with at-risk and high-risk foot complications related to diabetes.

Objectives

NBPH has a contract with Mapua Podiatry to deliver a community-based podiatry service which entails interdisciplinary, cross-sectorial care teams providing comprehensive, holistic and continuous health services to enrolled populations of people.

Overview

The podiatry service is a mobile service which works with primary care, secondary care specialist services, providers of diabetes education and management, and Māori health providers that provide facilitation services or support for people with diabetes and their whānau.

The data presented in this report is a representation of the numbers of clients seen for the contract period July 2010 – June 2011

Number of new clients referred by quarter

| Ethnicity | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Total |
|----------------|-----------|-----------|-----------|-----------|-------|
| Other | 620 | 620 | 590 | 600 | 2430 |
| Māori | 130 | 112 | 103 | 105 | 450 |
| Pasifika | 8 | 9 | 5 | 5 | 27 |
| Total | 758 | 741 | 698 | 710 | 2907 |
| Target/quarter | 619 | 619 | 619 | 619 | 2476 |

The services to Maori Health providers have continued on a three monthly basis due to the higher risk this population present. People who identify as Maori made up 16% of the total number of contacts and 14% of new referrals. It is hoped that in the future services could be offered at varying locations e.g. Whakatū Marae and Te Āwhina Marae. Both Marae have expressed interest in a Marae-based clinic but this would require additional funding.

| Type of Referral | Number of clinical contacts | | | | |
|---|-----------------------------|-----------|-----------|-----------|-------|
| | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | Total |
| Diabetes with a history of gangrene, amputation, ulceration | 92 | 86 | 80 | 82 | 340 |
| Diabetes with absent pedal pulses | 190 | 190 | 170 | 175 | 725 |
| Diabetes with an active problem | 83 | 78 | 76 | 80 | 317 |
| Diabetes with Neuropathy | 155 | 146 | 143 | 147 | 591 |

| | | | | | |
|--|----|----|----|----|-----|
| Diabetes with patient in need of preventative toe nail clippings | 94 | 92 | 92 | 95 | 373 |
| High risk for other reason identified by GP | 68 | 66 | 60 | 65 | 259 |
| Peripheral vascular disease | 70 | 69 | 65 | 65 | 269 |
| Rheumatoid Arthritis | 43 | 41 | 40 | 45 | 169 |

Kaiatawhai Whānau Ora Liaison Service

Purpose

The NBPH Kaiatawhai Whānau Ora Liaison service is available for all general practices to work with. This service supports Māori patients and their whānau enrolled with a general practice to access the health screenings and services that are available to them, such as: CVRA, smears, mammograms, vaccinations, and Diabetes Annual Reviews. The Kaiatawhai Service also supports the implementation of management plans for clients when they are found to have high risk of developing chronic conditions.

Objectives

- Support Māori patients and whānau to access general practice health care and assessments
- Work with hard-to-reach enrolled Māori patients and whānau
- Support patient referrals to other health providers
- Work with general practices in the development and facilitation of patient wellness plans
- Support whānau members not enrolled with a general practice to enrol with a practice.

Programme Description

Accessing services at general practice

This service has two Kaiatawhai whānau ora liaison staff who receive referrals from general practices to support Māori patients enrolled in their service to access health care and assessments.

First contact is made through:

- Phone calls (many phone calls are made outside of the normal working hours)
- Cold calling (home visits).

When contact is made with patients and whānau they are encouraged to make their own appointments with the general practice. Staff follow up to ensure appointments are made and kept or will follow up those who do not attend.

Self-management support

The Kaiatawhai service works with the general practice and Maori Health Providers and other community-based providers to support the development and implementation of self-management strategies for clients with chronic conditions. This may involve referrals to other services such as Aqua aerobics, Budget advice, Gym membership, traditional Maori games, Miri Miri (Traditional Massage Therapy), nutrition service, Green Prescription, mental health, respiratory, arthritis and many others.

Performance Summary

This quarter the Kaiatawhai service has received a total of 69 referrals from 13 general practices in the Nelson Bays region.

- Of the 69 referrals 40 were male (58%) and 29 were female (42%).
- There were 14 people who declined the service after they were offered it.
- There were 39 assessments accessed by clients at their general practice. These assessments include:

- 25 Vascular Risk Assessments (VRA)
- 2 Diabetes Annual Reviews (DAR)
- 7 Mammograms
- 5 Smears
- Eleven of the patients who were referred to the service are patients with long-term chronic conditions and therefore require significant self-management support to achieve goals set out in their self-management care plans.

The Kaiatawhai service has also been providing clinical supervision to three clinical staff working for Maori Health providers.

Future developments

The Kaiatawhai service is looking at offering their service to other government organisations to ensure they are able to connect with high need communities. Community Probation Service Richmond Centre (CPS) have met with the Kaiatawhai service and recognised the value of the service to their clients. The issues raised by CPS clients were; not enrolled with a general practice, little knowledge of primary health care services and how to access the service and understanding what service they provided.

ACC Falls Prevention

Purpose

Nelson Bays Primary Health (NBPH) has been contracted by ACC to lead and coordinate falls prevention activity within the wider primary health care sector, focusing on the wellbeing of older people.

Objective

The aim is to reduce the incidence and impact of falls among the 65+ age group.

Programme Description

Activity focuses on shifting the emphasis from Tai Chi to Falls Prevention, making the programme more accessible, to more participants, with improved impact, capacity, cost effectiveness and quality controls. We have developed a two-pronged approach to Falls Prevention, one prong is the development of Upright & Able, a 6-week self-management programme that educates, empowers and samples strategies while building confidence.

Performance Summary

Programme delivery started on 24 February 2010. To date we can report that:

- Twenty (20) Upright & Able 6-week courses have been completed with 240 people participating in 5 or more sessions. The total number of people participating in a community programme delivering Falls Prevention activities this quarter is 890.
- Recently ACC funded UMR Research to undertake a qualitative and quantitative evaluation of the Upright & Able programme. At the time of the evaluation, 197 participant records were included in the analysis. The results of the evaluation highlighted:
 - The Upright and Able programme is having a positive impact on participants' strength and balance over the duration of the six week programme.
 - Fewer participants are identified as having a 'falls risk' after completing the programme and many stay active (maintain regular exercise) after they completed the programme.
 - Six months after completing the programme 89% self-reported as being regularly active.

- Six months prior to the programme **51% had fallen** and six months after completing the programme only **16% had fallen** and of those falls only **4 injuries** required medical treatment.

Specific resourcing has been ring-fenced for provision of services to Māori. Contractual specifications allow for Māori and Pasifika people over the age of 55 to be included in delivery targets (>65 for others) and this is reflected throughout subcontracting and programme planning. NBPH has delivered Falls Prevention initiatives to 22 Pasifika people (20 females and 2 males) and is currently working with Victory Community Health Centre to make this a regular event.

Future developments

NBPH GRx service in Motueka is developing a Kaupapa Māori Strength and Balance programme to include Upright and Able modules, to be rolled out in the next quarter. Discussions are also underway with two Māori kaumatua groups in Nelson to roll out a Kaupapa Māori Strength and Balance programme to include Upright and Able modules and traditional Māori games and activities. There are three Maori Health providers interested in working with NBPH to deliver these programmes to their Kaumatua.

Breastfeeding and Lactation Coordination

Purpose

The Breastfeeding Coordination Contract delivers on a range of actions from the Nelson Marlborough (NM) Breastfeeding Action Plan. A new contract between NMDHB and NBPH based on the revised Action Plan is currently being finalised.

NBPH is committed to continue to fund and support the delivery of Mum4Mum. NBPH currently supports Motueka Family Service Centre with the delivery of the Mum4Mum Peer Counselling Programme and is planning to extend this programme into the rest of Nelson/Tasman.

Additionally, NBPH has started a Community Lactation Consultant Service to support referred breastfeeding mums who have breastfeeding problems and need specialist input.

Objective

To increase breastfeeding initiation and duration rates in particular for Māori, Pasifika peoples and low-income women.

Programme Description

The focus of the Breastfeeding Programme and Services is on improving multi-disciplinary and community support for breastfeeding, as well as providing an expert Lactation Consultant advice. The peer Counselling contract focuses on Mum4Mum breastfeeding support in high needs communities.

Performance Summary

Ruth Brodbeck is now employed as 0.75 FTE Lactation Consultant and Childbirth Educator. NBPH holds two contracts with NMDHB (Breastfeeding Co-ordination and Childbirth Education). The additional programmes (Mum4Mum and LC Services) are funded internally by NBPH.

- Motueka Mum4Mum volunteers continue to deliver breastfeeding support in the community. Contact with Te Āwhina Marae is on-going. Distribution of the Mum4Mum pamphlet in the wider community is letting providers know that the Mum4Mum Peer Counsellor service is available in the area.
- Breast pumps are available (funded by NBPH at no cost to the parents) through Plunket for mothers with a medical reason or who are from high needs population groups.

- Early planning and familiarising with international campaign 'World Breastfeeding Day Latch-on' events will be promoted and supported amongst local breastfeeding support groups
- The focus for the third quarter of 2011 will be on the continued roll-out of Mum4Mum in Nelson/Tasman and the Lactation Consultant Services in Primary Care and Community.

Community Nutrition Service

Purpose

The overall purpose of the service is to assist in reducing the incidence of lifestyle-related chronic disease and improving the health status of those who already have these conditions. The service works to improve the capacity of other health workers and has a focus on reducing inequalities in health.

Objective

The objective of the Community Nutrition Service is to deliver nutrition advice as part of multi-disciplinary teams. The service has a strong focus on nutrition capacity building of the primary health care and community workforce and the development of sustainable programmes.

Programme Description

The Community Nutrition Service continues to work as a consultative service where it provides expert nutrition education and advice to the primary health care workforce and the NBPH enrolled population, in the area of chronic disease prevention and management. The service sees referred clients in both individual and group settings. The team is also involved in the development and implementation of preventative community based programmes and services.

Performance Summary

This quarter 279 individual patient consultations have been offered across the NBPH region. Eighty four percent of clients (234) were referred by General Practice Teams and 16% (45) by community providers such as Plunket, Public Health Nurses, GRx and Māori providers. Thirty group education sessions including the MEND (Mind, Exercise, Nutrition... Do it!) Childhood obesity management programme were delivered this quarter to a total of 173 participants. This quarter we saw 21 Māori clients for an individual consultation which is 7.5% of the total. Māori clients also participated in group sessions including the MEND programme.

Regular contact and meetings are taking place with Whānau Ora workers at Te Korowai Trust and the Maori Green Prescription (GRx) staff at Whakatū and in Motueka. The team continues to see patients with the NBPH Kaiatawhai liaison staff as appropriate.

Number of referrals received from April 2010 to June 2011 by Ethnicity

| Referrals | Māori | NZ Pākēhā | Target |
|-----------|------------|-----------|--------|
| Q4 09/10 | 10 (5%) | 195 | - |
| Q1 10/11 | 23 (11.4%) | 194 | 250 |
| Q2 10/11 | 23 (9.5%) | 243 | 250 |
| Q3 10/11 | 20 (10.5%) | 245 | 250 |
| Q4 10/11 | 21 (7.5%) | 279 | 250 |

Māori clients and providers have also participated in group and workforce sessions. We continue to prioritise work with Māori providers and have on-going contact with Whakatū and Te Āwhina Marae and Te Korowai Trust. Joint client consultations have occurred with the Kaiatawhai whānau ora liaison staff. The dietitians are participating and enjoying the Te Reo language course.

Health Education Assessments (HEA)

Purpose

To improve the interagency partnerships around the social, health and education needs of children and young people who come into care, in order to improve the outcomes for these children.

Objective

To develop a sustainable process that will enable the continued provision of HEA, after the completion of the pilot. A key mechanism for this is to develop the capacity and capability of all key agencies in coordinated service delivery for high needs groups.

Programme Description

The Health and Education Assessment pilot will be facilitated by Health coordinators appointed by Nelson and Marlborough PHOs who will be based alongside the team at CYF and be fully embedded into their team. They will work with CYF systems and staff to implement Health and Education Assessments and embed the process of HEA into everyday practice in CYFs.

Performance Summary

NBPH has employed a HEA coordinator, latterly named Gateway Coordinator in a 0.4FTE position. One assessment has been completed and another three have been triaged and are awaiting assessment. There have been four referrals from CYF. The Gateway Coordinator attended the Māori Health Reference Group and the Pacific Peoples Reference Group on 15 April 2011. The Group's feedback included:

- CYF need to access key document Te Puao te Ata tu.
- Recommendation that cultural assessment is included in the Gateway Assessment.
- Recommendation that CYF develop a process for appointment of Maori (not solely an iwi rep) onto the Care & Protection panel, who is a registered Social Worker, experienced in Care and Protection issues and qualified to assess culturally
- Request that if further guidance is required to return to MHRGPPRG for this.
- Request to come back and present an update. This has been planned for July 2011.

Service development completed including:

- Development of resources for CYF social workers – a resource booklet, which is now superseded by the recently released updated information.
- Establishment of the Gateway Triage Panel, including representatives from Primary Care (a GP), Secondary Care (community paediatrician), Group Special Education, Child and Adolescent Mental Health Service, Primary Health, and CYF.
- Identifying, mentoring and supporting our first GP in primary care to complete Gateway Health Assessments. This person has offered on-going availability to continue assessments and to be on the Triage Panel as required.
- Identification of two Practise Nurses keen to be involved in the Triage Panel.
- Ongoing liaison, education and support with various providers, especially GP practices regarding the importance of timely information provision and the requirements of the Health Assessment.

The pilot project has its foundation in place in Nelson, it has been tested with one completed assessment and three more underway. The service is now ready for full utilisation and is well supported.

Vascular Risk Assessment Programme (VRA)

Purpose

To systematically (and opportunistically) perform cardiovascular risk assessments, using the electronic clinical decision support tool “bestpractice”, across the eligible Nelson Bays population within primary care, with the aim of reducing cardiovascular disease, which is the leading cause of death in New Zealand.

Objective

- To ensure all NBPH general practices offer VRA within general practice.
- To ensure all clinical staff have been trained to provide VRA using “bestpractice”.
- To collect and collate VRA data, ensure data accuracy and integrity, and provide clinical feedback to practices on their clients’ data.
- To assist practices to identify and invite their eligible populations for a VRA.
- To ensure practices meet their targets for VRA and are remunerated for VRAs performed.

Programme Description

General practices invite eligible patients to participate in this programme by letter, by telephone, or they may opportunistically offer a VRA. The VRA, in most practices, is conducted through a nurse-led consultation; it requires a fasting blood test, examination and a clinical history to assess a person’s estimated % risk of having a CVD event in the next 5 years. Once a patient’s risk is assessed, they are given information and education on how to reduce this risk and are placed onto an appropriate clinical pathway, with referral to other initiatives, e.g. Green Prescription, and follow-up as appropriate. Services to Improve Access funding for a GP consultation is available to patients who are Māori, Pasifika or reside in NZ Dep decile 9 and 10, with a VRA $\geq 15\%$ and who require further medical management.

Performance Summary

General practice has embraced this programme and continues to see its value in improving patient health:

- Since 1 October 2008, 14,153 screens have been completed. The target set by the Nelson Marlborough District Health Board (NMDHB) in 2008 was 21,169 screens to be completed by March 2012. NBPH has now completed 67% of this target.
- 60% of VRA completed this quarter were undertaken on males.
- 872 of these are Māori (6.2% of the total number of VRAs).
- 87 Māori participated during this quarterly reporting period; 30 had abnormal fasting glucose results (34% of the screens this quarter).
- Through the VRA programme, 17 probable new Māori diabetics have been identified (1 this quarter); and 232 are at risk of diabetes (29% of the Māori population screened).
- Those Māori who have been screened follow the national trend and are more likely to have a calculated CVD risk $\geq 15\%$, are more likely to smoke and have a fasting blood glucose level $\geq 7\text{mmol/L}$ (indicating a high possibility of diabetes) than any other ethnic group.
- SIA funding is being utilised for a free GP consult for Māori post nurse VRA if their CVD risk $\geq 15\%$ (and they are not enrolled in Care Plus), which assists patients to receive the care they require to reduce their CVD risk.
- NBPH Kaiatawhai liaison workers continue to support Māori to access the VRA programme.

Clinical reporting requirements have not been defined. The following data represents clinical and demographic trends within the NBPH VRA-screened population. Note: the data for this quarter includes data from 1 April 2011 to 30 June 2011 and is taken from the NBPH Halcyon database.

Ethnicity

Ethnicity - this quarter:

Ethnicity - since programme began:

| Ethnicity | Number of Screens | % of Total Screens |
|--------------|-------------------|--------------------|
| NZ European | 760 | 76.0% |
| NZ Māori | 87 | 8.7% |
| Other | 147 | 14.7% |
| Pasifika | 6 | 0.6% |
| Total | 1000 | |

| Ethnicity | Number of Screens | % of Total Screens |
|--------------|-------------------|--------------------|
| NZ European | 11766 | 83.1% |
| NZ Māori | 872 | 6.2% |
| Other | 1413 | 10.0% |
| Pasifika | 102 | 0.7% |
| Total | 14153 | |

The following information has been split by ethnicity. The percentage shown is calculated against the total number within the ethnic group.

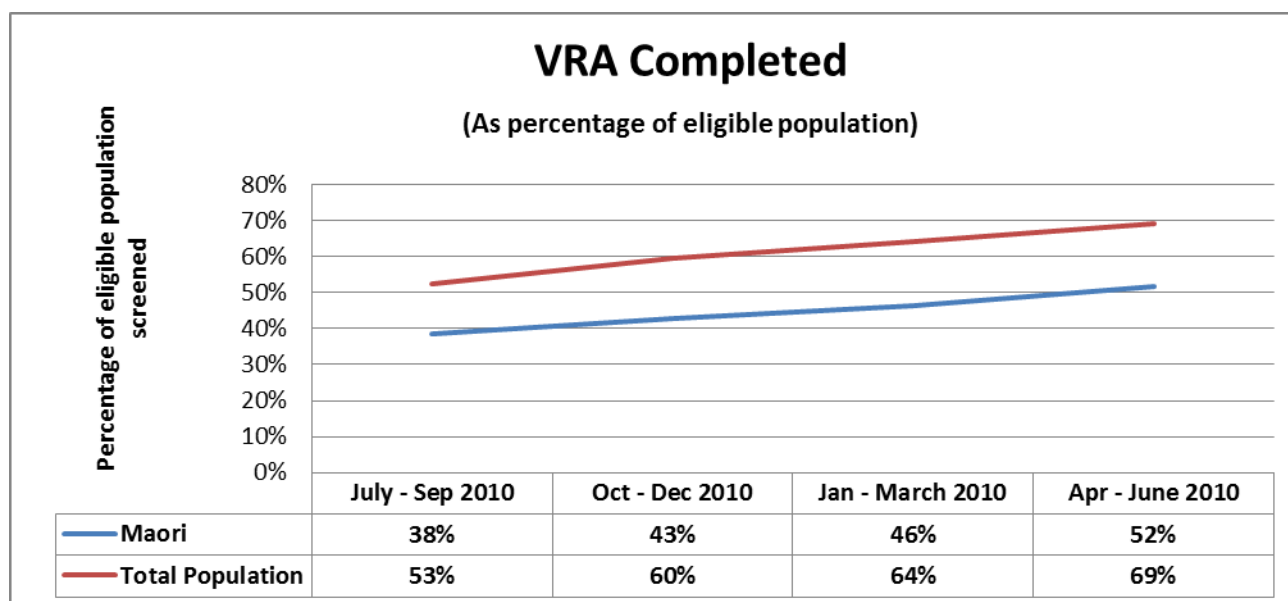
Gender

Gender - this quarter

| Ethnicity | Male | | Female | |
|--------------|------------|--------------|------------|--------------|
| NZ European | 453 | 45.3% | 307 | 30.7% |
| NZ Māori | 50 | 5.0% | 37 | 3.7% |
| Other | 96 | 9.6% | 51 | 5.1% |
| Pasifika | 3 | 0.3% | 3 | 0.3% |
| Total | 602 | 60.2% | 398 | 39.8% |

Gender - since programme began

| Ethnicity | Male | | Female | |
|--------------|-------------|--------------|-------------|--------------|
| NZ European | 6638 | 46.9% | 5128 | 36.2% |
| NZ Māori | 491 | 3.5% | 381 | 2.7% |
| Other | 844 | 6.0% | 569 | 4.0% |
| Pasifika | 62 | 0.4% | 40 | 0.3% |
| Total | 8035 | 56.8% | 6118 | 43.2% |



CVD Risk

CVD Risk - this quarter

| Ethnicity | CVD Risk < 10% | | CVD Risk 10 - 14% | | CVD Risk 15 - 19% | | CVD Risk ≥ 20% | | Risk clinically >15% due to a single risk factor | | Risk clinically >20%; known CVD, genetic lipid disorder | |
|--------------|----------------|--------------|-------------------|--------------|-------------------|-------------|----------------|-------------|--|-------------|---|-------------|
| | | | | | | | | | | | | |
| NZ European | 537 | 53.7% | 98 | 9.8% | 22 | 2.2% | 8 | 0.8% | 53 | 5.3% | 42 | 4.2% |
| NZ Māori | 52 | 5.2% | 19 | 1.9% | 0 | 0.0% | 1 | 0.1% | 8 | 0.8% | 7 | 0.7% |
| Other | 91 | 9.1% | 23 | 2.3% | 8 | 0.8% | 3 | 0.3% | 13 | 1.3% | 9 | 0.9% |
| Pasifika | 4 | 0.4% | 1 | 0.1% | 0 | 0.0% | 0 | 0.0% | 1 | 0.1% | 0 | 0.0% |
| Total | 684 | 68.4% | 141 | 14.1% | 30 | 3.0% | 12 | 1.2% | 75 | 7.5% | 58 | 5.8% |

CVD Risk - since programme began

| Ethnicity | CVD Risk < 10% | | CVD Risk 10 - 14% | | CVD Risk 15 - 19% | | CVD Risk ≥ 20% | | Risk clinically >15% due to a single risk factor | | Risk clinically >20%; known CVD, genetic lipid disorder or diabetes with renal disease | |
|--------------|----------------|--------------|-------------------|--------------|-------------------|-------------|----------------|-------------|--|-------------|--|-------------|
| | | | | | | | | | | | | |
| NZ European | 7285 | 51.5% | 1962 | 13.9% | 753 | 5.3% | 402 | 2.8% | 583 | 4.1% | 781 | 5.5% |
| NZ Māori | 420 | 3.0% | 227 | 1.6% | 63 | 0.4% | 48 | 0.3% | 51 | 0.4% | 63 | 0.4% |
| Other | 963 | 6.8% | 195 | 1.4% | 78 | 0.6% | 30 | 0.2% | 71 | 0.5% | 76 | 0.5% |
| Pasifika | 54 | 0.4% | 22 | 0.2% | 8 | 0.1% | 4 | 0.0% | 8 | 0.1% | 6 | 0.0% |
| Total | 8722 | 61.6% | 2406 | 17.0% | 902 | 6.4% | 484 | 3.4% | 713 | 5.0% | 926 | 6.5% |

Diabetes Detection

Diabetes Detection - this quarter

| Ethnicity | FG < 5.5 normal | | FG 5.5 - 6.0 possible IGT/IFG | | FG 6.1 - 6.9 probable IGT/IFG | | FG ≥ 7.0 probable new diabetics | |
|--------------|-----------------|--------------|-------------------------------|--------------|-------------------------------|-------------|---------------------------------|-------------|
| | | | | | | | | |
| NZ European | 550 | 55.0% | 166 | 16.6% | 42 | 4.2% | 2 | 0.2% |
| NZ Māori | 57 | 5.7% | 25 | 2.5% | 4 | 0.4% | 1 | 0.1% |
| Other | 108 | 10.8% | 30 | 3.0% | 8 | 0.8% | 1 | 0.1% |
| Pasifika | 3 | 0.3% | 1 | 0.1% | 2 | 0.2% | 0 | 0.0% |
| Total | 718 | 71.8% | 222 | 22.2% | 56 | 5.6% | 4 | 0.4% |

Diabetes Detection - since programme began

| Ethnicity | FG < 5.5 normal | | FG 5.5 - 6.0 possible IGT/IFG | | FG 6.1 - 6.9 probable IGT/IFG | | FG ≥ 7.0 probable new diabetics | | Known Diabetics | |
|--------------|-----------------|--------------|-------------------------------|--------------|-------------------------------|-------------|---------------------------------|-------------|-----------------|-------------|
| | Count | Percentage | Count | Percentage | Count | Percentage | Count | Percentage | Count | Percentage |
| NZ European | 8512 | 60.1% | 2253 | 15.9% | 596 | 4.2% | 81 | 0.6% | 324 | 2.3% |
| NZ Māori | 574 | 4.1% | 185 | 1.3% | 47 | 0.3% | 17 | 0.1% | 49 | 0.3% |
| Other | 1003 | 7.1% | 278 | 2.0% | 75 | 0.5% | 13 | 0.1% | 44 | 0.3% |
| Pasifika | 69 | 0.5% | 15 | 0.1% | 9 | 0.1% | 0 | 0.0% | 9 | 0.1% |
| Total | 10158 | 71.8% | 2731 | 19.3% | 727 | 5.1% | 111 | 0.8% | 426 | 3.0% |

FG = fasting glucose IGT = impaired glucose tolerance IFG = impaired fasting glucose

Diabetes Annual Review (DAR)

Purpose

To provide the Diabetes Annual Review (DAR) programme in general practice for people with a diagnosis of diabetes mellitus, based on the priorities identified in the 1997 Ministry of Health document “Strategies for the prevention and control of diabetes in New Zealand”, and to ensure that the updated information in diabetes registers is presented by NBPH to the Local Diabetes Team.

Objective

- Systematically screen for the risk factors and complications of diabetes to promote early detection and intervention.
- Agree on an updated treatment plan for each person with diabetes: The treatment plan (or equivalent) should be provided in writing for the person with diabetes, and any other providers of diabetes support.
- Update the information in the diabetes register used as a basis for clinical audit and planning improvements to diabetes services in the area.
- Prescribe treatment and refer for specialist or other care if appropriate.
- Encourage patients with HbA1c >64mmol/mol (8%), who are at risk of developing complications of diabetes, to engage in the Diabetes Enhanced Review pathway.

Programme Description

Patients with diagnosed diabetes mellitus are invited to an Annual Review by general practice through the recall facility on the Practice Management System. These checks are usually conducted by an appropriately trained Practice Nurse. Data is collected via the “bestpractice” electronic clinical decision support tool. Patients who have an HbA1c of greater than 64mmol/mol (8%) at the time of DAR are invited back to general practice, within six months, to have a further review to assess their progress and management with the aim to reduce their HbA1c and risk of complications.

Performance Summary

This quarter 634 DAR have been completed and processed by NBPH, which is up 3% compared to the same quarter last year.

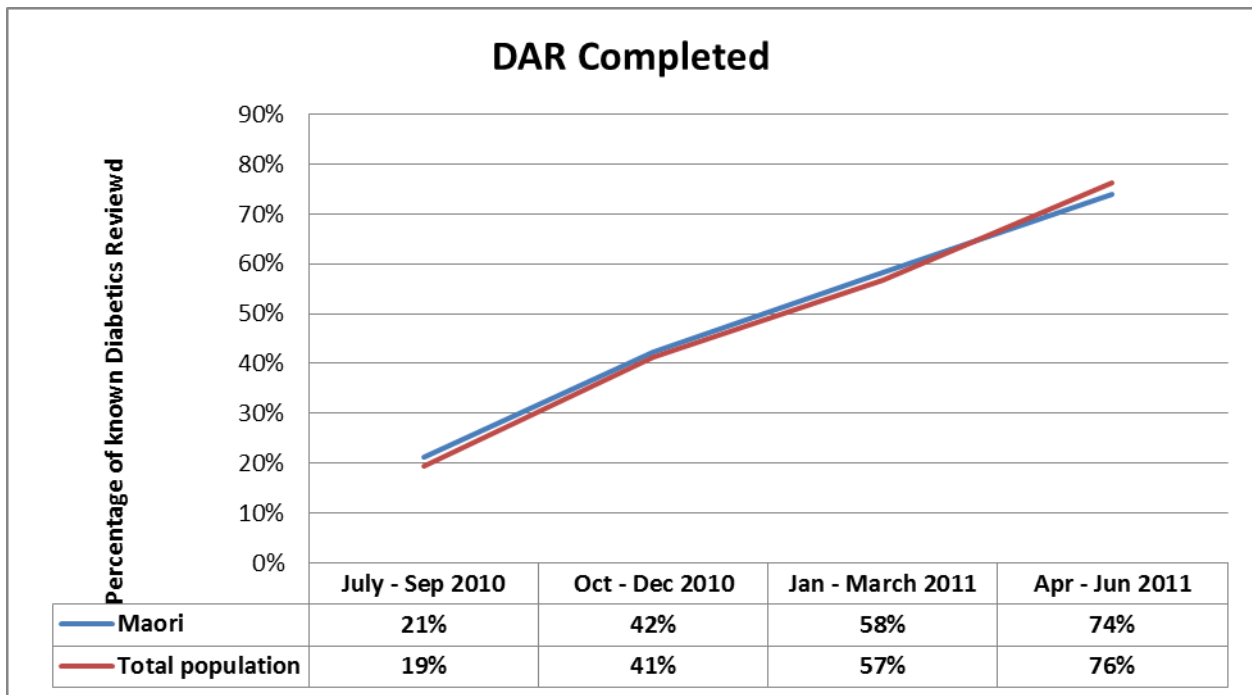
- Diabetes is a health gain priority area for Māori. Prevalence, morbidity and mortality rates from diabetes are all higher in Māori than people of European origin.
- 33 Māori (5.2% of DAR claims) have received a DAR in this quarter.
- 2 Māori have received Enhanced Care Management for their diabetes in this quarter (4% of Diabetes Enhanced Reviews).

This quarter numbers for Māori patients who completed a DAR has seen very little change compared to this time last year, from 35 down 2 to 33 this year. It is very similar with the other ethnic populations Pasifika 9 down 1 to 8 this year, other 25 to 23, and for NZ European there was a slight increase of 24 patients from 546 to 570 this year.

| | NZ Māori | Pasifika | NZ European | Other | Total |
|------------------|-----------|----------|-------------|-----------|------------|
| Type I Diabetes | 2 | 0 | 55 | 0 | 57 |
| Type II Diabetes | 31 | 8 | 515 | 23 | 577 |
| Total | 33 | 8 | 570 | 23 | 634 |

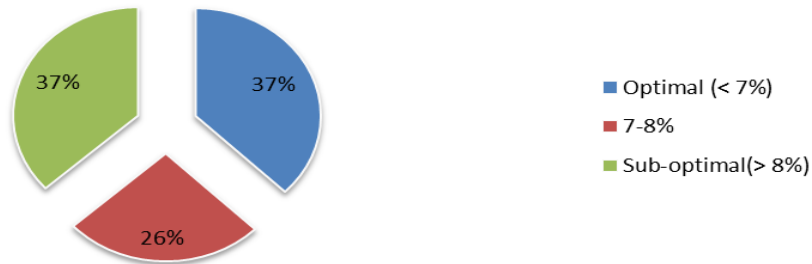
One of the major outcomes of DAR is to ensure that patients have an HbA1c of less than 64 mmol/mol (8%) to reduce complications; 75% of patients having a DAR, year to date, have achieved this goal. 48 patients with an HbA1c greater than 8% at their DAR engaged in the Diabetes Enhanced Review programme in this quarter.

| | HbA1c <7% | HbA1c 7-8% | Hba1c >8% | Total |
|------------------|-------------|------------|------------|-------------|
| Type I Diabetes | 30 | 82 | 147 | 259 |
| Type II Diabetes | 1178 | 624 | 482 | 2284 |
| Total | 1208 | 706 | 629 | 2543 |



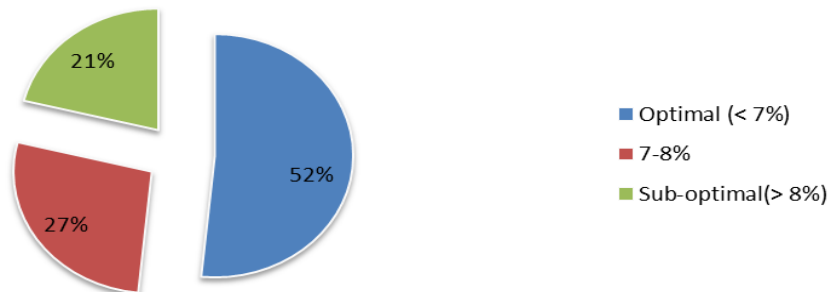
Diabetes Management

HbA1c Type 2 Maori



Diabetes Management

HbA1c Type 2 Total Population



Health Promotion

Purpose

Health promotion funding is a core part of revenue to Nelson Bays Primary Health (NBPH). NBPH has undertaken the strategic direction of reorienting its approach to programmes and services to align with comprehensive primary health care and health promotion philosophies.

Objective

NBPH is a health promoting organisation in which health promotion underpins and influences all activities from within the organisation and supports community development of health promotion initiatives for the various communities in our region.

Programme Description

Key areas of activity within Health Promotion for NBPH include:

- Supporting and building community capacity
- Developing health promotion 'group' initiatives that build community empowerment, sustainability and social support
- Community relevance and participation
- Linking initiatives between existing primary health care and community services
- Embedding health literacy principles in everything we do
- Strengthening health promotion across the wider primary health care sector
- NBPH organisational development.

Performance Summary

Programmes specifically addressing Māori health and other populations of health inequality include:

- **Māori Diabetes Education**
NBPH is supporting delivery of Type 2 Diabetes Education programmes for Māori and Pasifika via the Be Well Victory contract. Planning and relationships are currently in development.
- **Be Well Coordinators at Victory, Motueka, Golden Bay and Richmond**
The goal of these contracts is to improve health and wellbeing of high needs population groups.

During this reporting period we can report:

| | |
|------------------------------|--|
| Victory Community Health | 32 Maori have been supported with a health and wellness enquiry 3 Pasifika have been supported with a health and wellness enquiry 22 Pasifika have received Falls Prevention initiatives |
| Motueka Community House | 22 Maori have been supported with a health and wellness enquiry |
| Age Concern Nelson | 3 Maori have been supported with a health and wellness enquiry |
| Golden Bay Community workers | 1 Maori has been supported with a health and wellness enquiry |

- **Kaumatua Falls Prevention**
NBPH is currently working on the development of a programme best suited for Māori; a Kaupapa Māori Strength and Balance Falls Prevention programme for Kaumatua in Motueka and Nelson.
- **Support to Te Kahui Hauora o Ngāti Koata Trust staff for Aquatic training**
NBPH continues to support staff and volunteers from Te Kahui Hauora o Ngāti Koata Trust to deliver health education modules to participants attending the Aquatic swim programmes at Ngāwhatu Pool. Staff have gained significant motivation and confidence during this support and participant numbers are now reflecting this enhancement.
- **Māori GRx**
NBPH is working with Te Whare Hauora o Te Āwhina Marae, Te Amo Health and Whakatū Marae to develop and deliver a Māori Lifestyle Support programme targeting Māori. It is pleasing to report that Whakatū Marae have begun delivery on the Māori lifestyle programme.
- **Community Initiatives funding**
NBPH Community Initiatives Support aims to support non-government organisations with creative, innovative, community-identified health promotion initiatives that empower wellness for the Nelson Bays community. The following Community Initiatives Grant has been issued during this quarter which supports Māori:
 - Te Rapuora Health Services for a Whaia Ara Tika Tāne Retreat programme.

Implementation of Smoking Cessation ABC in Primary Care

Purpose

To reduce the prevalence of smoking in the Nelson Bays region and reduce the harm to health caused by smoking.

Objective

- To ensure smoking information is recorded, monitored and acted on by clinicians and healthcare workers.
- To actively promote the **ABC** approach to smoking cessation in the Nelson Bays region, where all people are: **A**sksed if they smoke, and if they are smokers, offered **B**rief Advice, and Smoking Cessation support.
- To ensure the ABC approach is integrated into everyday practice of all general practices so that an increasing percentage of their patients who smoke are provided with advice and help to quit.
- To ensure practice management systems record smoking status and that data collection is robust, providing feedback and evidence of performance to practices.
- To ensure training is provided to support staff to gain knowledge and skills to apply ABC effectively, and to provide timely and effective cessation support.
- To ensure quality improvement strategies are applied to the programme.
- To work collaboratively with the DHB-based and other community smokefree services to create a culture and environment that supports people to be smokefree and supports smokers to make Quit attempts.

Programme Description

This programme takes multiple approaches to achieve its objectives of upskilling general practice in the ABC approach to smoking cessation: embedding practice management system IT to collect data; using train-the-trainer education techniques offered in-practice by the Nelson Bays Primary Health Smokefree Facilitator; linking general practice to external smoking cessation providers using clear referral pathways; linking with DHB-based secondary care Smokefree Coordinator to ensure a transition from general practice to hospital and back to general practice with a focus on helping patients quit; to link the ABC approach to the new PHO Performance Programme smoking indicators for general practice.

Performance Summary

The PHO Performance Programme (PPP) has focussed on obtaining an initial target of >70% of enrolled patients aged 15-75 years with a smoking status recorded. Achieving this initial goal allows NBPH to participate in incentive payments for current smokers to be offered brief advice and smoking cessation from January 2011. The initial 70% goal was reached in the Jan-Mar 2011 quarter. In this quarter, progress has continued towards the national goal of 90% of enrolled patients aged 15-75 years with a smoking status recorded.

The Smoking Status information, collected via the PHO Clinical Performance Indicator report to the end of March 2011, shows that 76.7% (7422) of the high needs population have a smoking status recorded (up from 72.3% (6872) at the end of December); of those with a status recorded, 32.9% (2442) are current smokers. High needs population data represents Māori, Pasifika and those people residing in NZDep deciles 9&10. This information allows practices to target Māori as a priority group to offer brief advice and smoking cessation support.

Smoking Cessation

Purpose

To provide funding to all NBPH-aligned general practices to carry out smoking cessation counselling with patients within the general practice setting.

Objective

The objective is to identify high priority smokers and provide in-house cessation services and follow-up to assist them to quit.

Programme Description

The Smoking Cessation programme consists of the following components:

- Brief Intervention
 - A brief assessment of a smoker’s willingness to quit
 - Referral to an appropriate cessation programme if they are ready to quit
 - Provision of appropriate cessation messages if they are not ready to quit
 - There is no payment to practices for the brief intervention.
- Cessation Consultation
 - Intensive consultation for those smokers referred after a brief intervention
 - Development of a quit plan, providing practical problem-solving skills and offering nicotine replacement therapy as appropriate.
- Follow-up
 - 3 follow-up consultations are recommended for practice-based cessation services and may be claimed through this contract.

Performance Summary

A total of 498 claims were processed this quarter. There has been a continual increase in the numbers of patients accessing this programme over the past year and there has been an increase in the numbers completing the full programme as a result of the promotion of the smoking cessation guidelines throughout the region. Of those who completed the programme in this quarter, 24 (45%) report they are now smokefree and 20 (37.7%) have reduced their smoking. Māori and Pasifika peoples account for 18.9% of consultations made this quarter. The programme is currently within allocated funding and NBPH is able to open the eligibility to include those residing in NZ Dep quintiles 4 and 5 from 1 July 2010.

Māori are considered a priority population to receive Smoking Cessation services within general practice. This quarter, 90 claims received (18%) were for Māori accessing Smoking Cessation services within general practice, 36 had initial consultations, 27 follow-up 1 consultations, 21 follow-up 2 consultations and 6 follow-up 3 consultations. Of those who have fully completed the programme 3 report they are now smokefree and 3 have reduced their smoking.

| | | Quarter 1 | Quarter 2 | Quarter 3 | Quarter 4 | 1 July 2010 – 30 June 2011 |
|-----------------------------|--------------|------------|------------|------------|------------|----------------------------|
| Initial consultation | NZ Māori | 18 | 20 | 37 | 36 | 111 |
| | Pasifika | 5 | 4 | 2 | 3 | 14 |
| | Asian | 1 | 0 | 5 | 3 | 9 |
| | NZ European | 82 | 88 | 96 | 129 | 395 |
| | Other | 4 | 8 | 7 | 9 | 28 |
| | TOTAL | 110 | 120 | 147 | 180 | 557 |

| | | | | | | |
|----------------------------------|--------------|-----------|-----------|-----------|------------|------------|
| Follow-up 1 | NZ Māori | 10 | 14 | 21 | 27 | 72 |
| | Pasifika | 1 | 3 | 4 | 3 | 11 |
| | Asian | 2 | 1 | 3 | 4 | 10 |
| | NZ European | 40 | 46 | 67 | 111 | 264 |
| | Other | 4 | 1 | 4 | 8 | 17 |
| | TOTAL | 57 | 65 | 99 | 153 | 374 |
| Follow-up 2 | NZ Māori | 2 | 8 | 11 | 21 | 42 |
| | Pasifika | 0 | 1 | 4 | 1 | 6 |
| | Asian | 0 | 1 | 2 | 1 | 4 |
| | NZ European | 21 | 18 | 45 | 83 | 167 |
| | Other | 2 | 0 | 2 | 6 | 10 |
| | TOTAL | 25 | 28 | 64 | 112 | 229 |
| Follow-up 3 | NZ Māori | 1 | 5 | 11 | 6 | 23 |
| | Pasifika | 0 | 0 | 2 | 0 | 2 |
| | Asian | 0 | 1 | 2 | 1 | 4 |
| | NZ European | 18 | 16 | 28 | 43 | 105 |
| | Other | 1 | 0 | 0 | 3 | 4 |
| | TOTAL | 20 | 22 | 43 | 53 | 138 |
| Smoke free at follow-up 3 | NZ Māori | 2 | 2 | 7 | 3 | 14 |
| | Pasifika | 0 | 0 | 0 | 0 | 0 |
| | Asian | 0 | 1 | 1 | 0 | 2 |
| | NZ European | 14 | 9 | 17 | 20 | 60 |
| | Other | 1 | 0 | 0 | 1 | 2 |
| | TOTAL | 17 | 12 | 25 | 24 | 78 |

Green Prescription (GRx)

Purpose

A Green Prescription (GRx) is a health professional's written advice to a patient to be physically active, as part of the patient's health management. It is a cost-effective way to assist and support the patient as they work towards staying active and achieving better health outcomes.

Objective

The core objectives of the Green Prescription (GRx) programme are to:

- Increase levels of physical activity in the adult population, building on the National Health Committee (NHC) and Ministerial Taskforce recommendation of 30 minutes of moderate physical activity on most days;
- Enable GPs and Practice staff to improve the overall health and wellbeing of their patients;
- Provide an effective and evidenced-based tool (programme) to GPs and practice staff to reinforce the "Get Active" message to patients.

Programme Description

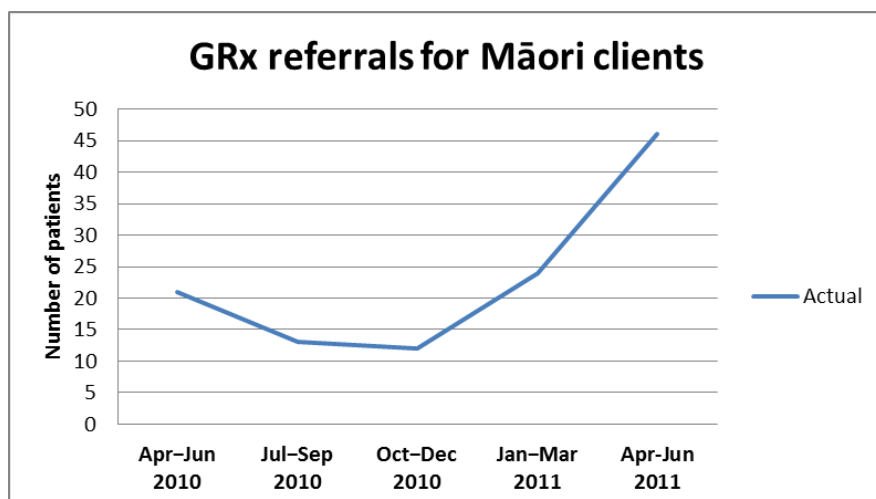
NBPH use GRx as a method by which member GPs and their practice staff and other health care providers promote physical activity to their patients and to deliver GRx as per MoH guidelines. For NBPH the annual expected GRx referral numbers for 2010/2011 is 1284.

Performance Summary

NBPH GRx coordinator is continuing to support Te Kahui Hauora o Ngāti Koata Trust staff as they continue encouraging whānau to participate in the pool programme. It is an on-going success story – classes have been structurally improved, education sessions provided and it is very pleasing to see the creativity and thought going into these sessions. The weekly Tāne aqua class has room for more men but as this session is during a lunch time this may preclude some from attending. Updates with the instructor are held and feedback given regularly.

At Te Āwhina Marae Māori GRx support is now provided. Together with office-based appointments, accessing the marae gym room and linking with the Te Amo Health nurse we are confident of an improved service for Motueka whānau.

Whakatū Marae Whānau Ora GRx service is progressing well and building an excellent base for supporting whānau to improve their health and wellbeing.



Strengthening Families (Whakapiripiri Ngā Whānau)

Purpose

Strengthening Families is a community-based initiative that helps families/whānau in Aotearoa New Zealand get access to the services they need. Strengthening Families brings together a family and all the agencies that have a part to play in helping that family. Together, the family and agencies develop an action plan that reflects the family's needs and a lead agency is identified.

Objective

Strengthening Families aims to shift the focus from crisis intervention to providing early support to families, so as to prevent difficult situations from escalating. The Strengthening Families process is designed to better co-ordinate support to families/whānau that requires a multi-agency co-ordinated approach.

Programme Description

Strengthening Families Facilitators play an important part in ensuring that a family's voice is heard and that an agreed multi-agency plan is developed. Facilitators are trained and experienced in facilitation, have a good understanding of the principles of the Strengthening Families model and are independent of the key agencies working with the family. Facilitators have access to training and supervision. The facilitator of Strengthening Families case conference will have been agreed to by the family/whānau and does not have a case-work relationship with the family.

Performance Summary

The LMG includes representation by the Māori health provider Te Kahui Hauora o Ngāti Koata. The Strengthening Families Coordinator ensures that whānau have a number of choices in regards to where whānau hui is held, who will be invited to attend, which of the Māori facilitators will guide the process and which service will take a lead to oversee the implementation of the action plan. Four Māori facilitators are currently engaged in the facilitator pool and represent these agencies: Te Kahui Hauora o Ngāti Koata, Family Start, and Big Brothers Big Sisters.

In this quarter 13 new families have been referred. These cases have involved 29 children and young people. Of the 29 children referred 15 (51.7 %) of the children and young people who were the subject of referral identified as Māori. (Note: 36.4% financial year 2010/11).

Number of Children by Age and Ethnicity April - June 2011.

| Ethnicity | NZ European | | Māori | | Other | | Not Stated | | Total | | |
|-------------------|-------------|----------|-----------|----------|----------|----------|------------|----------|-----------|-----------|-----------|
| | M | F | M | F | M | F | M | F | M | F | All |
| 0-5 years | 3 | 2 | 6 | 2 | 1 | 0 | 1 | 0 | 11 | 3 | 14 |
| 6-10 years | 1 | 0 | 2 | 1 | 0 | 0 | 0 | 1 | 3 | 2 | 5 |
| 11- 13 yrs | 0 | 2 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 3 | 3 |
| ≤14 years | 2 | 2 | 2 | 1 | 0 | 0 | 0 | 0 | 4 | 3 | 7 |
| Total | 6 | 6 | 10 | 5 | 1 | 0 | 1 | 1 | 18 | 11 | 29 |

Most common presenting issues; Parenting skills/child management issues, behaviour at school, isolation from whānau/financial hardship, lack of support and housing issues.

Primary Mental Health Brief Intervention Service

Purpose

To deliver a primary mental health Brief Intervention Service (BIS) across our region.

Objective

The service will have an immediate and significant impact on health outcomes for consumers by empowering primary care providers to use more flexible and responsive alternatives for people with moderate mental health problems.

Programme Description

NBPH has three mental health workers: a Motueka-based worker and two Nelson-based workers, who make up the BIS team. The service can accept referrals from Māori organisations and GPs. The service offers up to four sessions with the service user to provide support, assessment, treatment or referral to appropriate services. The service may include other family members or support person as appropriate. The emphasis is on assisting the service user to identify and build resilience through recognising their strengths and abilities to take control of their life, with a recovery focus.

Performance Summary

It was envisaged that this service would help identify currently unmet need and provide better information on the mental health needs of the Māori community. Māori organisations can refer directly to the Brief Intervention Service.

Referral numbers remain steady. The total number of clients referred to the BIS service during this quarter was 161. This was similar to the previous quarter (minus Feb Christchurch earthquake presentations).

Where ethnicity is stated 16% (26) of the referrals for this quarter were for Māori tāngata whaiora. Of those referrals, Māori organisations were responsible for making 3 referrals to BIS for persons identifying as Māori. Not all referrals from Māori organisations are for Māori and not all consumers who are Māori have been referred by Māori organisations.

Depression (43%) and anxiety (25%) continue to be the most common diagnosis given by GPs for clients that have been referred to the service. The most common reasons for referral (not diagnosis) for the period included (in no specific order):

- Relationship issues
- Work related stress
- Sleep disturbance and ruminating thoughts

Females made up a larger percentage 22 (85%) of the referrals, than did males 4 (15%). The age range 18 – 25 years accounted for the largest percentage 8 (31%) of referrals.

Referrals by ethnicity for 1 April 2010 to 30 June 2011

| Ethnicity | Number of referral this quarter | | | | | Percentage of total | | | | |
|-------------|---------------------------------|------|------|------|------|---------------------|------|------|-------|------|
| | 2010 | 2011 | 2012 | 2013 | 2014 | 2010 | 2011 | 2012 | 2013 | 2014 |
| Māori | 21 | 11 | 26 | 29 | 26 | 20% | 8% | 13% | 15.5% | 16% |
| NZ European | 82 | 128 | 154 | 150 | 135 | 80% | 92% | 85% | 81% | 84% |
| Other | 0 | 0 | 3 | 6 | 0 | 0 | 0 | 2% | 3.5% | 0 |
| Total | 103 | 139 | 183 | 185 | 161 | 100% | 100% | 100% | 100% | 100% |

Primary Mental Health Initiative

Purpose

To ensure that people with mild to moderate mental health problems have access to appropriate services as soon as possible, within available resources. The role of primary care practitioners is to ensure that individuals return to their full level of functioning by identifying and subsequently managing a mental health problem.

Objective

The service will have an immediate and significant impact on health outcomes for consumers by empowering primary care providers to use more flexible and responsive alternatives for people with mild to moderate mental health problems.

Programme Description

The Primary Mental Health Initiative (PMHI) is open to all GPs and Māori organisations. Extended GP consultations and packages of care are used to help individuals address mild to moderate mental health problems. There is no charge to consumers for this service. Nelson Bays now has two choices for referrers, PMHI or the Brief Intervention Service (BIS). BIS is also free to consumers and is provided by staff employed by NBPH.

Performance Summary

During this quarter 372 referrals were made to the Primary Mental Health Initiative. GP practices and Māori Providers continue to make good use of the initiative. The impact of the PMHI is indicated using a before-and-after measure of psychological distress which is completed by consumers. NBPH uses the PHQ9 for this purpose. The overall average change in the PHQ9 score for this quarter is a 5.4 point drop.

Māori organisations have open access to the Primary Mental Health Initiative. At this point in time rationing does not apply to referrals from Māori organisations.

Where ethnicity is stated 7.5% (28) of the total referrals for this quarter were for Māori tāngata whaiora. Of those referrals, Māori organisations were responsible for making referrals to the PMHI for 14% of those persons. Not all referrals from Māori organisations are for Māori and not all consumers who are Māori have been referred by Māori organisations.

Females made up a larger percentage 18 (65%) of the referrals, than did males 10 (35%). The age range 45-54 years accounted for the largest percentage (28%) of referrals, followed by both 18-25 years and 26-35 years of age (21%). Similar to last quarter, there were no referrals to PMHI for the age ranges 46-55 years or 56-65 years.

Referrals to PMHI by ethnicity, 1st April to 30th June 2011

| Ethnicity | Referral Numbers | Percentage of total |
|------------------------------|-------------------------|----------------------------|
| NZ European | 320 | 86% |
| Maori | 29 | 7.5% |
| Pacific Island | 6 | 1.5% |
| Other (European or SE Asian) | 18 | 5% |
| Total | 373 | 100% |

Pilot Youth Alcohol and Other Drug Service

Purpose

This report is to inform NMDHB about the activities that have occurred as a result of contracting Nelson Bays Primary Health (NBPH) for the Pilot Youth Alcohol and Other Drug (AOD) Service during January, February and March 2011.

Objective

The contract is to deliver a Youth AOD service to:

- Provide a mobile, community-based service, which is culturally appropriate;
- Improve the access to AOD services for young people with co-existing mild to moderate mental health/alcohol and other drugs diagnosis;
- Initially, provide this service for students in Alternative Education (AE) and in Youth Transition Services (YTS) in the 14–18 years age group.

Programme Description

This is a one-year pilot project, staffed by a 0.5FTE position. The service is primarily a mobile counselling service for young persons with a current mental health and AOD diagnosis of mild to moderate severity. The clients of this service will be students enrolled in Alternative Education (AE) and Youth Transition Services/Facilities specified. The pilot includes establishing an evaluation methodology.

Performance Summary

NBPH has employed a Youth Alcohol and Other Drugs Counsellor in a 0.5FTE position. Helen Inkster, Registered Clinical Psychologist, started on 31 August 2010. The Youth AOD Counsellor takes referrals directly from the Nurse employed under the Targeted Youth Health Service.

A co-operative working relationship has developed and continues to develop between the YAOD counsellor and AOD counsellors from both Ngāti Koata and Te Āwhina Marae. The CAMHS Tamariki/Rangatahi worker and YAOD counsellor have developed a relationship fostering working in a culturally appropriate manner.

| Referrals | Q1 10/11 | Q2 10/11 | Q3 10/11 | Q4 10/11 |
|-----------------------------------|----------|----------|----------|----------|
| Number Referred | - | 17 | 13 | 5 |
| Number Discharged | - | 8 | 8 | 4 |
| Active Clients as of 30 June 2011 | - | 9 | 14 | 11 |

| Ethnicity | Q1 10/11 | Q2 10/11 | Q3 10/11 | Q4 10/11 |
|-----------------------------------|----------|----------|----------|----------|
| Number Māori Referred | - | | 6 | 2 |
| Number Discharged | - | | | 4 |
| Active Clients as of 30 June 2011 | - | | | 4 |

Associate Director of Nursing, Primary Health

Purpose

The purpose of this position is to provide nursing leadership, strategic direction and advice for primary care nursing in the Nelson Bays region. The role is pivotal to strengthening nursing capacity and capability within general practice. This role is also responsible for the line management of appropriate nursing roles within Nelson Bays Primary Health (NBPH).

Objective

- Provide effective clinical nursing leadership in partnership with NMDHB Director of Nursing and Midwifery (DONM) across the primary health care nursing network
- Influence and lead the Nelson Marlborough District Health Board (NMDHB) and NBPH strategic directions for primary health care nursing
- Provide effective and focused line management for appropriate and designated nursing roles within NBPH
- Provide effective and timely leadership for primary health care nursing workforce development and initiatives
- Provide nursing leadership to practice nurses within general practice and other community settings, including implementing new evidence-based clinical programmes and assisting the General Practice Programme Coordinator with clinical audit review and feedback and quality improvement initiatives e.g. PHO Performance Programme.

Programme Description

- To provide Continuing Nursing Education (CNE) of a high quality that meets the learning needs of primary care nursing workforce especially in general practice
- Develop a strategic overview of all primary health care nurses and the activities in which they are engaged across Nelson Bays region, ensuring optimisation of the impact of these professionals currently and into the future
- Ensure all professional nursing care is focused on clients and their family/whānau and groups cared for in the community by primary health care nurses.

Performance Summary

This quarter has seen a period of establishment for the role of Associate Director of Nursing, Primary Care. The focus has been to orientate to the position, develop linkages with key nursing groups and establish the position as a leader of nursing in the Nelson Tasman region. In addition, line management has been demanding with the orientation and induction of five new nurses into NBPH, providing direction, support and leadership to enable them to develop relationships with general practice and the wider primary health care community. The objective of increasing visibility of the ADON, Primary Care position through linking with practice nurses and wider primary health care nursing networks has been met head on, with many opportunities especially education forums to meet this challenge.

Other activities supported by the ADON:

- Supporting the Māori health representative on the Nursing Advisory Forum
- Supporting Māori primary health care nurses to access clinical training
- Support and guidance of Enrolled Nurse transitioning to new scope of practice at Te Korowai Trust
- Supporting the outreach nursing model at Tahuna Medical Centre for young at-risk families
- Supporting the on-going development of the Māori primary health care forum.

Targeted Youth Health Service

Purpose

To improve outcomes for students in Alternative Education (AE) and in Youth Transition Services (YTS). This is done by providing health assessments, improving access to primary health care and improving interagency partnerships.

Objective

- Improve the access to primary health care of young people with high needs, specifically students in Alternative Education (AE) and in Youth Transition Services (YTS);
- Ensure that appropriate and timely referrals are made in order to improve youth health and reduce inequalities;
- Promote overall improvement in the provision of services to young people in this district, through developing workforce and best practice approaches.

Programme Description

This service is primarily a nursing service provided by registered nurses who are skilled in youth health and youth development. The clients of the service are students enrolled in Alternative Education (AE) and Youth Transition Services. The focus of the services is on improving outcomes for individuals and reducing inequalities.

Performance Summary

The data presented in this report is a representation of the numbers delivered from 1 April to 30 June 2011. There were 50 health clinics held this quarter. There were 69 initial youth health assessments completed in the quarter and four annual health checks. There were 423 follow-ups this quarter. The service has typically seen a considerably high percentage of Maori, than would be expected. For the quarter, of the health assessments completed, 42% of the clients (29) identified as Maori.

Health Assessments by Ethnicity July 2010 to June 2011

| Ethnicity | July – Sept 2010 | Oct – Dec 2010 | Jan – March 2011 | April – June 2011 |
|---------------|------------------|----------------|------------------|-------------------|
| NZ Pākehā | 45.8% | 50.9% | 51.5% | 55% |
| NZ Māori | 41.1% | 34.5% | 43.5% | 42% |
| Other | 13.1% | 14.6% | 5% | 3% |
| Total Numbers | 85 | 55 | 65 | 69 |

Health Assessments by Gender July 2010 to June 2011

| Gender | July – Sept 2010 | Oct – Dec 2010 | Jan – March 2011 | April – June 2011 |
|---------------|------------------|----------------|------------------|-------------------|
| Male/Tāne | 60.66% | 55% | 55.3% | 55% |
| Female/Wāhine | 38.66% | 45% | 44.6% | 45% |
| Total Numbers | 85 | 55 | 65 | 69 |

Main issues students present with include: Drugs, Alcohol and other drugs; Sexual Health; Mental Health; Oral Health; Vision and Hearing.

Community Asthma

Purpose

This report is a summary of the activities which have occurred as a result of contracting the Nelson Asthma Society for the community asthma service during April, May and June, 2010.

Objective

The contract with the Nelson Asthma Society is to deliver a community-based asthma and chronic obstructive pulmonary disease (COPD) and education service, which entails interdisciplinary, cross-sectoral care teams providing comprehensive, holistic and continuous health services to enrolled populations of people with asthma and COPD.

Programme Description

This service is focussed on people with mild, moderate and severe asthma and chronic obstructive pulmonary disease. It includes treatment, assessment, medication, health education and management plans.

Performance Summary

The data presented in this report is a representation of the numbers delivered from 1 April 2010 to 30 June 2010. Data collection has been via the new database designed and constructed by NBPH staff which has been transferred over to a new reporting template.

In this quarter:

- 122 new individuals seen by the service
- These individuals presented as follows:
 - Mild: 42
 - Moderate: 60
 - Severe: 47
- 22 self-management plans produced
- 63 follow-up reviews were completed
- 15 Community Education Sessions held.

| Ethnicity | Number of new patients |
|-----------|------------------------|
| Māori | 7 |
| Pasifika | 1 |
| Other | 114 |

A Professional Development Session was delivered at Te Awhina Marae during Asthma Awareness week.

Care Plus

Purpose

To provide funding to all NBPH-aligned general practices to target people with high health needs due to chronic conditions, acute medical or mental health needs, or terminal illness. Care Plus is a national primary health care initiative, rolled out in July 2004.

Objective

- To improve a patient's chronic care management through better understanding of their conditions and support to make lifestyle changes.
- To reduce inequalities, a percentage of Care Plus places must be allocated to deprived people, and Māori and Pasifika people.
- To improve primary health care teamwork.
- To reduce the cost of services for high-need primary health users.

Programme Description

Patients, identified as eligible, are offered an initial comprehensive assessment where their health needs are explored in more depth. An individual care plan is developed to set realistic, achievable health and quality of life-related goals, with quarterly follow-ups. Claims are made electronically via the Practice Management System.

Performance Summary

There are currently 4249 patients registered in the Care Plus programme (down from 4393 last quarter). At the end of the quarter, registrations were at 82% of the eligible population, which is 2% less than last quarter.

| Activity | |
|---------------|------|
| Registrations | 1067 |
| Reviews | 2458 |
| Exits | 282 |

| Current Registrations by Ethnicity | |
|------------------------------------|------|
| Māori | 331 |
| Other | 3884 |
| Pasifika | 34 |

| Current Registrations by Deprivation | Number | % of Total Registrations |
|--------------------------------------|--------|--------------------------|
| Quintile 0 | 76 | 1.8 |
| Quintile 1 | 558 | 13.1 |
| Quintile 2 | 938 | 22.1 |
| Quintile 3 | 894 | 21.0 |
| Quintile 4 | 1267 | 29.8 |
| Quintile 5 | 516 | 12.1 |

The NBPH Care Plus programme has 331 Māori currently registered at the end of this quarter (up from 314 last quarter) and there were 164 reviews this quarter. For Māori residing in NZ Dep quintile 5, enrolment is at 109% of the eligible population. Analysis of Care Plus enrolments shows that 7.8% of the enrolments in Care Plus are for Māori.

Care Plus Exceptional Circumstances

Purpose

To provide funding to all NBPH-aligned general practices to target people with high health needs due to chronic conditions, acute medical or mental health needs, or terminal illness. Exceptional Circumstances funding is extra funding for patients who have an acute exacerbation of their illness.

Objectives

- To assist in the acute care of a patient with an acute exacerbation of a chronic disease.
- To ensure the patient receives timely access to care, where cost may be a barrier, so that hospitalisation can be avoided.
- To allow practices discretion in funding patients they think will most benefit from this top-up funding.

Programme Description

Patients, with an acute exacerbation of a chronic condition, may access general practice for a consultation that may prevent hospitalisation, without cost as a barrier. Claims are made electronically via the Practice Management System to NBPH.

Performance Summary

Patients, with an acute exacerbation of a chronic condition, may access general practice for a consultation that may prevent hospitalisation, without cost.

In this quarter there have been 365 consults for 241 patients in 22 practices with \$12,987 paid in claims. This is considerably more activity than last quarter, probably because this quarter represents the end of the financial year for this programme. Twelve practices have now reached 100% of their allocated funding. Two practices have not used the programme at all, indicating 24/26 practices have accessed some degree of the funding. The practices that have not accessed the programme have very few patients on Care Plus and the opportunities to use the funding according to the eligibility criteria have been limited. General practices have continued their favourable response to the use of the discretionary funding element of this programme. The Nelson Marlborough District Health Board has provided an on-going contract for this programme.

Trend of Care Plus EC Claims

