

# East Health Trust

Primary Health Organisation

Annual report  
2014 - 2015





# About Us

East Health Trust is a primary health organisation with medical provider teams across the Howick, Pakuranga, Botany, Half Moon Bay, Beachlands, Maraetai, Clevedon and Manukau areas. Via our general practice clinics with 98 General Practitioners and over 80 Practice Nurses we provide healthcare services to 98,768 enrolled patients. East Health's enrolled population continues to grow, increasing by nearly 6,000 people this year.

**East Health Trust PHO strives continually to deliver high quality healthcare based on core strategic initiatives, to:**

- Improve health and wellbeing especially for those with the greatest health needs
- Provide a collaborative coordinated response in community health care
- Commit to continuously improve quality services
- Promote leadership and innovation
- Develop and support the primary care workforce
- Secure viability and sustainability of health initiatives

It is with great pleasure the East Health Trust PHO Board of Trustees presents this 2014-2015 Annual Report.

## Values

- Empowerment of individuals, providers and the community to improve health and wellbeing
- Integrity
- Fairness
- Respect for the individual
- Collaboration
- Professionalism, skills and knowledge
- Cultural diversity

## Mission Statement

**East Health Trust Primary Health Organisation, for its enrolled and potential population and community, will:**

- Empower personal and community health & wellbeing by promoting quality information, facilitating innovative programmes and endorsing healthy lifestyle choices
- Ensure the provision of quality preventative and interventional medical care
- Enhance the skills and knowledge of personnel and providers
- Ensure that everyone is treated with respect and dignity, their culture is valued and the principles of the Treaty of Waitangi are acknowledged.



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# Chairman's Report



I am pleased to report that to the year end 30 June 2015 East Health Trust PHO has continued to set high standards of care for its community and build on gains made from previous years.

There continues to be a healthy relationship and cooperation at all levels of the Trust as we continue to strive to improve the health and wellbeing of our community and provide cost effective, high quality medical care.

## Leading Health Target Achievements in New Zealand

Our general practice teams have continued to work hard together this year and their significant contributions are reflected in the Integrated Performance and Incentive Framework (IPIF) results. East Health Trust was ranked one of the top two PHOs in the country based on achievement of IPIF targets.

## Programme Expansion

There has been a very good uptake of programmes which are promoted to improve the health of our community by the general practice teams and the community itself. These include Self Management for diabetes, weight and smoking cessation, Osteoarthritis Physiotherapy, Falls and the Healthy Eating Active Lifestyle programme.

The At Risk Individual Programme use continues to grow. It has encouraged the development of multidisciplinary teams and innovation to assist patients to develop better understanding of their conditions and better health.

## Building Capability Through Innovation

East Health Trust PHO presented its first Health Symposium in September 2015. A multidisciplinary programme of seminars were provided aimed at clinic administration staff, practice nurses and general practitioners. Overall it was extremely successful and congratulations go to the organisers.

A significant piece of work for East Health Trust PHO this year has been developing innovative business intelligence to assist our general practice teams with integrated, centralised data analytics. A data warehouse is the platform that will inform proactive patient care planning and decision making. It will also support East Health's drive for continual quality improvement and enable us to better monitor our community's health, and forecast future health trends rather than acting reactively.

## Building Strong Foundations for Better Health of our Community

East Health Trust PHO, a partner in the Counties Manukau Health District Alliance, is the lead PHO for the Eastern Locality supporting the district governance group's plans for improved integration between primary and secondary services, and more 'joined-up' planning around local health needs and local models of care.

The development of a local community health hub has been a key focus for East Health Trust PHO, in conjunction with Counties Manukau Health this year. The health hub, planned for Botany Road, will be designed to allow more services to be devolved closer to where our community lives, so health services that cannot be accessed through the GP will still be provided in a facility closer to the patients home. Avoiding lengthy and overnight hospital stays.

## Governance & Leadership

The Board of Trustees continues to function well contributing their skills and experiences to the effective governance of the Trust. Members of the Trust have continued to contribute their skills to various committees, programmes and organisations at Counties Manukau Health, regionally and nationally.

The success of the Trust undoubtedly could not have been but for the dedicated and hardworking management staff. Similarly there have been significant contributions from the Clinical Advisory Committee and Community Advisory Committee.

Finally I would like to thank the hardworking general practice teams who have been crucial to the continuing care and improvement of the health status of our patients.

A handwritten signature in black ink, appearing to read 'DK Lee', written over a light blue horizontal line.

Dr Denis Lee  
Chairman  
East Health Trust PHO

# Our People



ENROLLED  
POPULATION  
**98,768**

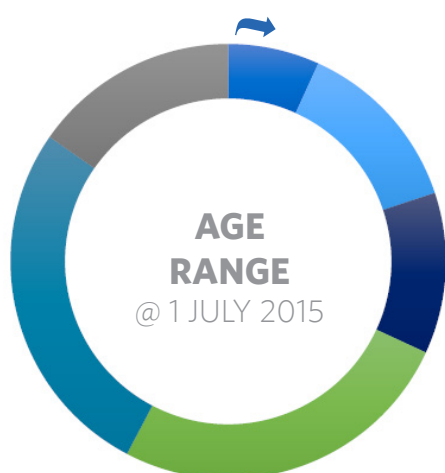


GP COUNT  
**98**  
NURSE COUNT  
**84**

FTE GP/  
PATIENT  
RATIO  
**1358**



	PERCENTAGE BY POPULATION	NUMBER OF PATIENTS
European	65.6%	64,778
Maori	3.3%	3,209
Pacific Island	2.4%	2,411
Asian	25.6%	25,270
Other	2.6%	2,575
Not Stated	0.5%	525



	PERCENTAGE BY POPULATION	NUMBER OF PATIENTS
0 - 5 years old	6.8%	6,727
5 - 14 years old	13.1%	12,975
15 - 24 years old	12.0%	11,800
25 - 44 years old	25.8%	25,453
45 - 64 years old	27.0%	26,734
65+ years old	15.3%	15,079







# Governance and Leadership

East Health Trust PHO is governed by a team of dedicated and experienced Trustees, Chief Executive Officer, and two appointed sub-committees with delegated duties and responsibilities.

MEMBER	PROVIDER REPRESENTATIVE	PORTFOLIO HELD	ROLE
<b>Dr Denis Lee</b> (Chairman)	Management Services Organisation: East Health Services Ltd	<ul style="list-style-type: none"> <li>◦ Operational</li> <li>◦ Finance</li> <li>◦ Clinical Governance</li> <li>◦ Clinical Programmes</li> <li>◦ Organisational Relationships</li> </ul>	General Practitioner
<b>Dr Brett Hyland</b>	Principal General Practitioners	<ul style="list-style-type: none"> <li>◦ Strategy</li> <li>◦ Finance</li> <li>◦ Operational</li> </ul>	General Practitioner
<b>Dr Richard Coleman</b>	Principal General Practitioners	<ul style="list-style-type: none"> <li>◦ Clinical Governance</li> <li>◦ Clinical Programmes</li> <li>◦ Finance</li> </ul>	General Practitioner
<b>Dr John Betteridge</b>	Associate General Practitioners	<ul style="list-style-type: none"> <li>◦ Organisational Relationships</li> <li>◦ Operational</li> </ul>	Locum General Practitioner
<b>Sheila Alexander</b>	General Practice Nurses	<ul style="list-style-type: none"> <li>◦ Clinical Governance</li> <li>◦ Clinical Programmes</li> <li>◦ Organisational Relationships</li> </ul>	Locum Practice Nurse
<b>David Bryant</b>	Community	<ul style="list-style-type: none"> <li>◦ Community Liaison</li> <li>◦ Finance</li> </ul>	
<b>Kitty Chiu</b>	Asian Community	<ul style="list-style-type: none"> <li>◦ Community Liaison Asian population</li> <li>◦ Strategy</li> <li>◦ Operational</li> </ul>	



## Sub-Committees

CLINICAL ADVISORY COMMITTEE	OCCUPATION
<b>Denis Lee (Chair)</b>	<b>Director/Trustee/General Practitioner</b>
<b>Loretta Hansen (CEO, East Health Trust PHO)</b>	<b>Chief Executive Officer</b>
Anna Stevenson	Clinical Advisory Pharmacist
Anne Williamson	Coordinator of Service for Older People
Cathy Martin	Practice Operations and Quality Manager
David Harrison	Nurse Leader
Dr Eileen Sables	General Practitioner
Dr Kulvant Singh	General Practitioner
Dr Marcus Hawkins	General Practitioner
Dr Richard Coleman	General Practitioner
Dr Simon Russell	General Practitioner
Mel Beattie	Practice Nurse
Karen McCormick	Practice Nurse
Jordyn Kipa (minute-taker)	Project Administrator

COMMUNITY ADVISORY COMMITTEE	OCCUPATION/REPRESENTATIVE
<b>David Bryant (Chair)</b>	<b>Trustee</b>
<b>Loretta Hansen (CEO, East Health Trust PHO)</b>	<b>Chief Executive Officer</b>
Chris Bolton	People living with a disability
Kitty Chiu	Asian population
Penelope Frost	Auckland Regional Manager, Stand Children's Services
Lance Watene	Senior Community Development Facilitator, Auckland Council
Jordyn Kipa (minute-taker)	Project Administrator



# Clinic Teams

## **Beachlands Medical Centre**

44 Wakelin Road, Beachlands

## **Botany Doctor Medical Practice**

564 Chapel Road, Botany Downs

## **Botany Junction Medical Ltd**

110 Michael Jones Drive, Flat Bush

## **Botany Terrace Medical Centre**

301/F Botany Road, Golflands

## **Botany Town Centre Medical Practice**

564 Chapel Road, Botany Downs

## **Clevedon Village Medical Centre**

9 Main Road, Clevedon

## **Crawford Medical Centre**

4 Picton Street, Howick

## **Eastern Family Doctors**

Unit L, 17 Aviemore Drive, Highland Park

## **Eastside Family Doctors**

98 Ti Rakau Drive, Pakuranga

## **Highgate Surgery**

139 Millhouse Drive, Howick

## **Highland Park Medical Centre**

14 Highland Park Drive, Highland Park

## **Howick House Medical Centre**

43 Moore Street, Howick

## **Juliet Ave Surgery**

59 Juliet Avenue, Howick

## **Marina Medical**

Level 1, Compass Building, The Marina, Half Moon Bay

## **Millhouse Integrative Medical Centre**

128 Millhouse Drive, Howick

## **M.I.T Health and Counselling Centre**

Gate 9, S Block, South Campus, Otara Road, Otara

## **Pakuranga Medical Centre**

17 William Roberts Road, Pakuranga

## **Picton Street Surgery**

12 Picton Street, Howick

## **Selwyn House Medical Centre**

46 Wellington Street, Howick

## **Sommerville Surgery**

E3 119 Meadowlands Drive, Howick

## **The Doctors - Ti Rakau**

316 Ti Rakau Drive, East Tamaki

## **Vincent Street Family Doctors**

80A Vincent Street, Howick



# Achievements/Highlights

## Excelling in Health Target Achievement in 2014/15

### Increased Immunisation

**East Health Trust PHO achieved in the highest 2% of PHOs across New Zealand** exceeding the national immunisation target, reaching 97% of all eight-month-olds having their primary course of immunisation at six weeks, three months and five months on time.

### Smoking

Ranked in the top 10 of all PHOs, **East Health Trust PHO were in the highest category delivering smoking brief advice and cessation support for patients** who smoke, reaching 95% of all smokers.

### More Heart & Diabetes Checks

Coming in within the top 3% across the country reflects the dedication and commitment of PHO staff and clinics to improve cardiovascular risk screening and diabetes checks for the enrolled population. **91% of all eligible patients received a CVD risk assessment** within the last five years.

## At Risk Individuals

Rollout across the PHO clinics this year of the At Risk Individual (ARI) programme is delivering more innovative health interventions and proactive care planning to patients. ARI is a key element supporting primary care to extend services and operate as 'healthcare homes' for the enrolled community, encouraging patients and whaanau to self-manage their health and stay well.

**21 of our 22 clinics are delivering the ARI programme.** Uptake has increased throughout the year providing targeted care and services to over 2,000 patients, and growing.

## Patient Portal - Health Care Online

Patient Portals are a secure and convenient online tool that helps patients to interact and communicate with their healthcare providers. This year a key focus has been to grow portal implementation across our clinics to further encourage patients and whanau to self manage their health and engage as partners in their own health care.

- **Five clinics now provide electronic portal access to core health information**
- **12,151 enrolled patients are now accessing their own portal**

## Data Warehouse

In January 2015 development began on the data warehouse, an innovative solution that will transform how we collect, store and analyse a range of information to support better patient health.

The project supports:

- **Planning aggregate services to meet future population needs**
- **Identification of individuals at risk of high-impact/high-cost diseases, for pre-emptive intervention and proactive patient care planning**
- **Understanding performance of programmes in achieving health policy goals**
- **Quality improvement and feedback to individual services**

Project production is well advanced and now in validation phase to identify gaps in information and highlight any process improvements.

## Inaugural Health Symposium

East Health Trust PHO launched a successful health symposium in May 2015, held at Waipuna Hotel and Conference Centre.

- **26 Physicians and Specialists from Counties Manukau Health, Auckland City Hospital, General Practice and East Health Trust PHO**
- **22 practical, interactive and engaging relevant health and personal performance workshops**
- **Over 120 delegates attended the one day event.**

*A future symposium is planned that builds upon this year's event*





# Eastern Locality Clinical Partnership

The Eastern Locality, a cohesive partnership between primary and secondary health care includes twenty two general practice clinics belonging to East Health Trust PHO, four ProCare clinics and one National Hauora Coalition clinic. The Eastern Locality enrolled population is 104,144; the Eastern Locality residential population is 142,488.

The Eastern Localities plan for the 2014/15 period included the establishment of two exciting new programmes:

## Early Intervention Osteoarthritis Programme

A local Osteoarthritis Physiotherapy Course for early intervention in osteoarthritis of the hips and knees started in August 2014 to address the burden and the high impacts on quality of life for people with osteoarthritis.

Osteoarthritis affects around 15% of adults in NZ and is an increasing problem for younger people due to obesity. The Eastern Locality has approximately 15,000 people over 65 years old, many of whom are expected to have osteoarthritis.

85 people with an early osteoarthritis diagnosis have been referred to this physiotherapist-led, inter-professional programme of education, self-management, exercise (range of movement, flexibility, strengthening cardiovascular components), nutrition and medication management over five sessions.

At conclusion the course provides facilitating entry into existing community programmes such as gentle exercise class, Never 2 Old, Tai Chi or Aqua Aerobics to empower people to maintain and build on gains made through the programme.

## Collaborative Joint Replacement Alternative Pathway Pilot

A new integration initiative between East Health Trust PHO and the Counties Manukau Health surgical team, launched this year, supports people through coordinated inter-professional care to self-manage their moderate-severe osteoarthritis with a view to delay or prevent the need for joint replacement surgery, if appropriate.



# Quality

## Provider Education & Professional Development

Improved patient care is at the heart of East Health Trust PHO's focus for ongoing, meaningful professional development. Local providers are supported through the wide and varied range of continuing education sessions and professional development offered by East Health.

In 2015 our programme delivered 45 education sessions to general practitioners, nurses and administrators aimed to maintain and grow skills related to provision of primary health care throughout the community, including local school nurses and aged residential care nursing staff.

Additional Mental Health specific related education was provided, in collaboration with Counties Manukau Health, in the hugely popular South Auckland Special Interest Group (SASi) sessions held at Counties Manukau Super Clinic to clinicians and allied health, who work in both primary and secondary care services. More recently workshops have extended to include workers from NZ Police, Corrections and the education sector.

East Health advises and supports our practice nurses to maintain their professional development under the district-wide Professional Development and Recognition Programme (PDRP). Our trained PDRP assessor provides nurse portfolio assessment, in line with Counties Manukau Health evidence guidelines, leadership to nurses as well as support and evaluation of competency for Primary Care Nursing to meet Nursing Council requirements.

## High Performance against Health Targets for 2014/15



Successful achievement against all but one of the 2014/15 National Health Targets contained in the Integrated Performance Incentive Framework (IPIF), was the culmination of dedicated hard work by our general practice and PHO teams.

IPIF is designed by primary care representatives, DHBs and the Ministry of Health to support the health system to improve the health of New Zealanders and reduce inequalities in health outcomes. The PHO provides clinical leadership, education and a range of innovative supports to help clinics develop their internal processes to achieve increased immunisation and cervical screening rates, more heart and diabetes checks for patients and better help for smokers to quit.

### IPIF Clinical Indicator (total population)



#### CVD Risk Assessment

Target | 90% East Health Achieved | 91.48%



#### Cervical Screening

Target | 80% East Health Achieved | 82.19%



#### Smoking Status Recorded

Target | 90% East Health Achieved | 95.91%



#### Smoking Brief Advice & Cessation Support

Target | 90% East Health Achieved | 95.10%



#### Childhood Immunisations - 8 month olds

Target | 95% East Health Achieved | 96.82%



#### Childhood Immunisations - 2 year olds

Target | 95% East Health Achieved | 93.00%

## Foundation Standard and Aiming For Excellence Accreditation

Foundation and Aiming For Excellence is an ongoing commitment to improvements in the quality of care provided by general practices. These two General Practice Quality Standards form the accreditation programme of the Royal New Zealand College of General Practitioners for general practice to review their internal systems and processes that support care provided to patients.

East Health provides funding to support clinics achieve Cornerstone Accreditation and maintain the standards they have reached, as an ongoing commitment to quality improvement throughout our general practice teams.

All East Health Trust PHO clinics are actively engaged in the Cornerstone programme. At 30 June 2015 81% of clinics had attained Cornerstone Accreditation with the remaining clinics working towards achievement by June 2016.

## Safety in Practice

Safety in Practice is a new reflective learning and improvement approach to reduce the number of events causing avoidable harm to people from healthcare delivered in primary care.

Counties Manukau Health are leading this initiative, a collaborative between the three metro Auckland DHBs, based on the hugely successful project in use throughout Scotland. This programme uses a range of tools and resources to support staff working within primary care to strengthen a patient safety culture within their teams.

In this first year four East Health Trust PHO clinics participated around four focus trigger areas:

- **Warfarin Management,**
- **Test Results Handling,**
- **Medicines Reconciliation; and more recently**
- **Management of opioids**

East Health is working with Counties Manukau Health to grow the campaigns coverage to include additional clinics in year two and broaden the range of trigger tools.





# Optimal Prescribing Programme

**Mission:** *To reduce related morbidity and mortality through optimal use of medicines.  
(Minimum medicines for maximum benefit)*

## Aim

- **Avoid unnecessary or low value expenditure**
- **Reduce medication related morbidity and mortality with a reduction in acute demand**
- **Improve the contribution of medicines to health outcomes and quality of life for people**
- **Improve collaboration between community pharmacists and other health providers (including GPs) to improve patient care and time efficiencies.**

The 2014/15 programme incorporated the following Medicines Management services, as well as supporting Aged Residential Care facility prescribing staff and community pharmacists:

## Population Reviews

- Two population reviews on patients with Heart Failure and Cardiovascular Risk conditions, covering 24,016 patients
- Long Term Condition clinical audits for Cornerstone

## Medicines Therapy Assessments

- 190 comprehensive clinical reviews of individual patient's medication
- 259 patients discussed as part of the VHIU/Eldercare multidisciplinary process
- 115 reviews of prescribing for patients in aged residential care facilities

## Medicines information

- 20 Medicines information query responses
- 5 Medicines information bulletins published

## Educational Activities

- 13 education sessions presented as part of audit feedback, self-management education and the East Health Symposium

## Best Use of Medicines

- Issued two prescribing interventions including comparative prescription data and clinical/self-management information for GPs, nurses and pharmacists:
  - Use of norfloxacin; and
  - Use of proton pump inhibitors

# Programmes

## ElderCare

ElderCare provides support, coordination and education to the Primary Health Care teams to assist them optimise their care and support of their older patients, enabling them to retain their health, independence and lifestyle for as long as possible therefore minimising their hospital and residential aged care admissions. The general public may access the ElderCare coordinator for advice and information on local and greater Auckland services available to them and their families.

### GOALS

**Improve and support the integration of relevant primary, intermediary and secondary services**

**Strengthen relationships between providers, including access to specialist geriatric advice to primary health teams**

**Reduce hospital admissions for people with chronic conditions by assisting primary health providers to identify their relevant cohort and ensure that the necessary services are in place**

**Improve discharge planning and coordination by working with primary and secondary providers**

**Reduce problems with medications by offering medication reviews**

**Offer education and information to public and providers to improve awareness**

**Support primary health teams to provide comprehensive continuous and coordinated care to their patients**

East Health Trust PHO (EHT PHO) has a proportionally higher number of older people than in other areas of the Counties Manukau District Health Board area. ElderCare's main focus is working with general practice teams supporting people who are 75 years and over, or Māori, 65 years and over, and those who have older age related relevant health and/or disability issues. However, General Practitioners (GPs), Practice Nurses (PNs) and all people aged 65 years and over and their families may seek information from ElderCare on health and disability related services.

### Integration of services across Counties region

ElderCare supports the integration of services for older people across Counties Manukau region and meets regularly with the Adult Rehabilitation and Health of Older People Service and other services providing care for older people at Counties Manukau Health (CMHealth). ElderCare was involved with the Adult Rehabilitation and Older People (ARHOP) strategic planning workshop. Information about new or updated services is disseminated to general practices via the EHT PHO quarterly newsletter and intranet.

ElderCare was involved in the planning, development and introduction of the CMHealth "At Risk Individual" (ARI) programme as a majority of these enrolled individuals are 65 years and over. In addition, the experience and knowledge gained in the ElderCare coordinator role and the networking with the CMHealth services assisted in informing the East Health Trust PHO project.

ElderCare works closely with the locally based Needs Assessment and Service Coordination (NASC), Home Health Care team and their Aged Care Assessment Team (ACAT), and the Community Geriatric Service. The geriatrician provides close support to GPs including clinics at two practices.

Advance Care Planning (ACP) was promoted across practices and GPs and PNs are encouraged to undertake Level Two training. The Level One online learning has been positively received.

Regular contact with the Koropiko - Mental Health Services for Older People (MHSOP) is maintained and opportunity for integration of services with primary care is promoted.

## Strengthening relationships with CMHealth, general practice teams and community specialty groups

Strengthening relationships between CMHealth providers, including access to specialist geriatric advice to primary health teams is key role for ElderCare. This year ElderCare has been involved with the pilot for the Totara Hospice South Auckland and the CMHealth Palliative Model of Care, and promoting palliative care education across primary health care.

It is pleasing to note the Genesis palliative breakfast lectures, introduced at EHT PHO in May 2014, have received very positive feedback by clinicians, who can now attend locally and still get back to their morning clinics. In the May and June breakfast lectures a total of 30 clinicians attended.

ElderCare assists general practice to identify people with long term conditions who may require additional services or input from other health professionals or community groups. Two of the ways this is done are through Middlemore Hospital post-discharge notification and Very High Intensity Users (VHIU).

Other services ElderCare is closely linked with are:

- **Needs Assessment and Service Coordination (NASC) and Home Health Care**
- **Locality Falls Prevention Programme**
- **Virtual clinic with a Senior Medical Officer**

## Improving discharge planning and medication compliance

Good discharge planning is essential to ensure that older people are well supported when they return to their home. ElderCare maintains regular contact with the services that provide support for older people, NASC and the geriatricians and ensures the latest information is available to the general practices.

ElderCare promoted the use of medication reviews by a Clinical Advisory Pharmacist to the GPs and PNs as well as through the East Health Trust PHO health promotion and diabetes self-management programmes.



## Networking with community groups supporting older people

Networking is an integral part of ElderCare as knowing what is available and disseminating this information to general practices and ultimately the older people in the community is important in helping people to age positively.

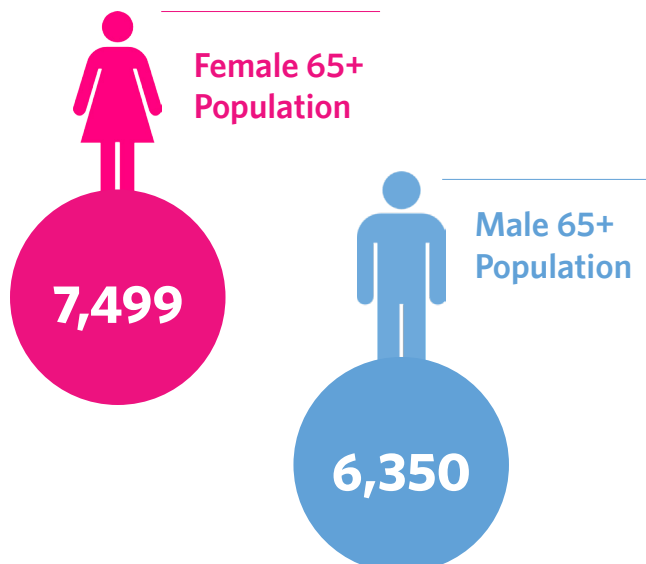
Community organisations and groups provide essential specialist services to support and inform older people and their families. NGOs which deliver more structured programmes and support for older people are valuable partners in care and are regularly contacted and information shared with the general practice team. These organisations include Alzheimers Auckland, Stroke Foundation, Manukau East Council of Social Services (MECOSS) and Selwyn Foundation.

In addition a telephone list of community services is maintained by ElderCare and available on the East Health Intranet. ElderCare updated the East Health Trust PHO Community Advisory Committee on ElderCare.

Community groups actively seek the support of ElderCare to distribute their new and existing information to the older people in our community. The ElderCare Coordinator, Anne Williamson is a member of the Age Concern Counties Manukau Elder Abuse and Neglect Prevention Advisory team and the Age Concern Networking group.

## Supporting primary health teams to provide comprehensive, continuous and coordinated care to their patients

General Practice visits are an ongoing part of the ElderCare coordinator's role. These visits also provide opportunities to enable ElderCare to assist practices to provide more appropriate services to older people. An online handbook with links to relevant services has been created.





# Mental Health & Addiction

East Health Trust PHO's Mental Health and Addiction service offers support and coordination of services for people experiencing mild to moderate mental health and/or addiction issues. Through this service we aim to reduce stigma and discrimination by promoting respect, rights and equality for people with experience of mental illness.

East Health's Mental Health and Addiction Coordinator is a skilled resource for our primary care clinics promoting continuity of care, encouraging and strengthening therapeutic relationships and assisting people to access primary mental health services within the community.

## GOALS

**Build effective links with secondary providers of mental health care, to enable coordinated care, thereby improve outcomes for those with significant and enduring mental illness and to improve access for those of our enrolled population requiring secondary mental health care**

**Develop the skill mix of the primary health care practitioners that will enable them to respond positively to the majority of mental health problems likely to be encountered in the primary care setting**

**To highlight and promote mental wellbeing within our community**

## Strong Linkages and Relationships with Secondary Care, Primary Care and Community Services

EHT PHO has focused on building collaborative relationships with Counties Manukau Health's Whirinaki and Te Rawhiti Community Mental Health teams to improve care delivery for those patients who have enduring mental illness and co-morbid physical complexities.

The Mental Health and Addiction coordinator attends and supports the Primary Care Liaison meetings which include Counties Manukau Health, PHOs and Non-Government Organisations (NGO's). The wider regional Primary Care Liaison meetings involve Waitemata and Auckland DHBs, PHOs and NGO's. The Mental Health and Addiction coordinator is also a member on the Counties Manukau Health Chronic Care Depression Clinical Governance Group.

Regular meetings are held with local community groups including MECOSS, Age Concern, Whirinaki / Te Rawhiti / Manukau Settlement Support Group and the NZ Mental Health Foundation. Mental Health education sessions are provided at various institutes including Manukau Institute of Technology, Auckland University of Technology and Massey University.

Close links are fostered with the following Advisory Groups:

- **Community Alcohol and Drug Service (CADs)**
- **EHT PHO Asian Health Advisory Network**
- **Kai Xin Xing Dong (Asian support group, NZ Mental Health Foundation)**
- **Counties Manukau Health, Chronic Care Management Depression Governance Group**
- **Altered High, Youth Drug and Alcohol Services**
- **Counties Manukau Health ARI Mental Health& Addiction Work stream group**
- **Age Concern Counties Manukau**



## NEW e-version for Alcohol and Substance Brief Intervention for Young People

EHT PHO has developed and recently launched an electronic version of the Substance and Choices Scale (SACS) tool that tailors brief intervention specifically to the 13-19 year old group of people. This age group are at such an incredible time of growth and change in their lives and the new tool, utilized by our general practice clinics, asks young people questions on their alcohol and substance consumption and behavior. This is providing health practitioners with valuable information to be able to support patient's to improve their health.

## Primary Care Professional Development and Education

- **Clinic support, guidance and development for our general practitioners and practice nurses, including awareness of substance screening tools, alcohol counselling services and other treatment providers**
- **Clinical supervision pilot for practice nurses to build knowledge and skills in the area of mental health and addictions**
- **General practitioners mental health peer review groups held locally at East Health and at the Manukau Super Clinic providing GPs with the opportunity to discuss case studies with clinical specialists in the field**
- **Integrated Care Coordinator guidance and support with specific mental health advice and information on appropriate interventions and referral pathways for their referred patients**

## NEW Credentialing Programme for Primary Health Care Nurses

EHT PHO is working with partners (Auckland Metro DHBs and PHOs) to develop and provide a regional mental health and addictions programme of learning for primary care nurses that is based on Te Ao Maramatanga New Zealand College of Mental Health Nurses.

East Health's Mental Health & Addiction Co-ordinator has been an active member of the programme co-ordination team with the development of the course programme and has also taken a lead in the Professional Supervision component of the programme.

# Health Promotion

The Health Promotion Coordinator works collaboratively across the community with health providers and other organisations to improve health outcomes and promote health awareness.

GOALS
Improve Asian health, in particular reduce mental health issues for our Asian community
To reduce non communicable diseases such as heart disease and type 2 diabetes, as well as some cancers
To have a population that is smokefree by 2025
To reduce stress and the health related impacts of stress for our community

## Asian Health

The Health Promotion Coordinator is one of nine local people selected to represent our area’s diverse ethnic communities on Howick Local Board’s Ethnic Affairs Consultative Committee. This year’s aim has been to connect communities by hosting intercultural events, learning about one another’s culture and promoting understanding with a view to increasing access to health services.

Our Health Promotion coordinator attends and supports the Counties Manukau Asian Mental Health and Addictions Forum, the South Asian Subgroup, the Ormiston Community Network and East Health’s Asian Health Group.

## Goal for a Smokefree Population

Smoking continues to make a significant contribution to disparities in health outcomes. Nationally tobacco kills about 5000 people annually and is our greatest preventable cause of death and illness.

Achieving a Smokefree Counties Manukau by 2025 is one of Counties Manukau Health’s major population health priorities. EHT PHO supports key initiatives to provide better help for smokers to quit:

### Smoking Cessation advice and support

Clinics are supported to record, offer brief advice and encourage every smoker to use cessation support (a combination of behavioural support and stop-smoking medicine).

This year ‘Motivational Telephone Interviewing’ and cessation referral pathway education was delivered to our clinic teams to further develop their call centre staff capabilities.

### Smoking Cessation Group Based Treatment Programme

A seven week course delivered by East Health’s trained Smoking Cessation practitioners.

EHT PHO is also an active partner with the Smoke Free Providers Network and Counties Manukau Smoke Free Services Network.

East Health’s Smoking Support Facilitators are working towards their NZQA level 3 Smoking Cessation qualification.





# Education

## Healthy Lifestyle Promotion

Healthy lifestyle education and support was delivered to community groups providing motivation and advice to help participants create lifelong healthy habits.

### Community group sessions:

- Selwyn Seniors Group
- South Asian Older Person's group (presented in Pujabi dialect)
- Shanti Niwas Charitable Trust

## New Migrants

East Health presented on available health services and navigating the New Zealand health system at the Local Settlement Network workshop in April 2015, facilitated by the Auckland Regional Migrant Services (ARMS).

## Self Management "Tools for Change"

### "Supporting patients and whanau to self-manage their health and stay well"

'Empowerment' is at the heart of supporting people with the tools and skills to increase patients confidence to manage their health better.

Integrating self-management support into routine health care practice is the driver behind East Health's extensive programme of Self-Management Education (SME).

### New Mindfulness Based Stress Reduction in 2014/15

A new 8 week course teaching mindfulness based stress reduction practices to patients has joined the suite of self-management East Health offers.

### Mindfulness in Mandarin

An introductory workshop this year delivered specifically in Mandarin, facilitated by local health psychologist Li Zuo, supported people experiencing language issues and cultural barriers who wanted to improve their knowledge around mindfulness and reduce stress. The four week pilot programme was successfully delivered in March 2015.

# Self Management Education

## Regional Diabetes Self Management Education

High blood glucose is a major contributor to the risk of a cardiovascular event, and to microvascular complications such as renal disease, retinopathy and peripheral neuropathy (amputation). Early education and encouragement for people with high blood glucose to 'manage' their own cardiovascular risk, particularly through lifestyle changes, is an effective way to reduce these complications of high blood glucose. The programme is facilitated by a Registered Nurse, Registered Dietitian and Registered Pharmacist.

The programme is designed to help people living with diabetes to maintain improved glycaemic control and lifestyle modification to reduce complications. The sessions are 2 hours duration and the programme runs for 6-weeks.

MEASURE	GOALS
To implement a structured SME group programme for people with pre diabetes and for those living with diabetes their family/ or support person within our PHO and other networks.	To deliver two self management groups within our PHO.
To inform, educate and empower people with diabetes and who require extra assistance with self management through the support of the SME Facilitator and their primary health service. This is achieved through the delivery of a comprehensive evidence based programme provided by trained self management facilitators.	To improve physical measures (HbA1c, blood pressure, lipid profile); improve attitude to having high blood glucose; improve lifestyle orientated behaviours; and measure patient satisfaction.
To deliver appropriate, relevant and consistent diabetes information to patients and their families.	To improve physical measures (HbA1c, blood pressure, lipid profile) and lifestyle changes.
To contribute to improved coordination of Diabetes SME patient education across Counties Manukau.	To ensure maximum access to the programme and adherence to a standard evidence based curriculum across Counties.
To ensure equitable access for all Maori and Pacific patients and their families.	Use of Maori and Pacific services to promote the programme and DSME Working Group to network with Maori and Pacific providers.

Number of  
courses held

2



Number of  
participants

49

**% of Participants reporting a substantial improvement at follow up session:**

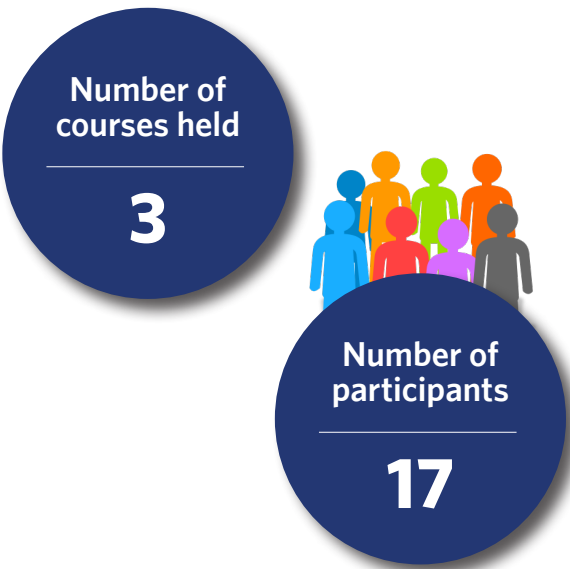
Health-directed behaviour	23.7%
Positive and active engagement in life	29%
Emotional wellbeing	21%
Self-monitoring and insight	55.3%
Constructive attitudes and approaches	29%
Skill and technique acquisition	55.3%
Social integration and support	32%
Health service navigation	23.7%

# Stanford Generic Self Management Education

Within New Zealand, long term conditions (such as diabetes, obesity, arthritis, cancer, depression, chronic lung and cardiovascular disease) are now responsible for 80% of all-cause mortality and 78% of all healthcare spending. Furthermore, long term conditions have been identified as the greatest contributor to continuing health inequalities with Maori and Pacific tending to experience more severe disease, disability and premature death than non-Maori, non-Pacific. For many families, particularly the most vulnerable, this translates to major barriers to independence, participation in the workforce and society as well as adverse quality of life and economic hardship.

People with long term conditions are referred to a self-management group, with family members / whanau or support people encouraged to also participate in the group meetings. Six, two and a half hour group sessions are run for each group.

MEASURE	GOALS
To implement the Stanford University Chronic Disease Self Management Programme (CDSMP) for people with any long term condition and their relevant support people.	To deliver at least two self management groups within our PHO.
To have two Master Trainers within the organisation enabling training of lay leaders to facilitate rolling the programme out to a wider population.	To improve healthy behaviour (physical activity, cognitive symptom management, coping and communications with physicians), improve health status (self-reported health, fatigue, disability, social/role activities and health distress), and decrease days in hospital.
To support people with long term conditions to self manage.	To build more capacity for support through training lay leaders to facilitate more programmes.
To contribute to improved co-ordination of SME patient education across Counties Manukau.	Ensuring the SME Steering Group is used to help provide both network support and consistent high standard training workshops.
To ensure equitable access for all Maori and Pacific patients and their families.	Use of Maori and Pacific services to promote the programme with Maori and Pacific providers.



### % of Participants reporting a substantial improvement at follow up session:

Health-directed behaviour	60%
Positive and active engagement in life	53.3%
Emotional wellbeing	40%
Self-monitoring and insight	46.7%
Constructive attitudes and approaches	33.3%
Skill and technique acquisition	60%
Social integration and support	33.3%
Health service navigation	53.3%





## Weight Self Management Education

Obesity is considered a major risk factor for many chronic, debilitating and life-threatening diseases. Over the past two decades the prevalence of obesity has more than doubled in New Zealanders.

People aged 18 and over with a body mass index (BMI) of 30 or over are referred to a self management group, with family members / whanau or support people encouraged to also participate in the group meetings. The Group is facilitated by a Registered Dietitian and Registered Nurse. Six, one and a half hour group sessions are run with regular follow up sessions.

MEASURE	GOALS
To develop and implement a structured SME group programme for people with a body mass index (BMI) of 30 or over.	To deliver at least two self management groups within our PHO.
To inform, educate and empower people with a body mass index (BMI) of 30 or over to address weight management.	To ensure sufficient programmes are run to meet demand of practice referrals and referral through other networks.
To deliver appropriate, relevant and consistent information on goal setting, nutrition, healthy eating, eating behavior and physical activity to patients and their families.	To improve physical measures weight, waist circumference and lifestyle orientated behaviours.
To contribute to improved co-ordination of SME patient education across Counties Manukau.	Active engagement with SME peers through the SME steering group to promote the programme and across wider networks.
To ensure equitable access for all Maori and Pacific patients and their families.	Use of Maori and Pacific services to promote the programme with Maori and Pacific providers.



### % of Participants reporting a substantial improvement at follow up session:

Health-directed behaviour	26.3%
Positive and active engagement in life	31.6%
Emotional wellbeing	52.6%
Self-monitoring and insight	58%
Constructive attitudes and approaches	21%
Skill and technique acquisition	58%
Social integration and support	37%
Health service navigation	31.6%

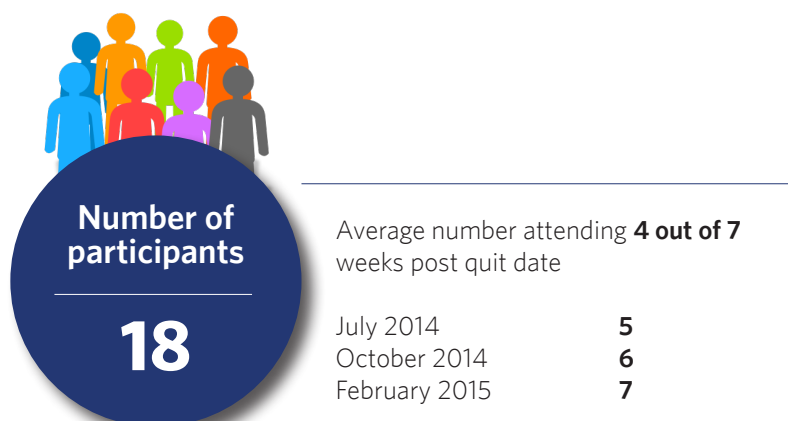
# Smoking Cessation Group Based Treatment Programme

Tobacco is an addictive and hazardous product which, if used as recommended by the manufacturer, results in the premature death of at least half of its long term users. In New Zealand tobacco kills about 5000 people annually, and is our greatest preventable cause of death and illness. Smoking Cessation Group based treatment (GBT) has an impressive track record in the United Kingdom, the success from the UK NHS stop smoking services Maudsley Model was published in 1989. This programme of GBT has been delivered to New Zealand with smoking cessation practitioners completing workshop training to facilitate smoking cessation group based treatment.

East Health Trust PHO now have two trained Smoking Cessation Practitioners, two Mandarin speaking and one Practice Nurse who can deliver this support to referred clients intending to quit smoking.

The course duration is seven weeks with the group committed to quit smoking at week three (quit week). A combination of medication including nicotine replacement therapy (NRT) or prescribed quit smoking medications from general practice are used alongside group support with a text buddy from week three providing motivational support to other participants.

MEASURE	GOALS
To deliver an evidence based smoking cessation group based treatment (GBT) to all referred clients.	To run at least two smoking cessation GBT programmes within our PHO.
To deliver non-judgmental smoking cessation group based treatment with respect to culturally diverse groups including delivery in other languages with support.	To provide participants appropriate treatment including NRT or referral to GP to access prescribed medicines.
To ensure PHO practice can refer clients promptly and easily using the PMS to generate a pre-populated template via enigma to the PHO.	To feedback to GP's and Practice nurses the results of the 7-week programme.
To ensure programme consistency is maintained using appropriate training tools, scripts and material.	To follow up and support participants at 3 months, 6 months and annually.
To ensure equitable access to all including Maori, Pacific and Asian clients.	Maintain text/telephone contact with participants to help with continued support and increase a successful quit outcome.



# Stanford Diabetes Self Management Education

High blood glucose is a major contributor to the risk of a cardiovascular event, and to microvascular complications such as renal disease, retinopathy and peripheral neuropathy (amputation). Early education and encouragement for people with high blood glucose to 'manage' their own cardiovascular risk, particularly through lifestyle changes, is an effective way to reduce these complications of high blood glucose.

The programme is designed to help people living with diabetes to maintain improved glycaemic control and lifestyle modification to reduce complications. The sessions are 2 hours duration and the programme runs for 6-weeks.

MEASURE	GOALS
To implement a structured SME group programme for people with pre diabetes and for those living with diabetes their family/ or support person within our PHO and other networks.	To deliver at least one self management group within our PHO.
To have two Master Trainers within the organisation enabling training of lay leaders to facilitate rolling the programme out to a wider population.	To improve physical measures (HbA1c, blood pressure, lipid profile); improve attitude to having high blood glucose; improve lifestyle orientated behaviours; and measure patient satisfaction.
To deliver appropriate, relevant and consistent diabetes information to patients and their families.	To improve physical measures (HbA1c, blood pressure, lipid profile) lifestyle changes.
To contribute to improved co-ordination of Diabetes SME patient education across Counties Manukau.	To ensure maximum access to the programme and adherence to a standard evidence based curriculum across Counties.
To ensure equitable access for all Maori and Pacific patients and their families.	Use of Maori and Pacific services to promote the programme and DSME Working Group to network with Maori and Pacific providers.



## % of Participants reporting a substantial improvement at follow up session:

Health-directed behaviour	27%
Positive and active engagement in life	7%
Emotional wellbeing	13%
Self-monitoring and insight	40%
Constructive attitudes and approaches	13%
Skill and technique acquisition	33%
Social integration and support	7%
Health service navigation	13%



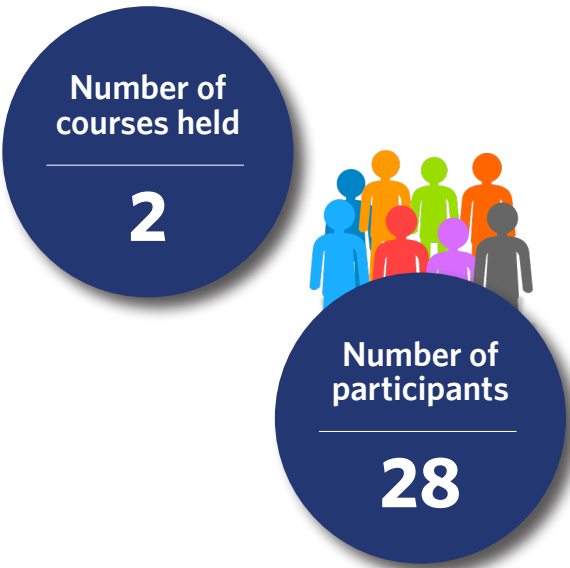
# Stanford Pain Self Management Education

The Pain Self Management Education Programme is an evidenced based programme and is designed to improve healthcare outcomes in people living with Chronic Pain beyond three to six months duration.

This programme provides tools to help manage chronic pain. The programme was first developed in Canada and has since been delivered in other countries and has been tested in 2 major scientific studies. Research has shown positive outcomes in relation to managing chronic pain and other symptoms.

People with chronic pain are referred to a Pain self management group, with family members / whanau or support people encouraged to also participate in the group meetings. The sessions are 2.5 hours each and the programme runs for 6 weeks.

MEASURE	GOALS
To implement the Stanford University Pain Self Management Programme for people living with chronic pain with family/ support.	To run at least one pain self management group.
To have two Master Trainers within the organisation enabling training of lay leaders to facilitate rolling the programme out to a wider population.	To improve healthful behaviours (physical activity, cognitive symptom management, coping, and communications with physicians), improve health status (self-reported health, fatigue, disability, social/ role activities, and health distress), and decrease days in hospital.
To deliver appropriate, relevant and consistent Pain self management information to patients and their families.	Deliver self-management education groups through marketing to practices, working with community groups and delivering the programme in various community settings.
To contribute to improved co-ordination of Pain SME patient education across Counties Manukau.	To ensure maximum access to the programme and adherence to a standard evidence based curriculum across Counties.
To ensure equitable access for all Maori and Pacific patients and their families.	Use of Maori and Pacific services to promote the programme to network with Maori and Pacific providers.



## % of Participants reporting a substantial improvement at follow up session:

Health-directed behaviour	38.5%
Positive and active engagement in life	27%
Emotional wellbeing	38.5%
Self-monitoring and insight	31%
Constructive attitudes and approaches	27%
Skill and technique acquisition	46%
Social integration and support	31%
Health service navigation	27%

# Healthy Eating Active Lifestyle (HEALs)

Over the last 50 years, the burden of disease and healthcare needs of our population has changed dramatically from a predominance of potentially curable acute infectious disease and injuries to a pandemic of non-curable infections and non-communicable long-term conditions.

Healthy Eating Active Lifestyle (HEALs) is a holistic programme covering health information/presentation, mental health wellbeing and physical activity along with action planning each week. HEALs is a health promotion programme which encourage people to maintain/improve their own health and wellbeing. The programme also supports those already living with a health condition to stay well. Label Reading, better breathing, coping with stress and menu planning are also included in the programme.

People wanting to live a healthier life are referred to a HEALs group, with family members / whanau or support people encouraged to also participate in the group meetings. The sessions are 2 hours each and the programme runs for 6 weeks.

MEASURE	GOALS
To facilitate the Healthy Eating Active Lifestyles programme (HEALs) for people wanting to maintain good health/manage their condition.	To run at least four HEALs groups.
To support people with long term conditions to self manage.	To improve healthful behaviours, physical activity, cognitive symptom management, coping, and communications.
To support people who are socially isolated within the programme through the promotion of a buddy/support system.	Deliver HEAL's through marketing to practices, working with community groups and delivering the programme in various community settings.
To contribute to improved coordination of HEALs across Counties Manukau.	To ensure maximum access to the programme and adherence to a standard evidence based curriculum across Counties.
To ensure equitable access for all Maori and Pacific patients and their families.	Use of Maori and Pacific services to promote the programme and DSME Working Group to network with Maori and Pacific providers.



## % of Participants reporting a substantial improvement at follow up session:

Health-directed behaviour	31.4%
Positive and active engagement in life	23%
Emotional wellbeing	34.2%
Self-monitoring and insight	28.6%
Constructive attitudes and approaches	20%
Skill and technique acquisition	43%
Social integration and support	31.5%
Health service navigation	23%

# Mindfulness Based Stress Reduction

Mindfulness Based Stress Reduction (MBSR) is an evidence based programme endorsed by The Royal New Zealand College of General Practitioners. The course is based on the programme designed by Jon Kabat-Zinn. MBSR was developed in 1979 at the Massachusetts Medical Centre for people suffering chronic and acute stress, chronic pain and illness and associated anxiety and depression. The World Health Organisation has estimated that depression will be a leading cause of disability worldwide, NICE guidelines recommend MBSR for recurrent depression.

MBSR uses a range of mindfulness practices to teach participants to cultivate an observant, accepting and compassionate stance towards their own internal experiences including cognitions, emotional states, body sensations and impulses. Patients are taught to skillfully respond rather than react, hence increasing self-efficacy. There is now a plethora of literature supporting the use of mindfulness interventions in primary and secondary care. The practice of mindfulness has also been demonstrated to benefit both our self-regulation (impact on mood, immune function and cardio-vascular health).

Patients enrolled onto the MBSR programme sign up to an 8 week (2.5 hours per week) commitment along with some home practice. The programme is facilitated by a trained teacher.

MEASURE	GOALS
To teach MBSR 8 week programme in promoting Health and Wellbeing by equipping communities with skills of mindfulness in responding appropriately rather than reacting.	To deliver at least 2 programmes each year.
To teach MBSR to patients (via referral from the GP Practice) who are experiencing stress, anxiety and not coping as well as they would like to.	To deliver at least 2 programmes each year.
To present and teach professionals basic skills for example breathing properly to enhance relaxation response, so that they can then teach their clients, patients, consumers these skills and hence reduce the stress response.	To facilitate at least 2 workshops, seminars or presentations each year.



### % of Participants reporting a substantial improvement at follow up session:

Health-directed behaviour	36.7%
Positive and active engagement in life	41.7%
Emotional wellbeing	25%
Self-monitoring and insight	57%
Constructive attitudes and approaches	40%
Skill and technique acquisition	63.3%
Social integration and support	47%
Health service navigation	40%



# Services To Improve Access

## Adolescent Sexual Health (ASH)

The ASH programme provides three free sexual health visits for any person under the age of 22 years old when attending any East Health Trust PHO clinic.

Number of  
visits funded

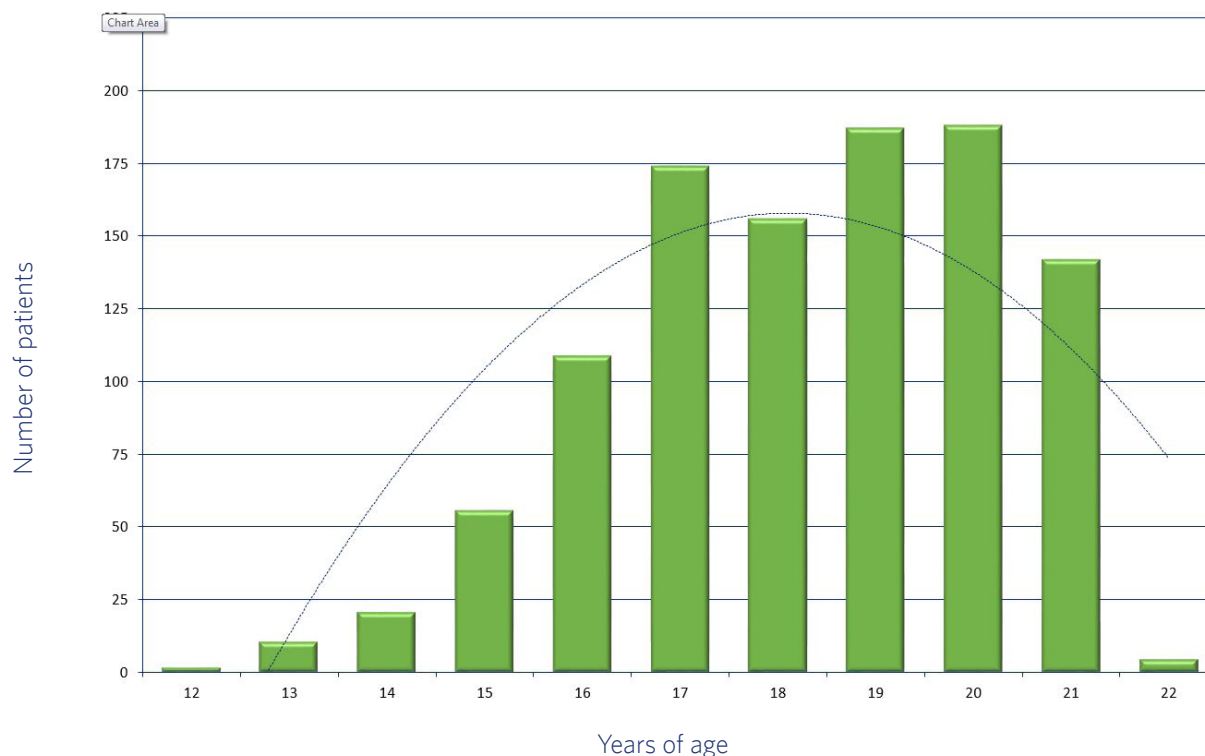
**1616**

Total number of  
patients

**1051**

ASH SUMMARY	NO. OF PATIENTS	% OF VISITS
Number of patients with <b>1 visit</b>	779	74%
Number of patients with <b>2 visits</b>	194	18%
Number of patients with <b>3 visits</b>	64	6%

### ASH Patients by Age 2014/15



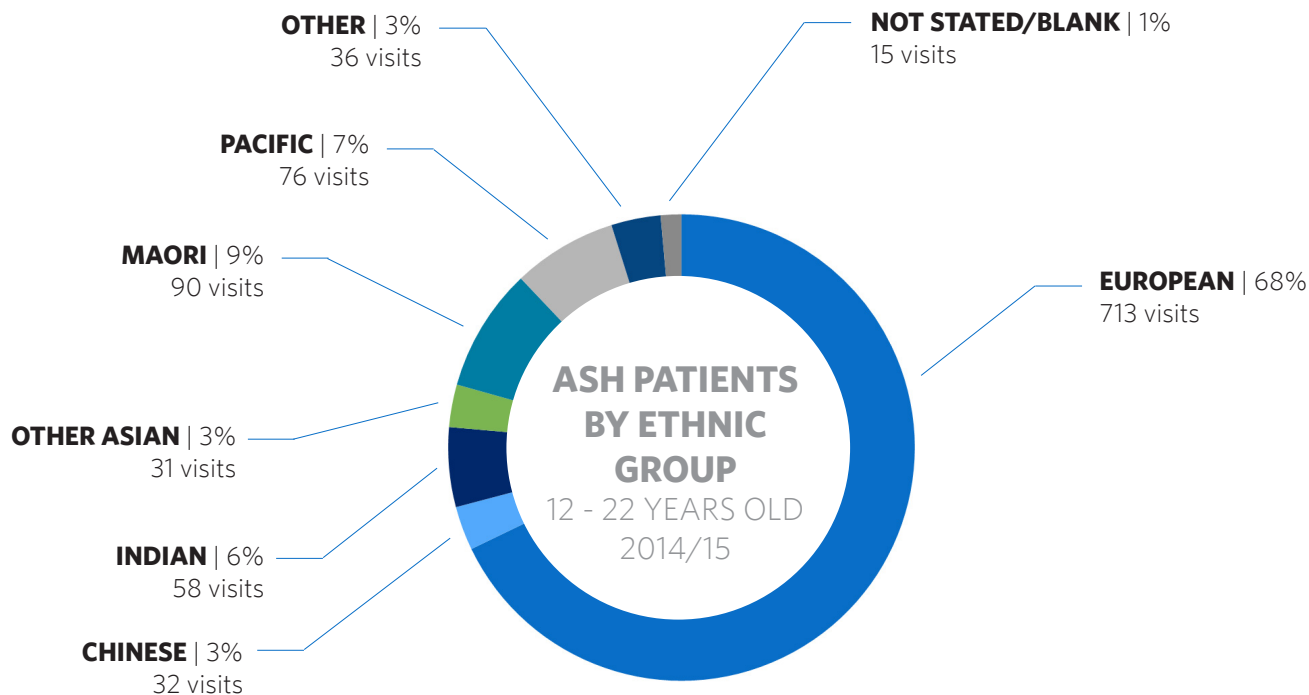
#### KEY



Number of ASH Patients



Poly. (Number of ASH Patients)



**Ethnicity and Age of ASH patients at time of visit 2014/15**



The Adolescent Sexual Health template and database allows us to capture the reasons for a sexual health visit and provides a basis for further review and evaluation of the programme.

ADOLESCENT SEXUAL HEALTH REASON FOR VISIT	VISITS
Cervical Screening + full sexual health assessment	149
Contraception (under 20 years of age)	622
Emergency Contraceptive Pill	31
Emergency Contraceptive Pill follow up visit	17
Other	1
Sexual Health Advice	404
Sexually Transmitted Infection Screen	278
Treatment of Sexually Transmitted Infections*	67
Unprotected sexual intercourse	47
Total funded visits	1616

* Treatment of Sexually Transmitted Infections	
Treatment of Chlamydia	78%
Treatment of Gonorrhoea	3%
Treatment of other sexually transmitted infection	19%

# Long Term Conditions

## Diabetes Care Improvement Package

Diabetes is a long term condition that leads to increased rates of mortality and morbidity if not well controlled. Counties Manukau Health (CMHealth) has the highest number of people with diabetes in NZ and therefore excellent control of diabetes is important for CMH population health outcomes and for management of flow on costs arising from complications.

The package provides an annual review for people who have a known diagnosis of type 1 or type 2 diabetes mellitus. At this check-up eligible people receive a blood test, retinal screen referral and foot check.

**The package also includes a range of services:**

### Insulin Initiation

Funding is provided for insulin initiation where clinically indicated to improve peoples' blood sugar control.

### Podiatry Services

An annual funded consultation with a podiatrist for patients with type 1 or 2 Diabetes.

### Dietetic Services

A referral to see a dietitian who will provide a range of dietary nutritional advice, healthy eating, carbohydrate counting and lifestyle changes to help people stay on track and better self manage their diabetes.

### Health Psychology

Provides patients funded consultations with a Health Psychologist to improve their understanding of their health conditions.

MEASURE	GOALS
Increased numbers of people who have good or reasonable blood sugar control (<64 mmol/mol).	Improve management and care for people with diabetes that result in improved patient outcomes.
Number of people with diabetes having received: <ul style="list-style-type: none"><li>• Diabetes Annual Review</li><li>• Insulin services initiated</li><li>• Podiatry and dietetic services</li><li>• Up to date retinal screen and foot check</li><li>• Health psychologist services</li></ul>	Increase the number of people having a Diabetes Annual Review having an HbA1C<64 mmol/mol within 5 years. Services integrated into a wider multidisciplinary set of services that are developed to ensure a coordinated approach to providing diabetes care.
Accurate collection, management, reporting and analysis of information collected.	Ensure ongoing quality improvement in diabetes services at a population level.
Increased access to high quality, culturally appropriate and effective health and disability services. Health care providers trained to recognise the cultural values and beliefs that influence the effectiveness of services for Maori people with diabetes.	Maori people to have a rate of blood sugar control no worse than that of the rest of the population.



NUMBER OF PEOPLE WITH DIABETES WHO RECEIVED:	NO. OF PATIENTS	PERCENTAGE
Diabetes Annual Review	2177*	
Up to date retinal screen and foot check	1583	72.7%
Insulin initiation services	41	1.9%
Podiatry consultations	330	15.2%
Diabetic services	245	11.3%
Health psychologist services	124	5.7%

\* eligible population aged 15 years and over

# Chronic Care Management Depression Programme

The CCM Depression Programme offers extended general practitioner or practice nurse time of up to twelve sessions over an 18 month period for the care of patients with mental health issues. These sessions are free to eligible people.

CCM Dep  
Reviews  
2014/15

4854

## CCM Depression Programme - Cognitive Behaviour Therapy (CBT)

CBT funded  
sessions

2973

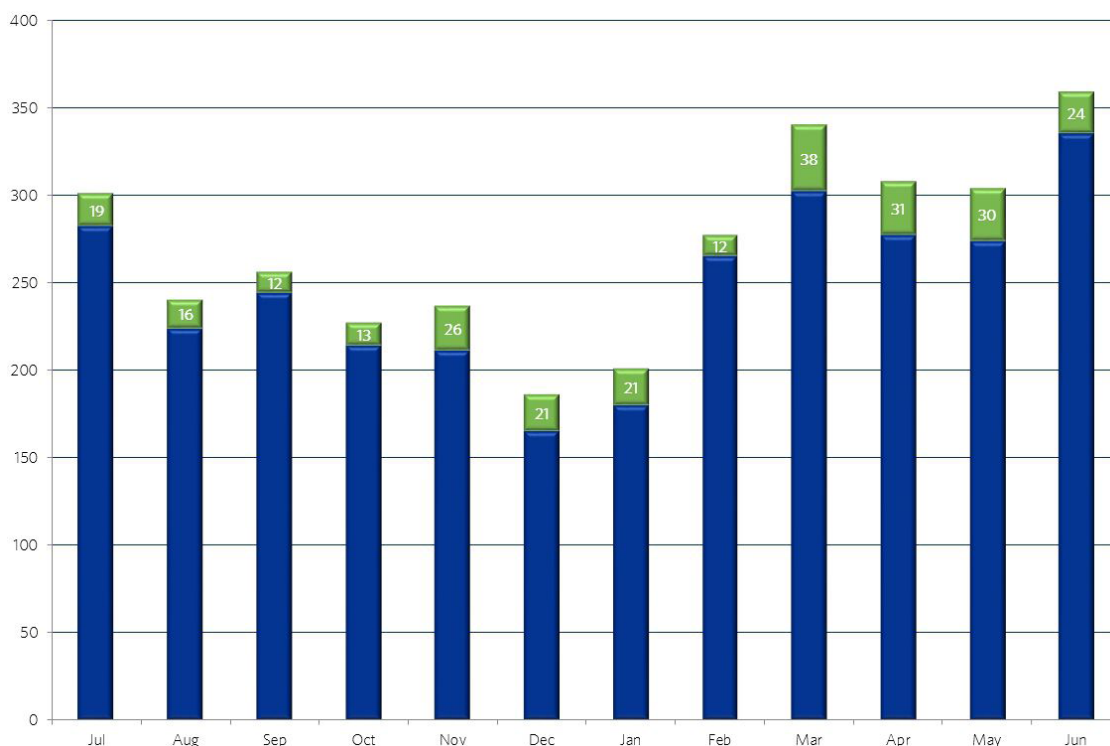
Referred  
patients

824

As part of the Chronic Care Management Programme the Mental Health and Addiction Coordinator reviews clients for eligibility to access cognitive behaviour therapy treatment (CBT) as referred by their general practitioner.

Clients can receive up to six funded CBT sessions provided by accredited psychologists in the local area. Positive response to this initiative continues with increased referrals.

CCM/CBT Psychologist Visits and DNAs 2014/15



### KEY

Number of Psychologist visits

Number of DNAs

# Financial Statement

## Statement of Financial Performance

INCOME	2015	2014
Provider Funding	13,656,434	12,881,345
Management and Administration	642,213	619,696
Health Projects	4,771,286	3,461,447
Dividends Received	7,522	12,896
Interest Received	89,761	47,745
Governance Contributions	8,075	10,125
<b>Total Income</b>	<b>\$19,175,291</b>	<b>\$17,033,254</b>

LESS EXPENSES	2015	2014
Provider Funding	13,656,434	12,881,345
Management and Administration	526,615	508,346
Health Projects	4,603,923	3,306,370
Expenses	265,276	231,160
<b>Total Expenses</b>	<b>\$19,052,248</b>	<b>\$16,927,221</b>
<b>Net Surplus</b>	<b>\$123,043</b>	<b>\$106,003</b>

## Statement of Movement in Equity

MOVEMENT OF EQUITY	2015	2014
Trust Equity at the beginning of the year	621,651	515,618
Net Surplus for the year	123,043	106,003
<b>Total recognised revenue and expenses for the year</b>	<b>123,043</b>	<b>106,033</b>
<b>Trust Equity at the end of the year</b>	<b>\$744,694</b>	<b>\$621,651</b>

## Statement of Financial Position

CURRENT ASSETS	2015	2014
Bank Assets and Cash	388,214	510,026
Term Deposits	2,009,512	1,450,349
Accounts Receivable	933,993	827,104
Tax Due	522	896
<b>Total Non-current Assets</b>	<b>13,340</b>	<b>13,340</b>
<b>Total Assets</b>	<b>\$3,345,581</b>	<b>\$2,801,715</b>

CURRENT LIABILITY	2015	2014
Accounts Payable	868,367	696,998
Accrued Expenses	2,000	5,000
Health Service Funding (Committed Funding)	1,667,536	1,073,151
Eastern Locality Partnership	62,984	404,915
<b>Total Liabilities</b>	<b>\$2,600,887</b>	<b>\$2,180,064</b>
<b>Net Assets</b>	<b>\$744,694</b>	<b>\$621,651</b>

For a more detailed breakdown of our financial statements please go to:

[www.easthealth.co.nz](http://www.easthealth.co.nz) → Click '**About**' tab → Click '**Publications**' tab



