



TE MATAKITE MĀORI HEALTH PLAN 2013-2014



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OVERVIEW

This Plan describes the Taranaki District Health Board's (TDHB) priorities in Māori health for the 2013-2014 year. The plan aligns with the requirements of the New Zealand Public Health and Disability Act (2000) which requires DHB's to reduce disparities and improve Māori health outcomes. It aligns to the TDHB's strategic framework that aims to achieve the vision of "Taranaki whanui, he rohe oranga" and the wider aspirations of Whānau ora as described in He Korowai Oranga, national Māori Health Strategy and Te Kawau Mārō, Taranaki Māori Health Strategy. The format of this plan and the indicators included follow the 2013-2014 Operational Policy Framework guidelines.

Local indicators were determined by the Whānau Ora Health Needs Assessment of Māori living in Taranaki published in February 2012,* the conceptual foundation of which is based on the Treaty of Waitangi and in the determinants of ethnic inequalities in health. Needs are prioritised within the four pathways of He Korowai Oranga so as to maintain health sector relevance and to maximise TDHB's contribution to Whānau Ora. The assessment is an authoritative evidence-based identifier of areas of greatest need and potential for gain for Māori living in Taranaki.

The targets and actions in this plan align with the TDHB Annual Plan and the Midland Region Services Plan. The Māori Health Plan gives a one-year subset of actions and aspirational targets related to Māori health. Longer term activities (2 – 5 years) to improve health for Māori and non-Māori are described in the 2013-2014 TDHB Annual Plan.

In 2013-14 we will focus on fewer local priorities that have the greatest likelihood of responding positively to intervention in the short term and that are not already prioritised for action in the Annual Plan. SUDI is a non-discretionary local priority determined by the Ministry of Health due to the Taranaki SUDI rates being amongst the highest in the country.

Quarterly performance results for the Māori Health Plan indicators will be disseminated to key audiences. First, results will be submitted to a joint meeting of the TDHB and Te Whare Punanga Korero Iwi relationship Boards to monitor progress against the Plan. Second, quarterly performance reports will be disseminated for review by the TDHB Executive Management Team, the relevant PHO Alliance Leadership Teams (National Hauora Coalition ALT and Midland Health Network Taranaki ALT) and the TDHB preferred Māori Health Services provider Te Kawau Mārō Alliance. These three groups represent governance and key operational audiences of the DHB and NGO organisations which are directly engaged in delivery against the Plan. Finally the DHB's Māori Health Plan performance will be presented in the DHB's Annual Report.

* Whānau Ora Health Needs Assessment, Māori Living in Taranaki, Ratima and Jenkins, Taranaki District Health Board, February 2012

1. SUMMARY OF INDICATORS

	National Priorities	National Indicators	Target	Baseline (TDHB)		
				Māori	Non-Māori	
1	N1-Data Quality	Ethnicity data accuracy	Audit tool to be implemented in 2013/14			
2	N2-Access to Care	Percentage of Māori enrolled in PHOs	98%	86%	99%	
3		ASH rates per 100,000 rate, Maori and All-National	0-4yr 45-64 0-74y	<142% <161% <164%	8,025 2,673 3,252	5,641 1,661 1,983
4		N3-Maternal Health	Percentage of infants exclusively and fully breastfed at: Six weeks Three months Six months	74% 57% 27%	57% 41% 10%	69% 58% 23%
5	N4-Cardiovascular Disease & Diabetes	High-risk patients that receive an angiogram within 3 days of admission	>70%	New measure		
6		>95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection.	>95%	New measure		
7		Percentage of the eligible population who have had their CVD risk assessed in the last 5 years	90%	58%	68.3%	
8	N6-Cancer	Breast screening rate among the eligible population (50-69yrs)	70%	61%	75%	
9		Cervical screening rate among the eligible population aged between 25-69	80%	72.8%	87.7%	
10	N7-Smoking	Percentage of adults 15+ admitted to hospital either acutely or for elective procedures who are provided with advice and help to quit	95%	93%	93%	
11		Percentage of smokers in primary care who are provided with advice and help to quit	90%	37%	38%	
12	N8-Immunisation	Percentage of 8 month olds fully immunised (by July 2014 90%, by December 2014 95%)	90%	83%	88%	
13		Seasonal influenza immunisation rates for Māori aged 65 years and over –	75%	66%	68%	
14	N9-Rheumatic Fever	2013/2014 rheumatic fever target – number and rate reductions, 10% below 3-year average –	0.8	1		
Local Priorities						
15	L1-Access to Services	Did-Not-Attend (DNA) rate for outpatient appointments –	<9%	19%	7%	
16	L2-Oral Health	Pre-school dental enrolment	68%	59.1%	74.6%	
17	L3-Sudden Unexplained Death of Infants Syndrome	SUDI mortality rate per 1,000 live births of Māori infants –	0.75	1.10	0.8	
18	L4-Primary Mental Health	Access by Taiohi Maori to packages of primary mental health Care	25% increase	No baseline available.		

ABBREVIATIONS

ABC	An approach to smoking cessation requiring health staff to ask, give brief advice, and facilitate cessation support.
ALT	Alliance Leadership Group
ASH	Ambulatory sensitive hospitalisation
BFCI	Breastfeeding Friendly Community Initiative
BOPDHB	Bay of Plenty District Health Board
COL	Colposcopy
COPD	Chronic Obstructive Pulmonary Disease
CVD	Cardiovascular disease
CVD-IHD	Cardiovascular disease – Ischaemic heart disease
DEN	Dental
DHB	District Health Board
DIA	Diabetes
dmf	Decayed, missing, or filled primary teeth
DMFT	Decayed, Missing, or Filled Teeth (permanent)
dmft	Decayed, missing, or filled teeth (deciduous)
DNA	Did not attend (used in the measurement of outpatient clinic attendance)
ENT	Ear, Nose and Throat
KARO	Knowledge, Actions, Results, Opportunity – reporting database through MOH
MHN	Midland Health Network
MOH	Ministry of Health
MSD	Ministry of Social Development
NGO	National Governance Organisation
NHC	National Hauora Coalition
PHO	Primary Health Organisation
PM	Portfolio Manager
PHN	Public Health Nurse
PMHI	Primary Mental Health Indicator
RFP	Request for Proposal
RS	Respiratory
SUDI	Sudden unexplained death of an infant
TDHB	Taranaki District Health Board
TLA	Territorial Local Authority

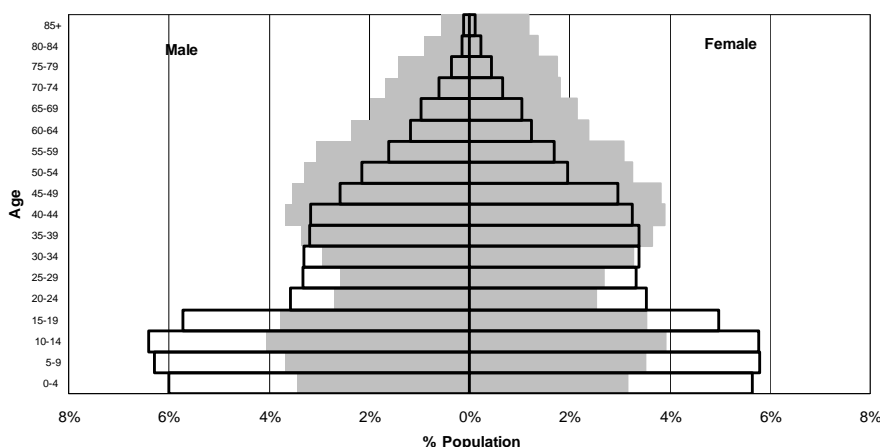
POPULATION PROFILE

- 1.1. Taranaki DHB serves 2.8% of the Māori population of New Zealand. At the 2006 Census, 15,816 Māori were resident in Taranaki; this represents the 14th highest number of Māori serviced by any of the DHB's. However Māori make up 15.2% of the total Taranaki DHB population which is slightly higher than the national of 14%.
- 1.2. In the regional context Taranaki DHB has the lowest number and lowest proportion of Māori living in its service area of all the Midland DHB's. The highest number and proportion of Māori live in the Midland region.

Age Distribution

The Māori population in Taranaki is very young compared to the overall populations as shown in Figure 4 below. For Māori, 35.9% of the population resident in Taranaki is under 15 years of age compared to 21.8% for the total population. The difference is even more marked for older Māori, with 4.7% of the Māori population resident in Taranaki aged over 65 years compared to 14.8% for the total population. This is, in part, a reflection of the lower Māori life expectancy relative to non-Māori.

Figure 4 Age Structure of Taranaki DHB, 2010
Māori Population (Black line) and Total Taranaki Population (Gray Shadow)



Source: Statistics NZ, Estimated Territorial Local Authority Population of TLA population June 2010.

Iwi

- 1.3. As at the 2006 Census the following was the population makeup of the eight iwi of Taranaki:

IWI	TOTAL IWI POPULATION	IWI POPULATION RESIDENT IN TARANAKI	% IN TARANAKI
Ngati Tama	1,167	306	26.2%
Ngati Mutunga	2,094	516	24.6%
Te Atiawa	12,852	2,721	21.1%
Ngati Maru	735	192	26.1%
Taranaki	5,352	1,473	27.5%
Ngaruahinerangi	3,726	1,449	38.8%
Ngati Ruanui	7,035	1,614	22.9%
Ngaa Rauru Kaitahi	4,047	726	17.9%
TOTAL	37,008	8,997	24.3%
Māori: non-Taranaki iwi		6,801	
Total Māori Population		15,798	

Geographic Distribution

- 1.4. TDHB comprises three territorial authorities. In 2006 the majority of the population were based in the New Plymouth District Council catchment (9369) while the largest proportion were based in the South Taranaki District (20.6%).

	South Taranaki District	Stratford District	New Plymouth District
Total Population	26,484	8,892	68,898
Māori (%)	20.7%	10.9%	13.6%

Population Growth

- 1.5. The Māori population in Taranaki is growing much faster than the non-Māori population, which is projected to decline. The Taranaki population is projected to increase from 104,280 in 2006 to 109,975 by 2026, an increase of 5.5%.

However, the Māori population is expected to increase to 22,800 over the same period, an increase of 44%. This means that, by 2026, Māori are expected to account for around 20.7% of the region's population compared to 15.2% in 2006.

- 1.6. The Māori population in the region will increase faster in the younger age groups. By 2026, Māori are expected to account for 36.7% (27.3% in 2008) of those aged under 15, and 33.6% (23.9% in 2008) of those aged between 15 and 24.
- 1.7. Māori who whakapapa to Taranaki iwi account for 57 percent of the local Māori population or around 9,000 people, while almost 43 percent whakapapa to iwi outside of Taranaki. Around one quarter of the 37,000 Taranaki uri live in the Taranaki region.

Deprivation

- 1.8. Taranaki had a higher proportion of people living in deciles 6 to 10. Māori make up a significantly higher proportion of Taranaki residents in deprivation deciles 8 and 9 and a much higher proportion of Māori in decile 10. Conversely in deciles 1 to 4, the proportion of non-Māori is much higher.

2. MĀORI HEALTH NEEDS ASSESSMENT

Leading Causes of Avoidable Mortality and Hospitalisation

The leading causes of avoidable death and Hospitalisation are ranked below. Similar issues ranked highly for Māori and non-Māori locally and nationally:

	Avoidable Mortality		Avoidable Hospitalisation	
	TDHB	NZ	TDHB	NZ
Māori	CVD - IHD	CVD-IHD	Angina and chest pain	Respiratory infections
	Lung cancer	Lung cancer	Asthma	Cellulitis
	Diabetes	Diabetes	Dental conditions	Angina
	COPD	COPD	Respiratory infections	COPD
	Cerebrovascular diseases	Road Traffic injuries	COPD	Asthma
Other	CVD-IHD	CVD-IHD	Angina and chest pain	Angina
	Cerebrovascular diseases	Lung cancer	Dental conditions	Respiratory infections
	COPD	Colorectal cancer	Cellulitis	Cellulitis
	Lung cancer	Suicide & self harm	Skin cancers	Road traffic injuries
	Colorectal cancer	Road traffic injuries	COPD	ENT infections

Health Needs Assessment

The health needs of Taranaki Māori and priorities for action are identified in the Taranaki DHB's Whānau Ora Health Needs Assessment† (Ratima and Jenkins, 2012) and are summarised below:

- a. **Te Ara Tuatahi Pathway One – 'Development of Whānau, hapu, iwi and Māori communities'**
The Māori community has a limited capacity to engage with work around Whānau Ora, and in this context Māori community development at whānau, hapū, iwi levels was important. A need to engage whānau in preventative and aspirational activities was identified. At the whānau level, work is required to strengthen whānau cohesion so that whānau are better positioned to exercise the positive functions of whānau. Strengthening cultural identity as a mechanism to achieve health gain was also identified. Whānau level development as a basis for Whānau Ora is a priority area. The challenge for funders and providers is to identify ways in which they may facilitate this development without taking leadership and risking engendering dependency.
- b. **Māori Participation and Leadership - Te Ara Tuarua Pathway Two – 'Māori participation in the Health and Disability Sector'**
Building the capacity and capability of Māori providers and the Māori health workforce are priorities. Key providers of health services for Māori in the TDHB region currently include:
 - Te Kawau Mārō strategic alliance between Tui Ora Limited and the National Hauora Coalition. The alliance is the preferred provider of Māori-specific primary health care services in Taranaki;
 - There are two PHOs in Taranaki: The **National Hauora Coalition PHO** incorporates the General Practices of Ruanui Health Services in Hawera with 57% or 3354 of its enrolled population being Māori, Te Atiawa Medical Services in New Plymouth with 1918 or 66% of its enrolled population being Māori and Te Waipuna Medical Clinic in Waverley with 41% or 744 Māori enrolled. Māori

† Whānau Ora Health Needs Assessment, Māori Living in Taranaki, M Ratima and B Jenkins, Taranaki DHB, February 2012

account for 13% of the **Midlands Health Network PHO** enrolled population for Taranaki, or 13,263 of 100,631;

- Two public hospitals - Taranaki Base Hospital in New Plymouth with 179 inpatient, 25 inpatient mental health, 21 emergency department and 18 maternity beds and Hawera Hospital with 20 inpatient, 7 emergency department and 4 maternity beds.

In terms of the Māori health and disability workforce, there is a lack of reliable information available to assess this currently. The Taranaki DHB regularly collects information on its workforce though accuracy of the data is limited, while currently no mechanism exists for gathering NGO workforce data. As at March 2013, 6.73% of Taranaki DHB staff or 114 from a total of 1694 identified as being of Māori ethnicity.

c. Health System Performance and- Te Ara Tuatoru Pathway Three – ‘Effective health and disability services’

Increased access to health services at all levels, and particularly at the primary health care level are priorities and include geographically equitable access to quality health care across the Taranaki Region and the implementation of Whānau Ora oriented service provision.

The priorities in terms of protective and risk factors and preventative care are smoking, alcohol and drug issues, breastfeeding, immunisation, breast screening and cervical screening.

Priority health conditions identified are diabetes, cardiovascular disease, lung cancer, breast cancer, respiratory disease (i.e. COPD and asthma), oral health, mental health and disability.

d. Social Determinants and- Te Ara Tuawha Pathway Four – ‘Working across sectors’;

It is well documented that there are systematic inequalities in access to social and economic determinants of health for Māori and that socio-economic status is a key factor contributing to health outcome disparity between Māori and non-Māori. There is clear evidence that Māori living in Taranaki have poor access to socio-economic determinants of health, and this is reflected in high relative levels of deprivation, compared to non-Māori. It is also reflected in barriers to health care and related needs (e.g. ability to pay for service provision and access to transport) identified through community engagement. Addressing determinants of health through intersectoral collaboration is a priority area.

3. IMPROVEMENTS UNDER WAY

Good progress is being made in reducing health inequalities for Māori in Taranaki DHB. Examples of success include:

- a. Significant improvements have been made in the collection of ethnicity data to the extent that the TDHB has moved from third worst performing DHB in 2010 to third best performing DHB currently. TDHB now exceeds the accuracy targets by which DHB's are measured with 1.23% (>2% target) of ethnicity records recorded as 'not stated' or 'other'.
- b. 91% of Māori have had their 2-year immunisations compared to 92% for non-Māori, almost an elimination of inequality in this indicator.
- c. Outpatient DNA rates have reduced by 6% since the beginning of 2011-12 and are now consistently trending downwards.

In terms of Health Sector Performance good progress has been to consolidate the Māori health sector. The TDHB preferred provider 'Te Kawau Mārō' alliance, a Tui Ora and the National Hauora Coalition joint venture, evolved from an RFP process seeking a single provider of services for Māori. TDHB is now working with the alliance to formulate population outcomes and performance measures to underpin a new outcomes-based contract due to start 1 July 2013. The new contract in effect merges 35 primary care contracts worth almost \$8M into a single outcomes-based 5-year contract. The formation of the alliance, and the move to outcomes-based contracting is expected to result in;

- The burden of reporting being significantly reduced
- Clinical and cultural safety significantly strengthened
- The partners have committed to developing a common Whānau Ora system for Taranaki
- strengthening the Whānau Ora assessment and navigation roles to maximise support to whānau
- reduction in operational overheads to release more funding to direct whānau support

4. PRIORITIES AND INDICATORS

The following section of the plan presents Māori health priorities and aligned indicators that have been selected at the national, regional and local levels. They are presented in tables in the following sections that summarise:

- What we are trying to do
- What we will focus on
- Who will be responsible

- What we are going to do and why
- Where we are at now
- Where we want to get to in the next year
- Key Issues

The 'inequalities box' at the bottom right of the tables provides a snapshot of the extent of disparities between Māori and non-Māori. The relative measure of inequality provided is a rate ratio based on the rate in the Māori population divided by the rate in the non-Māori population (where the denominator varies due to data availability, this is noted in a footnote). The absolute measure of inequality provided is the 'gap' between Māori and non-Māori such as a percentage difference. As well, the 'inequalities box' provides an indication of progress made in addressing inequalities for Māori over time. Where data is available (data used to determine progress will be described in a footnote), the progress measure will report on trends over a number of years using the following symbols already used by TDHB in reporting progress on ethnic inequalities indicators.

Quarterly, six-monthly and/or annual (as relevant to each indicator) quantitative assessment of disparities between Māori and non-Māori, where relevant, will be reported. The following symbols will be used to report progress on inequalities indicators:

Symbol	Key
☑	Progressing well
Ⓟ	Some progress
☒	No progress or worsening
⌋	Not yet sufficient time to judge
?	Further info or work required
↑	Increasing gap
↓	Decreasing gap

5. SECTION FIVE: NATIONAL PRIORITIES AND INDICATORS ACTION PLAN

National Indicator 1	DATA QUALITY	Who will be responsible: Portfolio Manager Primary Care		
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful		
Improve and maintain the quality of data collected locally and supplied to national collections	<ol style="list-style-type: none"> 1. Work with the National Hauora Coalition PHO (NHC) to participate in the Midland ethnicity data audit programme (BOPDHB lead) to determine baseline accuracy and then to set performance targets to improve and maintain accuracy and quality. 2. Continue to discuss with Midland Health Network (MHN) PHO to establish baseline ethnicity data accuracy and work towards achieving targets as required. 	Reduction in %age PHO enrolled population with ethnicity 'not stated'		
Why is this outcome important:			NHC	MHN
Accurate ethnicity data is essential for tracking progress in Māori health outcomes. The accuracy of ethnicity data in PHO databases is unknown at present.		Total Enrolled	5636	100,912
		Not Stated	8	672
		% Not Stated	0.14%	0.67%
		Gap (%)	Not known	

National Indicator 2.1	ACCESS TO CARE	Who will be responsible: Portfolio Manager, Primary Care		
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful		
Increased access by Māori to primary health care services	Continue to engage with PHO's to raise awareness regarding enrolment rates for Māori and work with PHO's to establish and achieve PHO enrolment targets.	98% of Māori will be enrolled in a PHO by 30 June 2014		
	Continue to discuss and work with PHO's to implement the best approaches to ensure Māori are enrolled with a PHO.			
Why is this outcome important:		Māori	86%	
PHO enrolment facilitates easier access to preventative health care and early condition management. PHO enrolment rates vary throughout the country. Māori enrolled with PHOs is 86% as at December 2012		Non-Māori	99%	
		Progress	Ⓟ	
		Gap (%)	13%	

National Indicator 2.2	ACCESS TO CARE	Who will be responsible: PM, Primary Care			
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful			
Increased access by Māori to primary health care services	<p>Continue to work with TDHB provider arm, PHO's and providers to report on ASH, to profile ASH presentations, identify unwarranted variation, and work on strategies to reduce ASH including:</p> <ul style="list-style-type: none"> • development and implementation of successful interventions to improve CVD risk assessment rates • introduction of MDT approaches into General Practice involving podiatry, dietetics, social workers, clinical pharmacy services for people with diabetes and CVD • supporting the implementation of programmes within hospital and primary care services aimed at reducing smoking and achieving Smokefree 2025 • increasing the percentage of eight month old Maori children who have completed their primary course of immunisations • increase the percentage of Maori aged 65 plus who have been immunised for influenza • reduce the rate of DNA's to TDHB Outpatient appointments • increase dental clinic enrolments of pre-school pepi and tamariki, and taiohi • Develop integrated Taranaki taiohi health teams to increase the number of packages of care available to Maori taiohi under the Primary Mental Health initiative. 	Improvement in ASH rates for all age groups ³ towards the national baseline.			
Why is this outcome important:			0-4y	45-64	0-74y
		Māori – Taranaki DHB	8,025	2,673	3,252
		All – National	5,641	1,661	1,983
Effective primary care can reduce ASH rates and ethnic inequalities in ASH rates.		Baseline Percentage	142%	161%	164%
		Gap (%)	42%	61%	64%

³ Ambulatory sensitive hospitalisation (ASH) rate (0-4y, 45-64, 0-74y) ASR per 100,000

National Indicator 3	MATERNAL HEALTH	Who will be responsible: PM, Population Health; Service Manager, Child and Maternal Health			
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful			
<p>Increase in breast feeding rates for Māori and reduce inequalities in breastfeeding rates between Māori and non-Māori</p>	<p>Support the implementation of the Breastfeeding Community Support Service which includes implementation of Breastfeeding Friendly Community Initiative (BFCI) and the Breastfeeding Peer Support initiative.</p> <p>Work with provider arm to maintain Baby Friendly Hospital accreditation of TDHB hospital facilities</p> <p>Maintenance and extension of BFCI accreditation with current 4 organisations.</p> <p>Training of 6 new Peer Support Counsellors using existing framework.</p> <p>Delivery of Peer Support Counsellor Service to 120 new referrals</p>	<p>Consistent increases in breastfeeding rates by 30 June 2014 for Maori at:</p> <p>6 weeks towards the target of 74%</p> <p>3 months towards the target of 57%</p> <p>6 months towards the target of 27%</p>			
<p>Why is this outcome important:</p>			6 wks	3 mths	6 mths
		Māori	57%	41%	10%
		Non-Māori	69%	58%	23%
<p>Breastfeeding contributes significantly to infant, maternal, and whānau health in both the short and long term. In recent years breastfeeding rates in Taranaki have been declining, the Breastfeeding Community Support Service is implementing strategies to improve rates of breastfeeding particularly for Māori. As of 1 July 2012 improved and consistent data collection and reporting processes have been implemented with Tui Ora Limited and Ngati Ruanui via KARO which will contribute to better understanding the overall breastfeeding picture for Taranaki.</p>		Progress	?	?	☒
		Gap (%)	12%	17%	13%

National Indicator 4.1		CARDIOVASCULAR DISEASE		Who will be responsible: Clinical Services Manager, Medical	
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful			
Reduced mortality through improved cardiovascular health	<p>Establish baseline data and a data collection and reporting system which provides quarterly data on access issues relevant to the indicators</p> <p>Process map referral pathways to identify gaps in services access and delivery for Maori</p> <p>Develop an action plan to improve access to meet the targets including monitoring of progress and appropriate follow up action</p>	<p>Indicator A - >70% of high-risk patients will have received an angiogram within 3 days of admission</p> <p>Indicator B - >95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection.</p>			
Why is this outcome important?:			Target	Māori	Non-Māori
<p>The rate of cardiovascular disease hospitalisation and mortality are higher for Māori than non-Māori in Taranaki and the extent of disparities is greater for mortality.</p> <p>Reducing inequalities in cardiovascular outcomes and improving access to CVD management are priorities for the Midland Māori population.</p>		Indicator A	New Measure		
		Indicator B	New Measure		

National Indicator 4.2		CARDIOVASCULAR DISEASE AND DIABETES		Who will be responsible: PM, Primary Care	
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful			
Reduced mortality through improved cardiovascular health	<p>Continue to work with PHOs and primary care providers to identify and implement successful interventions to improve CVD risk assessment rates</p> <p>MHN will introduce an MDT into GP Practices. This will provide Podiatry, Dietetics, Social Workers and Clinical Pharmacy services for people with Diabetes and CVD.</p>	By 30 June 2014, 90% of the eligible population will have had their CVD risk assessed in the last 5 years			
Why is this outcome important:		Māori	58%		
		Non-Māori	68.3%		
<p>CVD is the leading cause of death and the leading cause of avoidable hospitalisation for Taranaki Māori. Given the extent of the burden of CVD and wide ethnic inequalities in cardiovascular health outcomes, access to risk assessment and effective condition management are important interventions to improve outcomes.</p> <p>CVD is substantially preventable with early identification, lifestyle advice and treatment.</p>		Progress	Ⓢ		
		Gap (%)	10.3%		

National Indicator 6.1	CANCER (BREAST SCREENING)	Who will be responsible: PM, Cancer Services	
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful	
Reduced cancer mortality and morbidity	Continue to work with BreastScreen Aotearoa, PHOs and providers to strengthen local reporting of breast screening rates by DHB and ethnicity.	Breast screening coverage rates for Māori women aged 50 to 69 years will reach the target of >70% By 30 June 2014	
	Continue to work with BreastScreen Aotearoa, PHOs and Te Kawau Maro alliance to identify and implement effective interventions tailored toward Taranaki Maori women. Activities include: <ul style="list-style-type: none"> • Establishing a Maori Health subgroup as part of the Local Cancer Network, that will focus on increasing screening rates of Maori women across Taranaki • Working with Breast Screen Coast to Coast to influence the location of the mobile screening bus in 2013/14 to target areas with a higher Maori population • Identify opportunities for BSA to contract with te Kawau Maro alliance to expand delivery of the screening outreach programme into North Taranaki • Establish a framework to monitor delivery against planned actions as well as six-monthly monitoring of the overall coverage target. 	<ul style="list-style-type: none"> • Maori Health subgroup established and develops an Action Plan by September 2013 • BSC2C mobile screening bus delivers mobile screening service in Waitara and Opunake in 2013/14 • Contract in place by May 2014 • Monitoring framework in place by 30 September 2013 	
Why is this outcome important:		Māori	61%
		Non-Māori	75%
The purpose of Breast Screening is to detect breast cancer at an early stage, in order to reduce breast cancer morbidity and mortality. In Taranaki, the screening coverage rate among Māori women is lower than for other ethnicities. Achieving high rates of breast screening coverage for Māori women is important, given that according to national data, Māori women are more likely to be diagnosed at a later stage of breast cancer spread than non-Māori and that for many cancers at each stage Māori-specific mortality rates post diagnosis are higher.		Progress	Ⓟ
		Gap (%)	14%

National Indicator 6.2	CANCER (CERVICAL SCREENING)	Who will be responsible: PM, Cancer Services	
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful	
Reduced cancer mortality and morbidity	Continue to work with the National Cervical Screening Unit, PHOs and Te Kawau Maro alliance to establish and deliver six monthly reporting on rates for Māori and non-Māori in Taranaki.	Increase the % of Māori women aged 25 to 69 who have had a cervical smear in the past 3 years to 80%, by 30 June 2014	
	Work with the Taranaki Regional Screening Unit to continue to work with the National Cervical Screening Unit, PHOs and providers to develop and implement strategies to improve cervical screening rates for Taranaki Maori women		
	Health promotion activities continue to focus on Maori and include in 2013-14 for example <ul style="list-style-type: none"> ◆ WINZ youth service programme ◆ Pae Pae in the Park (Patea) ◆ Kaumatua at Te Roopu Pahake O Waitara ◆ Tui Ora Kaumatua group 		
	Activities continue with kaimahi making direct phone contacts for cervical screening with referrals from practice nurses for our Outreach service. All sessions are evaluated.		
Why is this outcome important:	Māori	72.8%	
	Non-Māori	87.7%	
	Progress	Ⓢ	
	Gap (%)	14.9%	
The cervical screening coverage for Māori women in Taranaki (73%) is lower than for non-Māori (85%). This focus is on increasing coverage for Maori Women. Cancer is a leading cause of mortality for Maori in Taranaki. Cervical cancer is largely preventable through regular three yearly cervical smear tests which can reduce a women's risk of developing cervical cancer by 90%.			

National Indicator 7.1	SMOKING (HOSPITAL)	Who will be responsible: Clinical Services Manager, Medical	
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful	
<p>Less people smoking National Vision and Government Goal– Smokefree Aotearoa 2025</p> <ul style="list-style-type: none"> ▪ Our Tamariki and Rangatahi deserve a future where smoking is history 	<p>Continue to work with TDHB provider arm to apply a focus on Maori patients and their whanau to:</p> <ul style="list-style-type: none"> • Work to ensure provision of advice and support to quit to hospitalised Maori who smoke, is embedded in routine clinical practice of staff • Strengthen systems to deliver a range of activities to support the achievement of the Tobacco Health Target in Secondary Care • Ensure a focus on Maori in the audit and evaluation plan including monitoring by ethnicity • Review and strengthen TDHB Smokefree/Auahi Kore Policy by January 2014 • Strengthen linkages between primary and secondary services • Continue ABC implementation for maternity services staff 	<ul style="list-style-type: none"> • By July 2014, 95% of Māori patients who smoke who are seen by a health practitioner in Public Hospitals, are offered brief advice and support to quit smoking • By January 2013, action plan reviewed and updated to ensure systems are updated to support the achievement of the Tobacco Health Target in Secondary Care • Monitoring by ethnicity will occur monthly and evaluation plan updated • Smokefree/Auahi Kore Workplace and Environment policy reviewed and strengthen by January 2014 	
Why is this outcome important:		Māori	93%
		Non-Māori	93%
<p>Smoking is a significant risk factor for Māori in the Taranaki Region. Māori have a higher prevalence of smoking than other New Zealanders. Some 47% of Taranaki Māori females and 38% of Māori males are regular smokers, compared to around 21% of New Zealand Europeans. The prevalence of regular smoking in Taranaki Māori females is also higher than the national average.</p> <p>Smoking kills an estimated 5000 people in New Zealand every year and smoking-related diseases are a significant opportunity cost to the health sector.</p>		Progress	<input checked="" type="checkbox"/>
		Gap (%)	0%

National Indicator 7.2	SMOKING - PRIMARY CARE	Who will be responsible: PM, Population Health	
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful	
<p>New Zealanders living longer, healthier and more independent lives National Vision and Government Goal – Smokefree Aotearoa 2025</p> <ul style="list-style-type: none"> ▪ Our Tamariki and Rangatahi deserve a future where smoking is history 	<p>Apply a focus on Maori patients and their whanau to:</p> <ul style="list-style-type: none"> • Identify core components to be included in practice based smoking cessation plans, and include these as part of the 2013-14 PHO quality plan process • A generic and routine data reminding and decision making support tool is available to all Taranaki MHN Medtech practices that will benefit Maori patients • A pregnancy pathway is implemented to ensure that help and support to quit is given to Mothers at the time of the confirmation of pregnancy within PHOs • Complete audit and evaluation of pregnancy pathway within PHOs • Work collaboratively with PHOs developing systems, linkages and communications with Smokefree/Auahi Kore services and stakeholders that are relevant for Maori • Implement a dedicated specialist cessation service to support quit attempts in Primary Care settings with a focus on Maori and high needs practices 	<p>90% of Māori patients aged 15 years and over who smoke and are seen by a Primary Care health practitioner in the last 12 months are offered brief advice and support to quit smoking</p> <ul style="list-style-type: none"> • Data reminder and decision making support tool implemented by 30 September 2013 • Pregnancy pathway implemented by 30 September 2013 • Pregnancy pathway evaluated by 30 June 2014 • Strengthen system and linkages between Primary and Secondary Care by December 2013 • A minimum of 478 patients provided with Free Cessation Support to quit by March 2014 	
Why is this outcome important:		Māori	37%
<p>Smoking is a significant risk factor for Māori in the Taranaki Region. Māori have a higher prevalence of smoking than other New Zealanders. Some 47% of Taranaki Māori females and 38% of Māori males are regular smokers, compared to around 21% of New Zealand Europeans. The prevalence of regular smoking in Taranaki Māori females is also higher than the national average.</p> <p>Smoking kills an estimated 5000 people in New Zealand every year and smoking-related diseases are a significant opportunity cost to the health sector</p>		Non-Māori	38%
		Progress	?
		Gap (%)	1%

National Indicator 8.1	IMMUNISATION	Who will be responsible: PM, Child & Youth	
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful	
Improved children's health	<p>Work with PHOs and providers to prioritise actions and implement interventions to address access for Māori</p> <p>Monthly reporting via immunisation dashboard including detailed geographical analysis on gaps in uptake.</p> <p>Work with Outreach Immunisation Providers to target the children identified through geographical analysis.</p> <p>Work with the PHOs, providers and Te Kawau Maro alliance to establish and deliver monthly monitoring of Maori coverage rates in Taranaki.</p>	85% of eight month old Māori children have completed their primary course of immunisations (6 weeks, 3 months and 5 months) by 30 July 2013, 90% by 30 July 2014 and 95% by December 2014.	
Why is this outcome important:		Māori	83%
		Non-Māori	88%
<ul style="list-style-type: none"> Immunisation is linked to primary care access and management Immunisation can prevent a number of diseases and is a cost-effective health intervention. 		Progress	Ⓟ
		Gap (%)	5%

National Indicator 8.2	IMMUNISATION	Who will be responsible: PM, Primary Care	
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful	
Reduced communicable disease	<p>Continue working with PHO's to develop a means of assessing influenza immunisation rates for Māori and non-Māori aged 65 years and over;</p> <p>Identify and implement interventions to address low immunisation rates for Māori.</p>	Increase the percentage of Māori aged 65 years and over who have been immunised for influenza to 75%	
Why is this outcome important:		Māori	66%
		Non-Māori	68%
The complications of influenza (more commonly known as 'flu') in elderly can be serious or life threatening. As a result, the Government funds the cost of influenza vaccinations and their administration for people aged 65 and over and		Total	
		Progress	<input checked="" type="checkbox"/>

people of any age with certain chronic conditions. Seasonal influenza immunisation rates for Māori aged 65 years and over 66.4%	Gap (%)	2%
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National Indicator 9		RHEUMATIC FEVER		Who will be responsible: PM, Population Health		
Outcome we want to achieve		What we are planning to do to achieve it		How we will know if we have been successful		
Reduce the incidence of Rheumatic Fever		<ul style="list-style-type: none"> • By 20 October 2013, develop and implement a rheumatic fever prevention plan appropriate to the level of intervention required. This may include: <ul style="list-style-type: none"> ○ Ensuring that primary care providers and other health professionals likely to see high risk children follow the National Heart Foundation Sore Throat Management Guidelines ○ Ensuring people with Group A streptococcal infections are treated appropriately within 7 days of developing symptoms ○ Ensuring that all cases of acute rheumatic fever are notified to the Medical Officer of Health within 7 days of hospital admission ○ Reviewing all cases of rheumatic fever to identify any identifiable risk factors and system failure points ○ Ensuring patients with a past history of rheumatic fever receive monthly antibiotics not more than 5 days after due date • National Hauora Coalition will support their providers with CME/CNE on prevention and treatment of rheumatic fever 		Hospitalisation rates per 100,000 DHB total population for acute rheumatic fever are 10% lower than the average over the last 3 years (measured by National Minimum Data Set).		
Why is this outcome important:					Baseline	Target
Rheumatic Fever left untreated can damage the heart leading to life long heart problems. Working to reduce and eliminate rheumatic fever can reduce the incidence of heart disease and/or related complications.				Total	1	0.8

LOCAL PRIORITIES AND INDICATORS ACTION PLAN

Local Indicator 1	ACCESS TO SERVICES	Who will be responsible: Clinical Services Manager, Medical	
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful	
Improved access to secondary care	<p>Complete the profile of Maori DNA FSA's and follow up appointments for CVD, diabetes, dental, colposcopy and respiratory-related clinics</p> <p>Review patient pathways including whanau feedback to identify issues that need to be addressed</p> <p>Drawing on successful experiences of other DHB's, develop and implement the action plan to reduce DNA rates in the particular specialties examined</p> <p>Establish a review process to regularly monitor progress towards reducing DNA's and make adjustments in approach where needed</p> <p>Look at implementing successful interventions across other DNA specialties.</p>	DNA rates reduced to <9% by July 2014	
Why is this outcome important:		Māori	19%
<p>Māori have double the DNA rate for first specialist outpatient appointments compared to "Other" ethnic groups in Taranaki and around three times the DNA rate for follow-up appointments. While DNA rates for the Taranaki DHB population are consistently lower than the national figures they have been increasing over the three year period and the extent of ethnic inequalities between Māori and non-Māori is similar.</p> <p>Higher disease burden coupled with higher DNA rates will result in ongoing unmet health need.</p>		Non-Māori	7%
		Progress	↑
		Gap (%)	12%

Local Indicator 2	ORAL HEALTH	Who will be responsible: Clinical Services Manager, Child and Maternal Health	
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful	
Improved oral health among Māori children	<p>Profile Maori under 5 year old dental enrolees, match against population data to identify enrolment gaps</p> <p>Work with the provider arm and NGO providers to increase the focus on enrolment of Maori pre-school children and develop strategies to target the identified enrolment gaps</p>	Dental clinic enrolments' of pre-school Maori children under 5 years of age will increase from 59.1% to 70% by July 2014.	
Why is this outcome important:		Pre-school Enrolments	
<p>The earlier children are enrolled with a dental service the more aware they, their mothers, caregivers and whanau are of good oral health practices. The likelihood of the child and whanau engaging in good oral health practices early to prevent dental decay is therefore much greater.</p> <p>59.1% of Maori pre-schoolers were enrolled with a dental clinic in 2012 compared to 74.6% of non-Maori. There is a correlation between early enrolment and oral health status.</p> <ul style="list-style-type: none"> Māori have higher average counts of decayed, missing and filled deciduous (dmft) and permanent (DMFT) teeth than non-Māori. All ethnic groups have an increasing number of decayed, missing, and filled primary teeth (dmf) at age five, but the dmf is worse for Māori Māori five-year-olds have a significantly higher dmf than other five-year olds The percentage of Māori children who were caries free at age 5 in 2012 was 29.87% compared to 61.39% for non-Māori. 		Māori	59.1%
		Non-Māori	74.6%
		Progress	<input checked="" type="checkbox"/>
		Gap (%)	15.5%

Local Indicator 3	SUDDEN UNEXPLAINED DEATH OF INFANTS SYNDROME	Who will be responsible: Clinical Services Manager, Child and Maternal Health	
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful	
Improved child health	<p>Work with the relevant TDHB departments, PHO's and NGO providers to develop and implement an action plan to:</p> <ul style="list-style-type: none"> • Improve the accuracy of ethnicity data to enable accurate reporting of Maori SUDI rates • Improve Maori breast feeding rates • Strengthen smoking cessation support for pregnant women and their whanau • Increase the proportion of 8 month old Maori children who have completed their immunisations • Develop and implement a Safer Sleeping Environment policy throughout maternity and child health services • Explore and develop if feasible, a project to produce and distribute wahakura or pepi pods to Mama with newborn pepi • Establish a process of reviewing progress against the actions planned with a view to modifying actions to improve results if required. 	0.75 SUDI deaths per 1,000 live births of Māori infants by 2015	
Why is this outcome important:		Māori	1.10
		Non-Māori	0.8
		Progress	T
		Gap (%)	0.3
Taranaki's SUDI rates for Māori 1.10 per 1,000 live births (3 deaths recorded for the 4 year period 2006-2010) which is above the national target of 0.5.			

Local Indicator 4	PRIMARY MENTAL HEALTH	Who will be responsible: Portfolio Manager, Mental Health & Addictions	
Outcome we want to achieve	What we are planning to do to achieve it	How we will know if we have been successful	
<p>Taiohi are emotionally and mentally well and are achieving their best possible educational outcomes</p>	<p>Develop Taranaki Taiohi Health Teams – integrated approach supporting, education, MSD and health.</p>	<p>Establish baseline figures for number and proportion of new packages of care and increase the number of packages of care available to Maori youth under the Primary Mental Health Initiative by 25%, by 30 June 2014.</p>	
	<p>Hold geographically based group workshops for e.g. PHNs, Counsellors, guidance counsellors, School Based Health Services, Heads of Departments, Youth Transition services and other NGO providers to increase responsiveness of professionals working with young people.</p>		
	<p>Improve pathways for earlier intervention of young people identified with mild to moderate mental health and addictions issues.</p>		
	<p>Develop school and other settings based group programmes for taiohi who are identified as likely to be experiencing distress now and into the future.</p>		
<p>Why is this outcome important:</p>	<p>Māori</p>		<p>New Measure</p>
	<p>Non-Māori</p>		<p>New Measure</p>
	<p>Progress</p>		<p>T</p>
	<p>Gap (%)</p>		<p>New Measure</p>
<p>At least 20% of young people experience emotional and mental health issues during the course of their adolescent years. There are a number of risk factors which impact on a young person being able to maintain good mental health including, family/whānau, cultural identity, peers and friendships, activities they are involved in, boredom and being engaged with the education system. Utilisation of primary mental health interventions can significantly reduce Young Māori are over represented in a range of statistics, including teenage birth rates being double the national average at 92.0 per 1000 population. Māori are also more likely to present to hospital for self related harm. In 2011/12 38% of admissions for taiohi were for Māori. School completion and educational attainment rates are 57% for Māori compared to 71% for non-Māori.</p>			

REFERENCES

1. Whānau Ora Health Needs Assessment, Māori Living in Taranaki, Ratima and Jenkins, Taranaki District Health Board, February 2012
2. TDHB Maori Health Plan 2012-2013
3. Te Kawau Maro, Taranaki Maori Health Strategy 2009 – 2029
4. Ministry of Health, 2013/14 Operational Policy Framework
5. Statistics NZ, District Health Board Area summary tables, Statistics NZ 2006
6. Taranaki Taiohi Health Strategy, Te Rautaki Hauora Taiohi o Taranaki 2013 – 2016, Tui Ora Ltd, Taranaki DHB, Midlands Health Network, Ministry of Social Development, Ministry of Education, National Hauora Coalition, 2013
7. Draft outcomes framework, Te Kawau Maro Alliance and Taranaki District Health Board