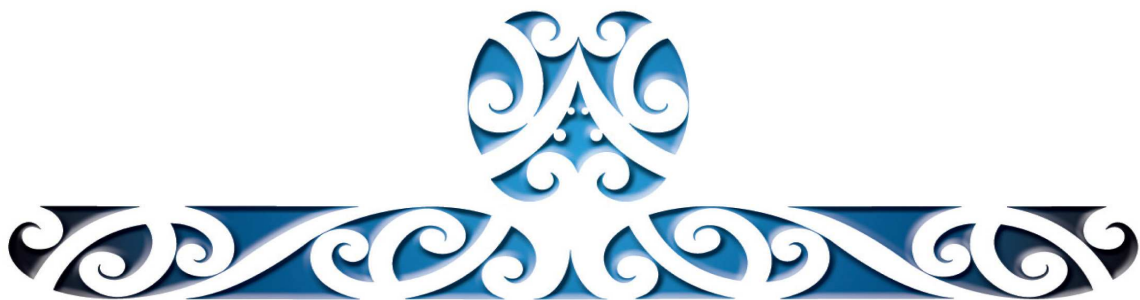




Māori Health Plan

2011-2012



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BACKGROUND

This Plan documents the direction for funding, planning and delivery of services in Taranaki over the next twelve months. Its primary focus is to improve Māori health status and reduce Māori health inequalities. It sits within a framework of DHB planning that aims to achieve the vision of “Taranaki Whanui, He rohe oranga” and the wider aspirations of whanau ora as described in He Korowai Oranga, national Māori Health Strategy and Te Kawau Mārō, Taranaki Māori Health Strategy.

The main audiences for the plan are:

- Taranaki DHB funder
- Taranaki DHB provider arm
- Taranaki DHB Public Health Unit
- National Hauora Coalition
- Midlands Health Network
- Māori NGO providers
- Mainstream NGO providers
- Intersectoral partners including Ministry of Social Development, Te Puni Kokiri, Territorial Local Authorities, Housing NZ, Ministry of Education, Sport Taranaki and others
- Philanthropic funders including TSB Community Trust

The draft plan is made up of four sections:

1. Section One – Profile of the TDHB population and Māori health status;
2. Section Two - National Māori Health Priorities and Actions
3. Section Three: - Regional Māori Health Priorities and Actions
4. Section Four: - Local Māori Health Priorities and Actions

Appendix A describes the methodology used to develop the national, regional and local indicators for the Taranaki DHB.

ACKNOWLEDGMENT

Taranaki DHB acknowledges the BOPDHB in particular for their support in allowing us to adapt their Māori Health Plan methodology and templates to accord the Taranaki Māori context.

1. SECTION ONE: TARANAKI DHB MĀORI POPULATION AND HEALTH NEEDS PROFILE

1.1. The Māori Population

The total Taranaki Māori population (2006 Census) is 15,798 of which 50.6% (7,994) are females and 49.4% (7,804) are males. The proportion of Māori living in Taranaki (15.8%) is similar to the rest of the country.*

1.2. Age Distribution

The Māori population has a younger age structure than the non-Māori population, with 35.9% of Māori aged under 15 years, compared to 21.8% for non-Māori. Just under half (47%) of Taranaki Māori are under the age of 20 years while over 60% of Māori living in Taranaki are under the age of 30 compared to 36% of non-Māori. The median age of Taranaki Māori (half are younger, and half older) is 22.3 years while the median age of the total Taranaki population is 38.0 years.

At the 2006 census 14.8% of the total Taranaki population were over the age of 65 compared to only 4.8% of the Māori population.

1.3. Geographic distribution

TDHB comprises three territorial authorities. In 2006 the majority of the population were based in the New Plymouth District Council catchment while the largest proportion were based in the South Taranaki District.

	South Taranaki District	Stratford District	New Plymouth District
Total Population	26,487	8,892	68,901
Māori (%)	21.7%	11.2%	14.1%

1.4. Population Growth

The Taranaki population is projected to increase to 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 15.8% in 2006.

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.

1.5. Health Service Providers

Key health service providers in TDHB region include:

- a. Two public hospitals:
 - i. Taranaki Base Hospital in New Plymouth with 179 inpatient, 25 inpatient mental health, 21 emergency department and 18 maternity beds;
 - ii. Hawera Hospital with 20 inpatient, 7 emergency department and 4 maternity beds.
- b. Three PHOs:
 - i. Te Tihi Hauora PHO is a Māori PHO made up of Ruanui Health Services and Te Atiawa Medical Services General Practices. Te Tihi Hauora O Taranaki PHO with an enrolled population of 5392 of which 3392 or 63% are Māori, is a member of the National Hauora Coalition;

* Taranaki District Health Board Health Needs Assessment 2007

- ii. Midlands Health Network has an enrolled population of 444,263 of which 98,685 or 22.2% are enrolled with Taranaki practices. Of these, around 11.5% or 11,371 identify as Māori;
 - iii. Te Oranganui Iwi Health Authority PHO has an enrolled population of 7381 of which 904 are enrolled with the Waverley practice. Of these, around 37% or 336 identify as Māori.
- c. Tui Ora Ltd Māori Development Organisation, service provider and provider of back-office services;
 - d. 10 independent non-profit Māori health providers affiliated to Tui Ora Ltd;
 - e. 3 iwi-based Māori health providers - Ngati Ruanui, Nga Ruahinerangi and Ngaa Rauru Kiitahi through Te Oranganui Iwi Health Authority.
 - f. 1 independent Māori health provider (Te Atiawa Medical Services)
 - g. Multiple local and national non-profit and private mainstream provider organisations

1.6. Service Utilisation

The highest number of Māori were enrolled with the Midland Health Network with 11,371 while 5,392 are enrolled with Te Tihi Hauora PHO (February 2011).

	Te Tihi Hauora O Taranaki	Midland Health Network	Te Oranganui PHO
Total Enrollees	5392	98,685	904 (Waverly practice only)
Māori %	63%	11.5%	37% (Waverly practice only)

1.7. Iwi

There are eight iwi in Taranaki:

IWI	TOTAL POPULATION	TARANAKI POPULATION	% 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 Kiitahi	4,047	726	17.9%
TOTAL	37,008	8,997	24.3%
Māori: non-Taranaki iwi		6,801	
Total Māori Population		15,798	

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.

There are over 50 hapū represented in nga Iwi o Taranaki and 42 Marae in the region. The majority of Marae are located in the southern part of the region across four iwi rohe - Taranaki, Ngaruahinerangi, Ngati Ruanui and Ngaa Rauru Kiitahi.

1.8. Deprivation

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.

1.9. Social Determinants of Health:

a. Education

26% of Māori in the TDHB region left school with little or no formal attainment compared to 11.5% of non-Māori school leavers;

b. Employment

Taranaki Māori were more than 3 times more likely to be unemployed than non-Māori in Taranaki at the 2006 census (8% compared to 2.5%);

c. Income

d. Māori were more likely than the European/other group to be categorised as low income (less than \$20k per annum) at the 2006 census;

e. Home ownership

A higher proportion of TDHB Māori do not own their own home compared with non-Māori – 57% compared to 41%;

f. Access to Telecommunications

Māori households in Taranaki were more than twice as likely to have no access to telecommunications and were less likely to have access to a telephone, internet or fax. However they were more likely to have access to a cellphone;

g. Access to Transport

In Taranaki, Māori households are more likely than non-Māori households to have no access to a motor vehicle.

1.10. Risk and Protective Factors

The significant inequalities in risk and protective factors between Taranaki Māori and non-Māori include:

- The rate of youth smokers 14-15 years is 35.9 per 100 for Māori females and 38.4 per 100 for Māori Males compared to 11.8 per 100 in non - Māori females and 21.6 in non-Māori males (2005);
- Prevalence of current adult smokers is more than two times higher for Māori than non-Māori (2006);
- Prevalence of obesity is nearly twice as high (1.8 times) for Māori than non-Māori males and females (2006/7)
- Prevalence of potential hazardous drinking was nearly three times higher for Māori females than non-Māori females (2006/7);

1.11. Access to Health Care

The significant inequalities in access to health care were evident in **Asthma hospitalisations (ASR per 100,000) for 0 – 14 year old** - Age Standardised Hospitalisation Rates in 2005-07 were much higher for Māori (540 per 100,000) than Non Māori (370 per 1000,000)

1.12. Quality of Health Care

Significant inequalities in the quality of care received are apparent in the following:

- **Diabetes** detection for Māori was less than half that of non-Māori in 2006;
- Māori experience far more **diabetes complications**. Age Standardised Admission Rates in 2002-03 for Diabetes complications (Renal failure with concurrent diabetes) in Māori Males was 491.9 per 100,000 compared to Non Māori males 226.2 per 1000,000. The rate for Māori Females was 558.8 per 100,000 compared to non-Māori females 154.9 per 100,000.

1.13. Health Outcomes – Disease and Mortality

The following significant inequalities in health outcomes were evident:

- Mortality from **all cancers** (2002-03) was higher in Māori females at 190 ASR per 100,000 than non-Māori females 119.1 ASR per 100,000. In Māori males 279.9 ASR per 100,000 compared to 164.9 for non-Māori males (2003-04 data);
- **Lung Cancer** - Age Standardised Cancer Registration Rates for Lung Cancer in 2003-04 were much higher for Māori females (115.5 per 100,000) than non Māori females (36.7 per 100,000). The rate for Māori males was 98.2 per 100,000 compared to non-Māori males at 20.3 per 100,000;
- **All Cardiovascular Disease Mortality** - Age Standardised Death Rates in 2002-03 were much higher for Māori Males (407.6 per 1000,000) than non Māori males (199.6 per 1000,000) while the rate for Māori females was 374.1 per 100,000 compared to 138.2 per 100,000 for non-Māori females;
- **Suicide** - Age Standardised Suicide Deaths in 2005-07 for Māori was 18.6 per 1000,000 compared to the non Māori rate of 16.4 per 100,000;
- **Decayed, missing and filled teeth at year 8** - DMFT score in 2009 was 1.53 teeth for Māori compared to 1.16 teeth for Other Ethnicity;
- **Chronic Obstructive Pulmonary Disease (COPD)** - Age Standardised Death Rates for COPD in 2002-03 were much higher for Māori males (86.2 per 100,000) compared to non Māori males (30.8 per 100,000). The rate for Māori females was 72 per 100,000 compared to 16 per 100,000 for non-Māori females.

1.14. Planned Actions

The action plan that follows describes the activities the Taranaki DHB will perform during 2011/12 to address the following national, regional and local priorities:

National Priorities and Indicators		
1	N1-Data Quality	Ethnicity data accuracy in PHO registers and TDHB Provider Arm services
2	N2-Access to Care	Percentage of Māori enrolled in PHOs
3		Ambulatory sensitive hospitalisation (ASH) rate 0-4y, 45-64, 0-74y ASR per 100,000
4	N3-Maternal Health	Percentage of infants exclusively breastfed at 3 weeks, 3 months and 6 months
5	N4-Cardiovascular Disease	Number of tertiary cardiac interventions
6		The proportion of the eligible population who have had the blood tests for CVD risk assessment in the last five years
7	N5-Diabetes	Percentage of diabetics who have attended a Diabetes Annual Review (DAR);
8		Percentage of diabetics who have completed DAR and are HbA1c <8%
9	N6-Cancer	Breast screening rate among the eligible population
10		Cervical screening rate among the eligible population
11	N7-Smoking	Percentage of adults 15+ admitted to hospital either acutely or for elective procedures who are provided with advice and help to quit
12		Percentage of smokers in primary care who are provided with advice and help to quit
13	N8-Immunisation	Percentage of 2 year olds fully immunised
14		Seasonal influenza immunisation rates for Māori aged 65 years and over

15	N9-Māori Health Workforce	Percentage of Māori staff in Management, Clinical, Allied Health, non-health support, Administrative positions in TDHB
Regional Priorities and Indicators		
16	R1-Cardiovascular Disease	Number of tertiary cardiac interventions
17	R2-Māori Health Workforce	Report on the total number of Māori recruited to Kia Ora Hauora
18	R3-Māori Provider Capacity Development	Report on the increase in investment in Māori providers
19		Results-based Accountability contracts in place for provision of Māori health services
20	R4-Monitoring Performance	Report on completion of 2 He Ritenga – Treaty of Waitangi principles cultural audits across selected service areas within the Taranaki DHB Provider Arm
Local Priorities and Indicators		
21	L1-Access to Services	Did-Not-Attend (DNA) rate for outpatient appointments
22	L2-Oral Health	Percentage of 5 year olds in Taranaki carries-free
23		DMFT scores at year 8 in Taranaki
24	L3-Respiratory Health	Asthma hospitalisation rate 0-14 years ASR per 100,000
25	L4-Sudden Unexplained Death of Infants Syndrome	SUDI mortality rate per 1,000 live births of Māori infants
26		DHB has achieved and maintained Baby Friendly Hospital accreditation
		Proportion of Māori mothers who breastfeed (Indicator 4)
27	L5-Māori Health Workforce	Report on the total number of Māori recruited to the Incubator programme

2. SECTION TWO – NATIONAL PRIORITIES AND INDICATORS

Section two summarises TDHB’s current and planned activities related to the National Māori Health priorities.

Health Priority N1		Data Quality	
Indicator 1		Ethnicity data accuracy in PHO registers and TDHB Provider Arm services	
Baseline		National Minimum Data Set reports Taranaki DHB as 0.82% for the December 2010 quarter of patient’s ethnicity ‘Not Stated’. National Minimum Data Set reports Taranaki DHB as 0.47% for the December 2010 quarter of patient’s ethnicity ‘Unidentifiable’. National Minimum Data Set reports Taranaki DHB as 0.04% for the December 2010 quarter of patient’s ethnicity ‘Other’. There is currently no known baseline of the accuracy of ethnicity data captured by TDHB or PHOs	
Target		TDHB – Numerator: Total number of NHI records created with ethnicity of “Not Stated”, ‘Response Unidentifiable’ and ‘Other’ is >0.5% and Denominator: Total number of NHI records created is <=2% PHOs – To be determined after performing an initial ethnicity data audit of PHOs	
Rationale		<ul style="list-style-type: none"> • The accuracy of ethnicity data in PHO and DHB databases is variable • Accurate ethnicity data is essential for tracking progress in Māori health outcomes 	
Population health outcome we desire:		Accurate population health information to inform planning and service delivery	
To help achieve this outcome we will focus on:		Improving the accuracy of ethnicity data in DHB and PHO databases	
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Identify best-practice approaches to auditing baseline ethnicity data accuracy in DHB and PHO databases	October 2011	A robust method for auditing DHB and PHO databases for ethnicity data accuracy	Efficient database auditing
2. Conduct an audit of 2 TDHB departments and 2 PHO enrolment sub-sets to determine baseline ethnicity data accuracy in their respective databases	March 2012	A report of the accuracy of ethnicity data in the Taranaki DHB databases A report on the accuracy of ethnicity data in the Midland Health Network PHO and National Māori PHO Coalition / Te Tihi Hauora O Taranaki PHO databases	The ability to set targets for ethnicity accuracy relative to baseline starting levels
3. Set ethnicity data accuracy performance targets for TDHB and PHO databases	May 2012	Ethnicity data accuracy targets at TDHB and PHOs An action plan for attaining targets.	Efficient resource allocation toward performance targets
4. Provide education package on ethnicity data collection to relevant personnel in TDHB and PHOs	June 2012	Training for PHO and TDHB staff who collect ethnicity data	Accurate collection of ethnicity data

5. Schedule subsequent DHB and PHO ethnicity data accuracy audits	April 2012	A schedule of database auditing Ongoing reports of ethnicity data accuracy Feedback to providers and other stakeholders	Observable ongoing improvement in ethnicity data accuracy Improved health outcomes reporting
6. Provide regular reporting of ethnicity data accuracy to the Māori Health Steering Group (MHSG)	To follow baseline and subsequent ethnicity data audits	Regular reports of the results from ethnicity data audits for the MHSG and other stakeholders	Information sharing with stakeholders Changes to the action plan

Health Priority N2.1	Access to Care		
Indicator 2	Percentage of Māori enrolled in PHOs		
Baseline	82% of Māori are enrolled with PHOs		
Target	95% of Māori will be enrolled with PHOs by 30 June 2012		
Rationale	<ul style="list-style-type: none"> • PHO enrolment rates vary throughout the country • PHO enrolment facilitates easier access to preventative health care and early condition management 		
Population health outcome we desire:	Increased access to primary care		
To help achieve this outcome we will focus on:	Raising the PHO enrolment rate for Māori to that of non-Māori		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Assess the current rate of PHO enrolment in TDHB for Māori and non-Māori stratified by age, location, and other variables	September 30	A report outlining PHO under-enrolment categorised by various demographic characteristics	Develop a plan to increase Māori enrolment in PHOs
2. Establish PHO enrolment targets	October 31	Intermediate and final enrolment targets	Comprehensive plan to increase Māori enrolment in PHOs
3. Establish a reporting system which provides monthly DAR rates for Māori and non-Māori	October 2011	A monthly report of DAR rates	Changes to the action plan based on performance data
4. Provide quarterly reporting to the MHSG	Quarterly throughout 2011/12	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority N2.2	Access to Care		
Indicator 3	Ambulatory sensitive hospitalisation (ASH) rate (0-4y, 45-64, 0-74y) ASR per 100,000		
Baseline	76.2% 0-4 years, 110.25% 45-64 years, 97.1% 0-74 years		
Target	<95%		
Rationale	<ul style="list-style-type: none"> • ASH rates for Māori are almost double those of non-Māori • Effective primary care can reduce ASH rates 		
Population health outcome we desire:	Improved access to primary care		
To help achieve this outcome we will focus on:	Reducing the ambulatory sensitive hospitalisation (ASH) rate		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Profile ASH presentations by diagnosis, age, location and other variables	December 31	A report outlining the leading causes of ASH stratified by age, location, and other variables	Targeted resource allocation towards the leading ASH conditions
2. Identify interventions to address the leading causes of ASH	January 31	A report outlining interventions to reduce ASH	Selection of interventions based on proven efficacy
3. Work with primary care to identify systems and strategies which will reduce ASH	January 31	Procedures and systems which improve access and management of ASH conditions in primary care	Improved access to primary care for ASH related conditions
4. Work with primary health care to implement interventions which address barriers to access and management	February 28	Initiatives which improve access and management of ASH related conditions in primary care	Improved access to primary care for ASH related conditions
5. Establish a reporting system which provides monthly DAR rates for Māori and non-Māori	October 2011	A monthly report of DAR rates	Changes to the action plan based on performance data
6. Provide quarterly reporting to the MHSG	Quarterly throughout 2011/12	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority N3	Maternal Health		
Indicator 4	Percentage of infants exclusively breastfed at 6 weeks, 3 months and 6 months (Plunkett Data)		
Baseline	6 Weeks Māori 60% by June 2010 3 months Māori 48% by June 2010 6 months Māori 13% by June 2010		
Target	6 Weeks Māori 62% by June 2012 3 months Māori 55% by June 2012 6 months Māori 18% by June 2012		
Rationale	There are benefits to baby if breastfed exclusively (not having any solid food) until six months old, and continuing to breastfeed once baby has started solid food, until at least 1 year of age (Plunkett New Zealand).		
Population health outcome we desire:	Reduce the SUDI mortality rate; Reduce cancer mortality rates; Reduce inequalities in breast feeding rates between Māori and non-Māori		
To help achieve this outcome we will focus on:	Improving Māori breast feeding rates		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Improve the co-ordination of breastfeeding activities and initiatives	September 2011	Services developed for Māori Women	<ul style="list-style-type: none"> ▪ Interventions targeted toward high needs groups ▪ Resource allocation towards interventions which address gaps in current service delivery ▪ Increased breastfeeding rates
2. Establish a peer support programme in the community, primarily for Māori women			
3. Continue the Implementation of the Breastfeeding Welcome Here Project in appropriate settings for Māori	July 2011	Appropriate premises accredited for Breastfeeding Welcome Here	
4. Develop better and simple data collection and reporting processes for breastfeeding statistics	January 2012	Regular and updated reporting of breastfeeding rates	
5. Provide quarterly reporting to the MHSG	Quarterly	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority N4.1	Cardiovascular disease		
Indicator 5	Number of tertiary cardiac interventions		
Baseline	N/A		
Target	N/A		
Rationale	Collection requested for information purposes only		
Population health outcome we desire:	Reduced mortality through improved cardiovascular health		
To help achieve this outcome we will focus on:	Monitoring the number of tertiary cardiac interventions for Māori and non-Māori in TDHB		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Determine the number of tertiary cardiac interventions for TDHB Māori for the 2010/11 year	31 July 2011	A report identifying the number and type of tertiary cardiac interventions provided to TDHB	Identification of intervention rates
2. Compare TDHB intervention rates with other regional and national benchmarks	31 August 2011	A report comparing tertiary cardiac intervention utilisation with local, regional and national populations	Changes to tertiary cardiac referral processes
3. Set up a reporting system which provides monthly tertiary cardiac intervention rates	31 August 2011	A quarterly report of tertiary cardiac intervention rates	Changes to referral processes based on performance data
4. Provide quarterly reporting to the MHSG	On-going	A quarterly report for the MHSG	Information sharing with stakeholders Changes to action plan

Health Priority N4.2	Cardiovascular disease		
Indicator 6	The proportion of the eligible population who have had the blood tests for CVD risk assessment in the last five years		
Baseline	56% of eligible population quarter two 2010/11 (69% total population)		
Target	90% by 30 June 2012		
Rationale	<ul style="list-style-type: none"> • Cardiovascular disease is the leading cause of mortality for Māori, with rates 2.5 times those of non-Māori • Māori hospitalisation rates are almost double those of non-Māori • CVD is substantially preventable with lifestyle advice and treatment 		
Population health outcome we desire:	Reduced mortality through improved cardiovascular health		
To help achieve this outcome we will focus on:	Increasing the proportion of cardiovascular risk assessments (CVRA) performed in the eligible population		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Monitor Quarterly Reporting on CVRA comparing Māori and non-Māori	Quarterly	A quarterly report showing the differences between CVRA for Māori and non-Māori	Develop a plan to address the inequalities
2. Establish a reporting system which provides monthly DAR rates for Māori and non-Māori	October 2011	A monthly report of DAR rates	Changes to the action plan based on performance data
3. Provide quarterly reporting to the MHSG	Quarterly through-out 2011/12	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority N5.1	Diabetes		
Indicator 7	Percentage of diabetics who have attended a Diabetes Annual Review (DAR);		
Baseline	98% at quarter 2 2010/11 (112% for total population)		
Target	95% by 30 June 2012		
Rationale	Diabetes is a major and increasing cause of disability and premature death, and it is also a good indicator of the responsiveness of health services for people in most need. The indicator monitors access to quality improvement programs in primary care.		
Population health outcome we desire:	Reduced mortality and morbidity due to diabetes through improved diabetes care		
To help achieve this outcome we will focus on:	Maintaining attendance at the diabetes annual review (DAR) in primary care		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Determine DAR rates by clinic and PHO for Māori and non-Māori	August 2011	A report on DAR results by clinic, PHO and areas	Resource allocation toward high-needs areas Support for high-performing areas
2. Identify effective interventions implemented in successful DHBs and clinics which are relevant to TDHB	October 2011	A report outlining key interventions conducive to improved diabetes care from DHBs with high health target performance	Efficient resource allocation toward those interventions with the highest cost effectiveness
3. Work with primary care providers and PHOs to implement selected interventions	December 2011	Implementation of interventions with proven track record in high-performing DHBs	Improved DAR rates
4. Work with TDHB's diabetes champion to identify effective interventions	December 2011	Identification of key strategies and interventions conducive to improved diabetes care	Improved DAR rates
5. Establish a reporting system which provides monthly DAR rates for Māori and non-Māori	October 2011	A monthly report of DAR rates	Changes to the action plan based on performance data
6. Provide quarterly reporting to the MHSG	Quarterly through-out 2011/12	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority N5.2	Diabetes		
Indicator 8	Percentage of diabetics who have completed DAR and are HbA1c <8%		
Baseline	69% at quarter 2 2010/11 (80% for total population)		
Target	80% by 30 June 2012		
Rationale	Diabetes is a major and increasing cause of disability and premature death, and it is also a good indicator of the responsiveness of health services for people in most need. The indicator monitors access and quality improvement programs in primary care, and the quality of care and risk of diabetes complications.		
Population health outcome we desire:	Reduced mortality and morbidity due to diabetes through improved diabetes care		
To help achieve this outcome we will focus on:	Improved management of Māori who have attended the DAR		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Determine HbA1c rates by clinic and PHO for Māori and non-Māori	August 2011	A report identifying HbA1c results by clinic, PHO, and area	Resource allocation toward high-needs areas Support for high-performing areas
2. Identify effective interventions implemented in successful DHBs and clinics which are relevant to TDHB	October 2011	A report outlining key interventions conducive to improved HbA1c rates from DHBs with proven performance	Efficient resource allocation toward those interventions with the highest cost effectiveness
3. Work with primary care providers and PHOs to implement selected interventions	December 2011	Implementation of interventions with proven track record in high-performing DHBs	Improved HbA1c rates
4. Work with TDHB's diabetes champion to identify effective interventions	December 2011	Identification of key strategies and interventions conducive to improved diabetes care	Improved HbA1c rates
5. Establish a reporting system which provides monthly HbA1c rates for Māori and non-Māori	October 2011	A monthly report of HbA1c rates	Changes to the action plan based on performance data
6. Provide quarterly reporting to the MHSG	Quarterly throughout 2011/12	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority N6.1	Cancer		
Indicator 9	Breast screening rate among the eligible population		
Baseline	Breast screening coverage rates for Māori women aged 45 to 69 years - 52.3% in June 2010 (75.0% non-Māori)		
Target	Targets to be determined by agreement with BreastScreen Aotearoa.		
Rationale	<ul style="list-style-type: none"> • Māori female breast cancer registrations are 1.3 times that of non-Māori • Breast cancer mortality is 1.8 times that of non-Māori • For older women, breast screening using mammography (breast x-rays) followed by appropriate treatment is the best way of reducing the chance of dying from breast cancer 		
Population health outcome we desire:	Reduced cancer mortality and morbidity		
To help achieve this outcome we will focus on:	Improved breast screening rates		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Explore with BreastScreen Aotearoa opportunities to strengthen local reporting of breast screening rates by DHB and ethnicity	August 11	A report outlining breast screening rates by provider, geography, and ethnicity provided	Improved breast screening rates
2. Identify with BreastScreen Aotearoa any effective interventions tailored toward populations with low screening rates in Taranaki	October 11	Prioritisation and planning of for implementation of interventions with proven track record in high-performing areas	
3. Establish a reporting system which provides monthly DAR rates for Māori and non-Māori	October 2011	A monthly report of DAR rates	Changes to the action plan based on performance data
4. Provide quarterly reporting to the MHSG	Quarterly through-out 2011/12	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority N6.2	Cancer		
Indicator 10	Cervical screening rate among the eligible population		
Baseline	Cervical screening coverage rates for Māori women aged 20 to 69 years increased from 57.6% in June 2006 to 66.6% in June 2010, an increase of 9.0%. During the same time the rate for non-Māori women increased by 5.2% from 86.9% to 92.1%.		
Target	69% of Māori women aged 20 to 69 have a cervical smear in the past 3 years		
Rationale	<ul style="list-style-type: none"> • Māori cervical cancer registrations are two times those of non-Māori • Cervical cancer mortality is 3.6 times that of non-Māori • Cervical cancer is one of the most preventable of all cancers and having a cervical smear test every three years can prevent cervical cancer (National Screening Unit). 		
Population health outcome we desire:	Reduced cancer mortality and morbidity		
To help achieve this outcome we will focus on:	Improved cervical screening rates		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Determine current cervical screening rates by ethnicity, age	September 2011	A report outlining cervical screening rates by ethnicity	Resource allocation toward high-needs areas
2. Implement interventions tailored toward populations with low screening rates	November 2011	Implementation of additional interventions	Improved cervical screening rates
3. Advocate for the establishment and delivery of monthly reporting from the National Cervical Screening Unit on rates for Māori and non-Māori in Taranaki	September 30	A monthly report of cervical screening rates	Changes to the action plan based on performance data
4. Establish a reporting system which provides monthly DAR rates for Māori and non-Māori	October 2011	A monthly report of DAR rates	Changes to the action plan based on performance data
5. Provide quarterly reporting to the MHSG	Quarterly through-out 2011/12	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority N7.1	Smoking		
Indicator 11	Percentage of adults 15+ admitted to hospital either acutely or for elective procedures who are provided with advice and help to quit		
Baseline	55% of Māori hospitalised smokers were provided with advice and help to quit in the quarter ended 31 December 2010		
Target	95% of Māori hospitalised smokers will be provided with advice and help to quit by July 2012		
Rationale	Smoking kills an estimated 5000 people in New Zealand every year and smoking-related diseases are a significant opportunity cost to the health sector.		
Population health outcome we desire:	New Zealanders living longer, healthier and more independent lives		
To help achieve this outcome we will focus on:	Increasing the proportion of hospitalised smokers who are offered cessation advice		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. System and processes in place within the sector to enable documentation of smoking status and the offer of brief advice and/or help to quit, and then to accurately capture and report this data to MoH.	October 2011	Accurate ethnicity recording and reporting of quit smoking advice and help given A report outlining barriers to the provision of smoking cessation advice	Targeted resource allocation proportionate to the level of inequality between Māori and non-Māori cessation advice provision Targeted resource allocation toward the most significant barriers to cessation advice provision
2. Training and education for all staff on the ABC approach to smoking cessation and smoking cessation (online training and face-to-face)	December 2011	Improved staff awareness and competency to offer advice and help to quit	Increased provision of smoking cessation advice
3. Buy in from senior managers and clinicians within the hospital and from iwi leadership and identification of champions	August 2011	Enabling and supportive environment for better help for smokers to quit	Increased provision of smoking cessation advice
4. Promotion of ABC approach within the sector and innovative initiatives to acknowledge performance against the target	October 2011	Enabling and supportive environment for better help for smokers to quit	Reduced smoking prevalence
5. Availability of NRT within the hospital	August 2011	Enabling and supportive environment for better help for smokers to quit	Increased provision of smoking cessation help

6. Strengthen linkages between primary and secondary care	October 2011 and on-going	Improve our ability to provide timely quit advice for patients	Increased provision of smoking cessation advice
7. Provide quarterly reporting to the MHSG	On-going	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority N7.2	Smoking		
Indicator 12	Percentage of smokers in primary care who are provided with advice and help to quit		
Baseline	Baseline data not currently available		
Target	90% of enrolled patients with General Practice will be provided with advise and help to quit by July 2012		
Rationale	Smoking kills an estimated 5000 people in New Zealand every year and smoking-related diseases are a significant opportunity cost to the health sector.		
Population health outcome we desire:	New Zealanders living longer, healthier and more independent lives		
To help achieve this outcome we will focus on:	Increasing the proportion of hospitalised smokers who are offered cessation advice		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. System and processes in place to enable documentation of smoking status and the offer of brief advice and/or help to quit, and then to accurately capture and report this data to MoH.	October 2011	Accurate ethnicity recording and reporting of quit smoking advice and help given A report outlining barriers to the provision of smoking cessation advice	Targeted resource allocation proportionate to the level of inequality between Māori and non-Māori cessation advice provision Targeted resource allocation toward the most significant barriers to cessation advice provision
2. Training and education for all staff on the ABC approach to smoking cessation and smoking cessation (online training and face-to-face)	December 2011	Improved staff awareness and competency to offer advice and help to quit	Increased provision of smoking cessation advice
3. Buy in from senior managers and clinicians within primary care and from iwi leadership and identification of champions	August 2011	Enabling and supportive environment for better help for smokers to quit	Increased provision of smoking cessation advice
4. Promotion of ABC approach within the sector and innovative initiatives to acknowledge performance against the target	October 2011	Enabling and supportive environment for better help for smokers to quit	Reduced smoking prevalence
5. Availability of NRT within the community	August 2011	Enabling and supportive environment for better help for smokers to quit	Increased provision of smoking cessation help
6. Strengthen linkages between primary and secondary care	October 2011 and on-going	Improve our ability to provide timely quit advice for patients	Increased provision of smoking cessation advice
7. Provide quarterly reporting to the MHSg	On-going	A quarterly report for the MHSg	Information sharing with stakeholders Changes to the action plan

Health Priority N8.1	Immunisation		
Indicator 13	Percentage of 2 year olds fully immunised		
Baseline	89.6% of Māori children fully immunised at 2 years old in quarter two 2010/11 (91.8% for non-Māori)		
Target	95% of Māori Children fully immunised by June 2012		
Rationale	<ul style="list-style-type: none"> • Immunisation is linked to primary care access and management • Fewer Māori are fully immunised at 2 years compared with non-Māori (Taranaki RR = 0.97) • Immunisation can prevent a number of diseases and is a cost-effective health intervention. 		
Population health outcome we desire:	Improved children's health		
To help achieve this outcome we will focus on:	Increasing the proportion of Māori children fully immunised by 2 years of age		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Profile patterns of immunisation uptake in Taranaki by Māori and location	March 2012	A report outlining immunisation rates by location, age, ethnicity, and other variables where possible	Targeted resource allocation toward those groups and areas with highest need
2. Prioritise interventions to address low immunisation rates through the Taranaki Immunisation Steering Group and the Taranaki Immunisation Strategic Plan	Sept 2011	A strategic approach to improvement of immunisation rates in place	Resource allocation toward increasing immunisation for Māori
3. Implement interventions to increase immunisation rates for Māori	From Sept 2011	Interventions directed at increasing immunisation rates	Increased immunisation rates for Māori
4. Ensure monthly immunisation rates are reported for Māori and non Māori through the Health Targets process	July 2011	A monthly report of immunisation rates	Changes to the action plan based on immunisation rate reporting
5. Establish a reporting system which provides monthly DAR rates for Māori and non-Māori	October 2011	A monthly report of DAR rates	Changes to the action plan based on performance data
6. Provide quarterly reporting to the MHSG	Quarterly throughout 2011/12	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority N8.2	Immunisation		
Indicator 14	Seasonal influenza immunisation rates for Māori aged 65 years and over		
Baseline	Seasonal influenza immunisation rates for Māori aged 65 years and over 63.1% in June 2010 (69% for non-Māori)		
Target	>68%		
Rationale	The complications of influenza (more commonly know 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 people of any age with certain chronic conditions.		
Population health outcome we desire:	Reduced communicable disease		
To help achieve this outcome we will focus on:	Increasing the proportion of eligible Māori who have received the seasonal influenza vaccine		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Assess immunisation rates for all Māori and non- Māori aged 65 years and over	Quarterly	A report outlining immunisation rates by ethnicity.	Develop an action plan to address the inequalities
2. Establish a reporting system which provides monthly immunisation rates	Quarterly	A monthly report of immunisation rates	Changes to the action plan based on immunisation rate reporting
3. Establish a reporting system which provides monthly DAR rates for Māori and non-Māori	October 2011	A monthly report of DAR rates	Changes to the action plan based on performance data
4. Provide quarterly reporting to the MHSG	Quarterly through-out 2011/12	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority N9	Māori Health Workforce		
Indicator 15	Percentage of Māori staff in Management, Clinical, Allied Health, non-health support, Administrative positions in TDHB		
Baseline	As at 31 March 2011 Māori accounted for 6.4% of the total TDHB workforce made up of: 4.9% of the clinical workforce 9.4% of the non-health support workforce 12.2% of the management workforce 8.7% of the allied health workforce 7.0% of the administration workforce There is currently a significant margin for error in the accuracy of ethnic workforce data		
Target	By 30 June 2012 Māori will make up 8% of the TDHB workforce. Further analysis will be undertaken to establish clinical and non-clinical targets		
Rationale	<ul style="list-style-type: none"> • The aim of Māori workforce development is to build a professionally competent workforce which is reflective of and responsive to the community it services • Increases across the board are required to improve sector responsiveness to Māori health needs. Emphasis in the short term is on increasing the clinical workforce 		
Population health outcome we desire:	A Māori health and disability workforce that is professionally competent, reflective of and responsive to the community it services;		
To help achieve this outcome we will focus on:	Increasing the recruitment and retention of Māori into the Taranaki DHB workforce;		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Determine baseline TDHB staffing by ethnicity	September 2011	A report outlining the makeup of the TDHB staff, by ethnicity	Targeted activity to increase the Māori workforce
2. Establish workforce targets within TDHB over a five-year period	September 2011	A report establishing workforce targets over a five-year period	Targeted activity to increase the Māori workforce
3. Review recruitment procedures to incorporate affirmative Māori recruitment strategies	October 2011	Revised policies and procedures to support Māori recruitment	Improved policy framework to support recruitment of Māori
4. Provide education on implementation of Māori recruitment strategies	October 2011 to June 2012	Training for recruiting managers	Affirmative action to recruit more Māori
5. Monitor recruitment to TDHB	Quarterly	Quarterly reports of TDHB staffing by ethnicity in management, clinical and administration	Observable increase in Māori workforce
6. Provide regular reporting of Māori recruitment into TDHB to MHSG	Quarterly	Regular reports of the TDHB workforce by ethnicity	Information sharing with stakeholders Changes to plan of action

3. SECTION THREE - REGIONAL PRIORITIES AND INDICATORS

Section 3 summarises regional Māori health indicators where TDHB will work collaboratively with other Midland DHBs. The Midlands DHBs are already working together in areas such as tobacco control, clinical services and mental health. The indicators below represent further areas of collaboration.

Health Priority R1	Cardiovascular Disease		
Indicator 16	Number of tertiary cardiac interventions		
Baseline	Baseline not yet established. Data will be collected as part of the national indicator set.		
Target	A Midland target will be established proportionate to both CVD burden and local and national tertiary cardiac intervention rates.		
Rationale	<ul style="list-style-type: none"> • A Midland cardiac services plan was developed in 2006 and has guided cardiac service development over the past five years; • A Midland Clinical Services Plan was developed in 2010; reducing inequalities in cardiovascular outcomes and improving access to CVD management are listed as priorities for the Māori Midland population. 		
Population health outcome we desire:	Reduced mortality through improved cardiovascular health		
To help achieve this outcome we will focus on:	Monitoring the number of tertiary cardiac interventions for Māori and non-Māori in Midlands DHBs		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Determine the number of tertiary cardiac interventions for TDHB Māori for the 2010/11 year	31 August 2011	A report identifying the number and type of tertiary cardiac interventions provided to BOPDHB	Identification of intervention rates
2. Compare TDHB intervention rates with other regional and national benchmarks	31 September 2011	A report comparing tertiary cardiac intervention utilisation with local, regional and national populations	Changes to tertiary cardiac referral processes
3. Set up a reporting system which provides monthly tertiary cardiac intervention rates	31 August 2011	A quarterly report of tertiary cardiac intervention rates	Changes to referral processes based on performance data
4. Provide quarterly reporting to the Midland DHBs Māori General Managers	On-going	A monthly report for Midlands DHBs Māori General Managers	Information sharing with stakeholders Changes to action plan

Health Priority R2	Māori Health Workforce		
Indicator 17	Report on the total number of Māori recruited to Kia Ora Hauora		
Baseline	30 Taranaki residents were registered on the Kia Ora Hauora website as at 30 November 2010		
Target	200 Taranaki residents registered with the Kia Ora Hauora project by 30 June 2012		
Rationale	Kia Ora Hauora is a national Māori health workforce development project that aims to increase and upskill the Māori health and disability workforce		
Population health outcome we desire:	A Professionally competent workforce reflective of and responsive to the community it services		
To help achieve this outcome we will focus on:	Increasing recruitment to the Kia Ora Hauora programme		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Implement Kia Ora Hauora (KOH) initiatives as per the KOH project management plan	On-going through-out 2011/12	Report on the total number of Māori recruited to the Kia Ora Hauora programme	Increase in the number of Māori working in the Midlands region health services Improvement in the skill base of the Māori health workforce
2. Provide quarterly reporting to the MHSG, Midlands GM's Māori and Midlands Iwi Relationship boards	Quarterly through-out 2011/12	A quarterly report for MHSG, Midlands GM's Māori, Iwi Relationship Boards and DHBs	Information sharing with stakeholders Changes to the action plan

Health Priority R3	Māori Provider Capacity Development		
Indicator 18 Indicator 19	<ul style="list-style-type: none"> • Report on the increase in investment in Māori providers. • Results-based Accountability contracts in place for provision of Māori health services 		
Baseline	<ul style="list-style-type: none"> • Investment in 16 Māori health providers as at November 2010 was \$6.71m (excludes PHOs); • 97% of TDHB funding is delivered by mainstream services; • Provider services are currently delivered through 31 separate service contracts; 		
Target	No quantitative target set. Supply of quantitative data is required.		
Rationale	<ul style="list-style-type: none"> • Increasing investment in Māori providers is indicative of increasing Māori capacity; • Māori Provider capacity contributes to improved cultural appropriateness of services for Māori through 'by Māori, for Māori' services and through increased support to mainstream services to/for Māori; • DHB provider contracting has created a highly competitive environment amongst providers which has been detrimental to sustainability and collaboration; • Results based contracting creates an environment enabling of provider innovation in service delivery 		
Population health outcome we desire:	Improved access to services by Māori and other high needs populations		
To help achieve this outcome we will focus on:	Increasing the investment in Māori health providers and implementing Results-based Accountability contracting		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Undertake a Whanau Ora Needs Assessment that identifies health and socio-economic status of Māori in participating Midlands DHBs	March 2012	A report outlining the health and socio-economic status of Māori and including Māori provider capacity, in participating Midlands DHBs	Targeted resource allocation toward those groups and areas with highest need
2. Develop relationships with relevant stakeholders to identify and prioritise collaborative approaches and interventions	August 2011	<ul style="list-style-type: none"> • Identify potential partners. • Collaborative interventions which may be implemented collaboratively 	Collaborative development and implementation of interventions Strategic relationships and developments focused on the needs of whanau
3. Implement Results-Based Accountabilities through a single Māori health services contract	October 2011	Provider innovation to implement effective strategies to improve access to services	Improved access to services; Improved quality of services; Reduction in clinical and cultural risk; Improved sector sustainability; Economies of scale; Enhanced collaboration
4. Support the development of	On-going, combined	Increasing the capacity of lead providers to	Improved access to services

Midland Health Network and the National Hauora Coalition as Whanau Ora centres	with BSMC strategy	coordinate Whanau Ora activity around the needs of whanau	
5. Provide quarterly reporting to the MHSG, Midlands GM's Māori and Midlands Iwi Relationship boards	Quarterly progress reports through-out 2011/12	A quarterly report for MHSG, Midlands GM's Māori, Iwi Relationship Boards and DHBs	Information sharing with stakeholders Changes to the action plan

Health Priority R4	Monitoring Performance		
Indicator 20	<ul style="list-style-type: none"> Report on completion of 2 He Ritenga – Treaty of Waitangi principles cultural audits across selected service areas within the Taranaki DHB Provider Arm 		
Baseline	No cultural audit tool currently in place		
Target	Complete 2 cultural audits within TDHB provider arm services		
Rationale	<ul style="list-style-type: none"> Currently there is no mechanism in place to support and monitor provider responsiveness to Māori health needs; He Ritenga: Treaty of Waitangi Principles Audit tool has been developed and piloted by BOPDHB; 		
Population health outcome we desire:	Reduction in Māori health inequalities		
To help achieve this outcome we will focus on:	Cultural audits of TDHB provider arm and NGO providers		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Trial a cultural audit using the He Ritenga tool in two TDHB provider arm departments	December 2011	Report on provider compliance with Treaty-based obligations Report on audit process findings	Improved Māori responsiveness Improved audit programme
2. Work with TDHB Internal Auditor to incorporate He Ritenga audits of provider arms services into TDHB's internal audit schedule	February 2012	He Ritenga audits incorporated into the TDHB internal audit schedule.	Improved Māori responsiveness
3. Establish a reporting system to identify and share findings arising from He Ritenga audits	February 2012	Progress reports as audits are completed on findings and audit related issues	Changes to audit approach based on audit findings Engagement with TDHB departments to address audit issues
4. Provide quarterly reporting to the MHSG, Midlands GM's Māori, Midlands Iwi Relationship boards and DHBs	Quarterly	A quarterly report for MHSG, Midlands GM's Māori, Iwi Relationship Boards and DHBs	Information sharing with stakeholders Identification of performance issues Changes to relevant plans
5. Monitor national and local indicators of performance	Quarterly ongoing	A quarterly report for MHSG, Midlands GM's Māori, Iwi Relationship Boards and DHBs	Information sharing with stakeholders Identification of performance issues and engagement with stakeholders to address issues

4. SECTION FOUR -LOCAL PRIORITIES AND INDICATORS

Section Four summarises TDHB's current and planned activities along with targets related to local Māori health priorities.

Health Priority L1	Access to Services		
Indicator 21	Did-Not-Attend (DNA) rate for outpatient appointments		
Baseline	Overall outpatient DNA rates for Māori July 2009-June 2010 were 2.3 times higher than non-Māori at 7.2% vs. 3.0%, doctor and non-doctor appointments);		
Target	4% by 30 June 2012		
Rationale	<ul style="list-style-type: none"> Higher disease burden coupled with higher DNA rates will result in ongoing unmet health need; If the DNA rate for Māori was equivalent to that of non-Māori there would be more than 900 fewer missed appointments per year which equates to significant unmet need; 		
Population health outcome we desire:	Improved access to secondary care		
To help achieve this outcome we will focus on:	Reducing the Did-Not-Attend (DNA) rate at outpatient appointments		
And perform these activities:	By these dates:	Which will deliver these outputs:	And will lead to these impacts:
1. Profile those who do not attend by age, ethnicity, domicile, NZDep, appointment specialty, and other variables	September 2011	A report clarifying the populations contributing to missed appointments along with areas most amenable to improvements	Efficient targeted allocation of resources towards high needs populations and specialties
2. Develop an action plan and targets based on the results of the DNA profile and literature reviews	November 2011	An action plan document specific to local needs and international best practice approaches to reducing DNA rates	Implementation of strategies to reduce DNA rates Changes to the invitation pathway Improved outpatient attendance rates
3. Establish a data collection and reporting system which provides monthly DNA rate	December 2011	A monthly report of DNA rates	Changes to the action plan, contracting, and resource allocation based on performance feedback data
4. Provide quarterly reporting to the MHSG	Quarterly	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority L2	Oral Health		
Indicator 22 Indicator 23	<ul style="list-style-type: none"> Percentage of 5-year olds in Taranaki caries free DMFT scores at year 8 in Taranaki 		
Baseline	<ul style="list-style-type: none"> The mean number of decayed, missing, or filled teeth (DMFT) for Māori children in Year 5 in TDHB in 2004 in fluoridated areas was 3.4 compared with 1.7 for non-Māori. These are higher than national DMFT scores of 2.8 and 1.6 respectively; In non-fluoridated areas the mean number of DMFT in Māori children in Year 5 (2004) was 3.9 compared to 2.5 for non-Māori children. 		
Target	<ul style="list-style-type: none"> 43% of Māori children caries free at 5 years of age by 30 June 2012 DMFT score at Year 8 of 1.25 by 30 June 2012; 		
Rationale	<ul style="list-style-type: none"> 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 Some reduction in disparity by school year 8 is evident although Māori children still had a higher dmf than non-Māori and were less likely to be caries-free 		
Population health outcome we desire:	Improved oral health among Māori children		
To help achieve this outcome we will focus on:	<ul style="list-style-type: none"> Percentage of 5 year olds carries-free; DMFT scores at year 8 		
And perform these activities:	By these dates:	Which will deliver these outputs:	And will lead to these impacts:
1. Audit the current levels of 5 year olds carries-free and DMFT scores at year 8 in TDHB region by age, ethnicity, domicile, NZDep and other variables	January 2012	A report outlining the number of 5 year old Māori children who are carries free and the number of decayed, missing, or filled teeth (DMFT) for Māori children in Year 8	Efficient targeted allocation of resources towards high needs groups
2. Process map the 5 and 8 year olds attendance pathway to identify gaps in service access and delivery	January 2012	A report outlining the 5 and 8 year olds attendance pathway along with focus points and key providers which can generate improved enrolment and attendance rates	Efficient targeted allocation of resources towards those parts of the care pathway which will generate the greatest gain
3. Develop an action plan and targets based on the audit and process mapping results	March 2012	An action plan document and performance targets tailored to local health needs	Clear contracting requirements and expectations with key providers Provider activity focused on high needs groups and key areas of the care pathway

4. Establish a data collection and reporting system which provides monthly dental clinic attendance rates	March 2012	A monthly report of preschool dental clinic enrolment rates	Changes to the action plan, contracting, and resource allocation based on performance feedback data
5. Provide quarterly reporting to the MHSG	Quarterly	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority L3	Respiratory Health		
Indicator 24	Asthma hospitalisation rate 0-14 years ASR per 100,000		
Baseline	The hospitalisation rate (ASR per 100,000) for 0-14 years females was twice that of non-Māori (509.6 vs. 260.8/100,000);		
Target	Targets to be determined on completion of action plan with intermediate and annual performance targets.		
Rationale	<ul style="list-style-type: none"> Poor asthma management in children has significant economic and social costs for individuals, families, and society due to absence from school or work, and medical management costs. (9) If the hospitalisation rate for Māori in TDHB was equivalent to that of non-Māori there would be around 250 fewer hospitalisations per year. 		
Population health outcome we desire:	Improved respiratory health		
To help achieve this outcome we will focus on:	Reducing the asthma hospitalisation rate for those 0-14 years of age		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Profile those presenting to hospital, and those going on to admission by age, ethnicity, domicile, NZDep, and other variables	September 2011	A report clarifying which populations most frequently present to hospital with asthma along with areas most amenable to improvements	Efficient targeted allocation of resources towards high needs populations
2. Complete an action plan with intermediate and annual performance targets	January 2012	An action plan with performance targets, timelines, and accountabilities	Planned implantation of evidence-based interventions
3. Develop relationships with relevant stakeholders and prioritise collaborative interventions	From January 2012	Identification of potential partners. Intersectoral interventions which may be implemented collaboratively	Collaborative activity and implementation of interventions
4. Provide quarterly reporting to the MHSG	Quarterly	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority L4	Sudden Unexplained Death of Infants Syndrome		
Indicator 25	SUDI mortality rate per 100,000 live births of Māori infants		
Indicator 26	DHB has achieved and maintained Baby Friendly Hospital accreditation		
	Proportion of Māori mothers who breastfeed at 6 weeks, 3 months and 6 months (Indicator 4)		
Baseline	SUDI rate of 1.16 per 1,000 live births (9 deaths recorded for the 5 year period 2005-2009); Taranaki Base and Hawera Hospitals have BFH accreditation 60%, 48%, 13% by June 2010		
Target	0.5 SUDI deaths per 1,000 live births of Māori infants by 2015 Maintain Baby Friendly Hospital accreditation 6 weeks = 62%, 3 months = 55%, 6 months = 18% by June 2012 (Indicator 4)		
Rationale	Taranaki has one of the highest rates of SUDI for Māori in New Zealand		
Population health outcome we desire:	Improved child health		
To help achieve this outcome we will focus on:	Reducing the rate of SUDI		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Audit the current levels of SUDI in TDHB region by age, ethnicity, domicile, NZDep and other variables	January 2012	A report outlining the number of SUDI in TDHB region by age, ethnicity, domicile, NZDep and other variables	Efficient targeted allocation of resources towards high needs groups
2. Develop relationships with relevant stakeholders to identify and prioritise collaborative approaches and interventions	February 2011	<ul style="list-style-type: none"> Identify potential partners. Collaborative interventions which may be implemented collaboratively 	Collaborative development and implementation of interventions
3. Develop an action plan and targets based on the audit results	March 2012	An action plan document and performance targets tailored to local health needs	Clear contracting requirements and expectations with key providers Provider activity focused on high risk groups and key areas of the care pathway
4. Set up a reporting system which provides regular SUDI rates	March 2012	A quarterly report of SUDI	Changes to planned actions as a result of performance data
5. Provide quarterly reporting to the MHSG	Quarterly	A quarterly report for the MHSG	Information sharing with stakeholders Changes to the action plan

Health Priority L5	Māori Health Workforce		
Indicator 27	Report on the total number of Māori recruited to the Incubator programme		
Baseline	51 students from two Taranaki secondary schools participated in the Incubator programme in 2010.		
Target	120 students enrolled in the incubator programme by June 2012		
Rationale	<ul style="list-style-type: none"> It is nationally and internationally recognised that workforce shortages now and into the future is a key strategic issue facing the health sector; Incubator is a workforce development initiative targeted at Year 12 and 13 students. The Incubator approach is to 'grow your own workforce' via an innovative programme aligned to increasing workforce supply. 		
Population health outcome we desire:	A Professionally competent workforce reflective of and responsive to the community it services		
To help achieve this outcome we will focus on:	Increasing recruitment to the Incubator programme		
And perform these activities:	By these dates:	Which will deliver these outputs:	Which will lead to these impacts:
1. Implement the Incubator Programme in Taranaki secondary schools	On-going through-out 2011/12	Report on the total number of Māori recruited to the Incubator programme	Increase in the number of Māori on pathways to health careers
2. Provide quarterly reporting to the MHSB	Quarterly through-out 2011/12	A quarterly report for MHSB	Information sharing with stakeholders Changes to the action plan

Appendix A

Methodology for Development of Local Indicators to Support the Taranaki DHB Māori Health Plan 2011/12

1. Learning from the Experience of Others

Bay of Plenty and Lakes DHBs have been pilot sites for Māori Health Plan development over the past six months and many useful tools and frameworks have been developed through a five step process involving:

- Identification of information sources;
- Identification of leading health issues;
- Ranking of health issues;
- Scoring the leading health issues; and,
- Review and finalisation

This work was used as the starting point for the development of the Local Indicator Set and has been adapted for the local Taranaki Māori context.

2. Identification of Project Resources

Resources for the project were identified within the Māori Health Team, Planning and Funding and the Public Health Unit to complete the project. Dr Mihi Ratima has been engaged from 18 February 2011 to provide Māori health expert advice taking into account project constraints. Specifically, advice has been sought with regard to adapting the BOPDHB methods, the range of indicators captured, shortlisting and filtering of indicators and organisation of the stakeholder hui.

3. Establishing a Conceptual Framework

The project has a strong focus on the development of indicators that are able to gauge the extent of ethnic inequalities in health. An overarching conceptual framework that is specifically concerned with ethnic inequalities in health and has high relevance to Taranaki Māori may usefully provide an explicit logic for indicator selection and/or intervention relevant to selected indicators.

A range of potential frameworks may be considered such as the Ministry of Health's Intervention Framework to Improve Health and Reduce Inequalities (structural, intermediary pathways, health and disability services, impact), the four pathways of He Korowai Oranga (development of Māori, participation in the sector, effective services, working across sectors), or the Health Inequalities Framework (basic causes, social status, surface causes, biological processes, health status). Dr Ratima recommended that TDHB use the ethnic inequalities in health framework developed by Jones (2001). Jones identifies three main pathways that contribute to ethnic inequalities in health. The framework is straightforward and is described in Hauora Māori Standards of Health IV (Robson and Harris 2007), and is suggestive of the types of indicators that could be aligned to each of the three pathways.

- a) ***Differential access to the determinants of health or exposures leading to differences in disease incidence.*** New Zealand evidence includes the very different profile of Māori to non-Māori with respect to the determinants of health such as education, employment, income, housing, income support, dealings with the criminal justice system, health literacy, deprivation, etc (Ministry of Social Development 2006). These factors also pattern exposures to other risks like tobacco use, poor nutrition, overcrowded and substandard housing, unsafe workplaces, problem gambling, and 'binge' patterns of alcohol use (Howden-Chapman and Tobias 2000; Jarvis and Wardle 1999; Shaw et al 1999). [Examples of relevant indicator sets – determinants, risk factors, protective factors]
- b) ***Differential access to health care.*** Examples include: Māori experiencing longer and slower pathways through health care (Sadler et al 2004); hospitalisation rates that are disproportionately low in disease categories where Māori have high death rates and a health service configuration where people without access to transport or resources have more difficulty attending health services

for both treatment and prevention (Ministry of Health 2006a). [Examples of relevant indicator sets – health outcomes, health service utilisation, health system performance]

- c) **Differences in the quality of care received.** Evidence of Māori being less likely to receive appropriate levels of care is seen in screening for and treatment of ischaemic heart disease (Bramley et al 2004), pain relief during labour and childbirth (Ministry of Health 2006b), the diagnosis and treatment of depression (Arroll et al 2002), diabetes screening and management (Ministry of health 2005), and higher levels of adverse events in hospital (Davis et al 2006) [Examples of relevant indicator sets – health outcomes, health service utilisation, health system performance]

4. Identification of Information Sources

The following data sources were identified and used to extract indicator data.

- TDHB health Needs Assessment (2007)
- TDHB Public Health Strategic Plan (2009)
- TDHB Cervical Screening Services
- National Immunisation Register
- Centre for Public Health Research Online www.cprhonline.massey.ac.uk
- Public Health Intelligence Online <http://www.phionline.moh.govt.nz/>
- New Zealand Health Survey (2006-07)
- Census Quick Stats 2006
- Hospital Admission Data provided by Bay of Plenty DHB

Data indicators have only been extracted where there is the ability to compare indicators for Māori and non-Māori in the Taranaki population.

5. Short listing Indicators

All data was collated into an Excel Spreadsheet and grouped in key indicator sets (determinants, risk and protective factors, health service utilisation, and health system performance) in line with the indicator framework. Indicators were then reviewed and shortlisted on the following technical criteria.

- Duplicate indicators from different data sources removed.
- Where more than one indicator was available but for different time periods the most up to date indicator was retained.
- Indicators on 'wish list' but where no data could be sourced in the timeframe were removed.
- Application of SMART criteria – specific (measurement appropriately captures the level of detail required), measurable (measurement process is possible within available resources), accurate (indicator measures the phenomenon it purports to measure), reliable (repeatability of measurements and statistical precision) and timely (data is available in a timely manner)

6. Calculation of rate ratios

Rate ratios were calculated for each indicator. This calculation provided one measure of the inequality between Māori and non-Māori and is a crude indicator only. The calculation is based on the rate in the Māori population divided by the rate in the non-Māori population. This provided an opportunity to assess the extent of inequality between Māori and non-Māori. For example

Prevalence of Current Smokers (adults) - Males from Census 2006:

Taranaki Māori 38.4 Taranaki non-Māori 21.6

Māori Rate is 1.8 times the non-Māori Rate

Or for a protective factor such as Breastfeeding:

Breastfeeding rates Exclusive and Full at 6 months (2009) Plunket

Taranaki Māori 13 Taranaki non-Māori 23

Māori Rate is 0.6 times the non-Māori Rate

7. Māori health significance criteria

Identification of indicators aligned to Māori health priorities should be based on rate ratio calculations and therefore evidence of ethnic inequalities, alongside factors that reflect Māori health significance in a broader sense. The following Māori health significance criteria were identified for application in the identification of Māori health priorities and aligned indicators:

- I. Volume (i.e. crude numbers) and severity of health outcome (e.g. disease burden and fatality)
- II. The extent to which an ethnic inequality is amenable to intervention
- III. Capacity for intervention to be driven by a local health sector response
- IV. Consistency with Taranaki Māori aspirations

Māori health significance criteria were applied through a stakeholder engagement process.

8. Stakeholder Engagement and Agreement of Indicators

On 28 February 2011 a meeting of stakeholders in the TDHB's annual planning process was held. The forum consisted of TDHB funder and provider representatives, and representatives of the Midlands Health Network, the National Hauora Coalition, and Te Tihi Hauora PHO. The forum included Māori leadership from each of the participating stakeholder organisations. Input was sought from participants into the prioritisation of local Māori health indicators.

The following process for prioritisation of indicators was facilitated.

- a) Brief overview of the project including project methods and the contribution sought from the meeting. [Chief Advisor Māori Health]
- b) Brief overview of the conceptual framework for understanding ethnic inequalities in health and a recommended process for indicator setting which focuses on the extent of ethnic inequalities and Māori health significance factors. [Māori health consultant]
- c) Discussion of data issues to inform small group work on prioritisation of indicators. [Healthy Taranaki Development Manager]
- d) Small group work on prioritisation of indicators. [Team]
- e) Large group discussion on prioritisation of indicators and agreement on indicator set.

9. Limitations

Available Data: Proposed, potential indicators are limited to those areas where data collection systems are already well developed to the extent that statistically significant differences between Māori and non-Māori are able to be identified and rate ratios calculated. While the reasons for this are obvious, there may also be room for a developmental approach if an important area for measurement is identified that requires improved DHB data collection systems.

Timeliness of Data: Due to the requirement to draw on existing data analysis, many of the indicators are reliant on data from pre-2005 (in some cases this may be the most up-to-date data).

Engagement with Taranaki Māori: Ideally the start point for local Māori health indicator development would be Māori health needs and priorities as identified by Taranaki Māori in their own forum and in the context of accessible evidence to inform discussion. In the longer term further work is required in order to best ensure that the methods for indicator setting reflect health priorities as defined by Taranaki Māori and consistent with best practice approaches to addressing ethnic inequalities in health. At the same time, however, it should be acknowledged that Taranaki Māori may prefer an approach that is less focussed on comparison with non-Māori but rather locates health indicator setting within the context of a wider Taranaki Māori development agenda.

Data Quality : Quality of ethnicity data and availability of analysis by ethnic group.

10. Proposed Indicators

The following indicators were proposed from the stakeholder hui for the Māori Health Plan 2011/12.

Priority Area	Indicator Description
Access to Services	<ul style="list-style-type: none"> Percentage of Did Not Attend (DNA) to hospital outpatient clinics in Taranaki hospitals
Oral Health	<ul style="list-style-type: none"> Percent of five-year-olds in Taranaki caries free DMFT scores at year 8 in Taranaki
Respiratory Disease	<ul style="list-style-type: none"> Asthma hospitalisations 5-14 Years ASR per 100,000

The following national priority areas were considered important by the stakeholder hui and their inclusion in the national indicator set was strongly supported.

Priority Area	Indicator Description
Child Health	<ul style="list-style-type: none"> Immunisation Injury Rate in 0-4 and 5-14 year age group
Diabetes	<ul style="list-style-type: none"> Diabetes Annual Review (DAR) Rates Improved Diabetes Management (HbA1C < 8%)
Respiratory Disease	<ul style="list-style-type: none"> Asthma Hospitalisations 5-14 Years ASR per 100,000

The following local priority areas were considered important by the stakeholder hui and indicators would be followed up further through the Māori Health Needs Assessment proposed for 2012/13.

Priority Area	Indicator Description
Mental Health and Well Being	<ul style="list-style-type: none"> Dual Diagnosis Rates
Breastfeeding	<ul style="list-style-type: none"> Breastfeeding Rates at 6 months including Tamariki Ora Well Child Providers (not just Plunket)
Diabetes	<ul style="list-style-type: none"> Diabetes Complications and Outcomes (eg amputation and renal failure)
Respiratory Disease	<ul style="list-style-type: none"> COPD Outcomes
Lung Cancer	<ul style="list-style-type: none"> Tobacco Smoking Access to Cessation Services Outcomes

11. Indicators Descriptions

The following indicators were proposed from the stakeholder hui for the Māori Health Plan 2011/12

Priority Area	Indicator Description	Source	Baseline Year	Target 2011/12
Access to Services	Percentage of Did Not Attend (DNA) to Hospital Outpatient Clinics in Taranaki Hospitals	TDHB Hospital Services	2009/10 To be confirmed	To be confirmed
Oral Health	Percent of children caries free at year 8 or age 5 – Taranaki	Ministry of Health	2009 35% Māori 63% other	2011 43% Māori
	Oral Health Decayed Missing Filled Teeth scores at year 8 - Taranaki	Ministry of Health	2009 1.53 Māori 1.16 Other	2011 1.46
Respiratory Disease	Asthma Hospitalisations 0-14 Years Age Specific Rate per 100,000	Ministry of Health	2005-2007 540 Māori 370 non-Māori	2006-2008 A reduction