Māori Health Plan 2013/14

Southern District Health Board

Our Vision

Better Health, Better Lives, Whānau Ora

Our Mission

We work in partnership with people and communities to achieve their optimum health and wellbeing.

The Southern Way

- Patients are at the centre of everything we do.
- Create a high performing organisation.
- Become a single unified DHB.
- Provide financially and clinically sustainable services to the community we serve.

Values that underpin the Māori Health Plan

- Whānaungatanga
- Manaakitanga
- Aroha
- Wairuatanga
- Kaitiakitanga
- Whakapono

Māori Health Plan

March 2013

Southern District Health Board

Private Bag 1921 Dunedin 9054, New Zealand

1 INTRODUCTION

Tēnā koutou ngā karangatanga i tuitui ai i ngā kaupapa o tēnei mahere, nau mai tauti mai I runga I nga ahuatanga o te wa, ki a ratou kua wheturangitia, moe mai ra, ki a tatou te hunga ora, tena koutou tena koutou, tena tatou katoa.

The health landscape of the day continues to challenge and ask questions of everyone. Our focus at Southern DHB has been on ensuring we deliver and measure effective and efficient health services to Māori. There is a significant gap between the health status of Māori and non-Māori and there needs to be change in how we fund and deliver services to Māori.

To ensure we deliver the best possible service to Māori, Southern DHB have developed formal relationships with Iwi and acknowledge their input and guidance as critical to the on-going development, scope and delivery of services to Māori. *He mihi nui rawa atu tenei ki te mana whenua, Ngai Tahu, Ngati Mamoe me Waitaha hoki.*

In order for health services to reduce Māori health outcome disparities, more collaborative ways to improve quality, safety and experience of care is needed. Southern DHB conducted a review of Māori Health Services as we wanted to know if we were delivering an effective service to Māori. In parallel with the review, was a stocktake of contracted Māori provider services to our community. The stocktake showed the need to update service specifications therefore in collaboration with Māori providers we are developing new service specifications focusing on health indicators within the Māori Health Plan. This process is being guided by the Results Based Accountability (RBA) framework.

Māori health services focus on the whānau as a whole; therefore their services address the tinana (physical) as well as hinengaro (mental). Physical and mental health is fundamentally linked. People living with serious mental illness may also have a wide range of serious health conditions which are often overlooked. This diminishes quality of life, general wellbeing and leads to very poor health outcomes. Therefore, we are working with primary care, Māori health providers and mental health services to tackle risk factors such as smoking and diet to improve quality of life.

Cardiovascular Disease (CVD) assessments for Māori are up 49% for the last two quarters ending December 2012. This is due to a Southern PHO targeted initiative to provide more efficient and effective services to Māori. We want more health care to be provided for patients and whānau at home in the community and primary care settings. We will support GPs to understand the barriers that exist for Māori who do not access services and provide them with information on services available to Māori in the community.

The local priorities build on the work of previous years and provide further emphasis on health issues affecting our community. These problems will be addressed with local solutions as we create a high performing organisation with a focus on quality. In 2012, we were pleased to be selected to pilot the Data Audit tool for hospitals alongside the Eru Pomare Research Centre. Ethnicity Data is a local priority and will be used to inform, plan, and evaluate services and policies by Southern DHB as we take a lead role across the country in Ethnicity Data collection for hospitals.

The regional priorities have been removed from the Māori health plan and are now included in the South Island Regional Health Services Plan 2013-2016. The South Island Alliance sought advice from Te Herenga Hauora, Māori General Managers across the South Island, to develop their plan and ensure visibility and emphasis on Māori Health outcomes.

The national priorities have been developed by the Ministry of Health, with some emphasis on addressing chronic conditions. An approach adopted by Southern DHB has been to ensure Māori Health is the responsibility of all staff. The Māori Health Directorate is working across the provider arm directorates to link and align the Māori Health Plan to secondary care services. We have spoken with our community, worked in collaboration with Southern PHO and asked how we can provide financially and clinically sustainable services.

The 2013/14 Southern DHB Māori Health plan has been developed to ensure we support all health services to achieve better outcomes for Māori.

We want to ensure that we have a robust health pathway from entry to discharge and Māori are supported when they return home to be with whānau. Our cultural education officers are assisting staff to understand some of the challenges and barriers that exists for Māori. Anecdotal evidence suggests Māori do not attend specialised appointments and we at Southern DHB want to ensure our 'Do not attend' (DNA) by Māori is low.

We are working together our health partners Southern PHO to improve Māori health in primary care and the community. We are building relationships with Whānau Ora provider collectives to support change for whānau. We want to support strategic change and build capacity of provider collectives. We want to work with providers to implement programmes of action and support them to be outcomes focussed. Southern DHB is putting in place change at all levels in the organisation. We have lifted the profile of Māori Health across the district as staff are better informed and supported to work with whānau.

Finally, we want to acknowledge the commitment of all Southern DHB staff who have literally picked up Māori Health and run with it; your support to your Māori community is much appreciated. We present to you the Southern DHB Māori Health Plan 2013/14; this plan outlines the path forward for Māori Health over the next 12 months.

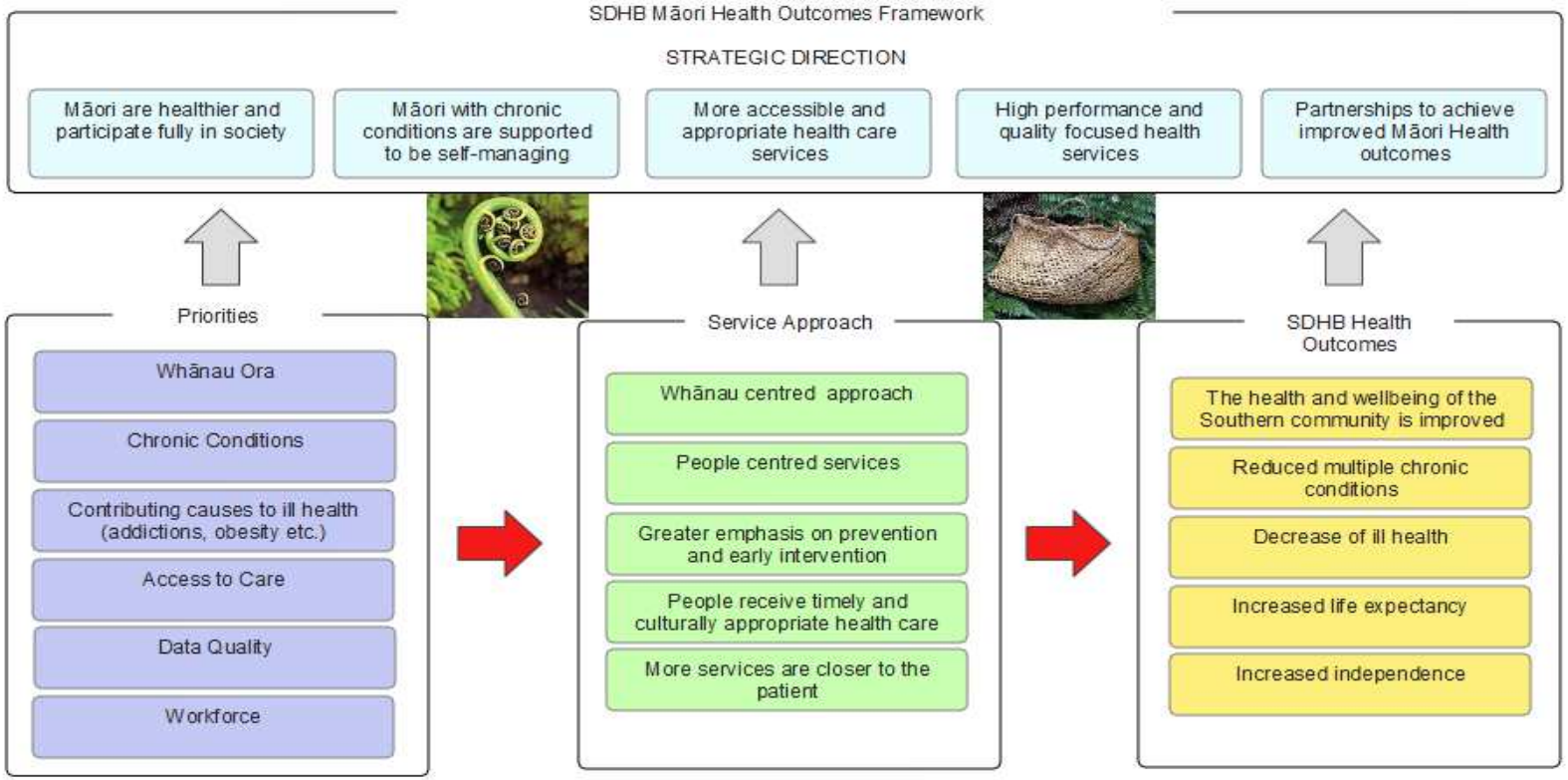
We have said previously "we cannot and will not do this alone". We look forward to working with you to make this change.

Heoi ano e ngā rangatira, i runga i ngā ahuatanga o te wā, mā te atua runga rawa hei manaaki, hei tiaki i ngā wa katoa.

Donovan Clarke
Executive Director Māori Health
Southern DHB

Pania Coote
District Manager, Māori Health
Southern DHB

2 SOUTHERN DHB MĀORI HEALTH OUTCOMES FRAMEWORK



The Māori health outcomes framework is to ensure a consistent understanding of the range of health priorities for Māori. The national and local priorities outlined in the Māori Health Plan are regularly monitored by the Southern DHB and Iwi Goverance[1], with progress on performance being reported quarterly and six-monthly as required. To progress these outcomes the SDHB Māori Health Directorate have developed five key strategic threads, which are linked and aligned to the Māori Health Plan, to guide and direct our priorities, actions, and activities.

[1] Te Rūnanga o Ngāi Tahu is the Iwi authority and overall representative governing body of Ngāi Tahu Whanui being descendants of the Ngāi Tahu, Ngati Mamoe and Waitaha tribes. Te Rūnanga o Ngāi Tahu is made up of 18 Rūnanga papatipu, seven of which are in the Southern district: Te Rūnanga o Awarua (Bluff), Waihōpai Rūnaka (Invercargill), Ōraka Aparima Rūnaka (Colac Bay), Hokonui Rūnanga (Gore), Te Rūnanga o Ōtākou (Dunedin), Kāti Huirapa Rūnaka ki Puketeraki(Karitane), Te Rūnanga o Moeraki (Moeraki).

This Māori health plan describes the activities that the Southern District Health Board will perform during 2013/14 to improve Māori health outcomes. The activities described in the plan link to national and local Māori health indicators as listed in the following table.

HEALTH ISSUE	NATIONAL INDICATORS	REPORTING
Data quality	Accuracy of ethnicity reporting in PHO registers.	Yearly
Access to care	(1) Percentage of Māori enrolled in PHOs. (2) Ambulatory sensitive hospitalisation (ASH) rates per 100,000 for the 0-4, 45-64, and 0-74 age groups.	(1) Yearly (2) Six monthly
Child health	Exclusive breastfeeding at six weeks, three months and six months.	Six monthly
Cardiovascular disease	(1) Percentage of the eligible population who have had their cardiovascular disease risk assessed within the last five years. (2) Number of tertiary cardiac interventions.	(1) Quarterly (2) Yearly
Cancer	(1) Breast screening coverage rate of women aged 45-69 years. (2) Cervical screening coverage rates of women aged 20-69 years.	(1) Six monthly (2) Six monthly
Smoking	(1) Percentage of hospitalised smokers provided with advice and help to quit. (2) Percentage of current smokers enrolled in a PHO and provided with advice and help to quit.	(1) Quarterly (2) Quarterly
Immunisation	(1) Percentage of eligible children fully immunised by eight months of age. (2) Seasonal influenza immunisation coverage rates in the eligible population (65 years and older).	(1) Quarterly (2) Yearly
Rheumatic Fever	Number and rate reductions, 10% below 3 year average.	Yearly
HEALTH ISSUE	**LOCAL INDICATORS**	**REPORTING**
Respiratory Conditions	Percentage of children aged 0-4 admitted to the Emergency Department with a respiratory episode.	Quarterly
Diabetes	(1) Percentage of enrolled patients coded as diabetic who are Māori, that have an HbA1c ≤ 64mmol/mol. (2) The number of people identified as Māori on the VDR (Virtual Diabetes register) who have had an HbA1c in the last 12 months	(1) Quarterly (2) Quarterly
Ethnicity data collection	Accuracy of ethnicity data collection in hospital settings (information only).	Yearly

3 SOUTHERN DHB DEMOGRAPHIC PROFILE

Table 1 below presents ethnicity data by 'total response', in which a respondent is counted in each of the ethnic groups they selected. With this method, the sum of the ethnic group population will exceed the total population (e.g. greater than 100%).

Just over six percent of Otago's total population identify as Māori, as illustrated in Table 1. Just under eleven percent of Southland's population identify as Māori.

Table 1 Percentage of the population in Otago and Southland by total response ethnicity, Census 2006

ETHNIC GROUP	OTAGO	SOUTHLAND
Māori	6.4%	10.6%
Pacific	1.7%	1.1%
Asian	3.8%	1.8%
European/Other	93.4%	86.5%

*Note: Privacy concerns cause small population numbers to be rounded which leads to slight differences in the total populations given here compared to previous tables.

IWI AFFILIATION

Table 2 presents the number of people in Otago and Southland indicating Iwi affiliation at the 2006 Census. Ngāi Tahu/Kāi Tahu was the most common affiliation in Otago and Southland with 29 percent and 35 percent, respectively, of people of Māori descent indicating an affiliation with this Iwi. Ngāpuhi (9.9 percent in Otago and 9.3 percent in Southland) and Ngāti Porou (7.5 percent in Otago and 8.5 percent in Southland) were the next most common Iwi affiliations. In the Otago and Southland regions, a total of 22 and 21 percent of Māori, respectively, did not know or did not want to comment on Iwi affiliation.

Te Rūnanga o Ngai Tahu is the Iwi authority and overall representative governing body of Ngai Tahu Whānui being descendants of the Ngai Tahu, Ngāti Mamoe and Waitaha tribes. Te Rūnanga o Ngai Tahu is made up of 18 Rūnanga Papatipu, and hold Mana Whenua status for both Otago and Southland regions: Otago district, has three distinct Rūnanga: Te Rūnanga o Moeraki (Moeraki), Kāti Huirapa Rūnaka ki Puketeraki (Karitane), and Te Rūnanga o Ōtākou (Dunedin). Southland district has four mana whenua roopu: Awarua Rūnanga (Bluff), Waihōpai Rūnaka (Invercargill), Hokonui Rūnanga (Gore), and Ōraka Aparima Rūnaka (Colac Bay).

Table 2 Iwi affiliation by Otago and Southland Regional Council, Statistics NZ, 2006

IWI	OTAGO	SOUTHLAND	TOTAL	OTAGO	SOUTHLAND
Ngāi Tahu / Kāi Tahu	4,683	4,632	49,185	29.0%	35.0%
Don't Know	3,582	2,721	102,366	22.2%	20.6%
Ngāpuhi	1,599	1,236	122,214	9.9%	9.3%
Ngāti Porou	1,206	1,119	71,907	7.5%	8.5%
Not Elsewhere Included	837	693	29,328	5.2%	5.2%
Kāti Māmoe	399	609	2,877	2.5%	4.6%
Tuhoe	375	441	32,670	2.3%	3.3%
Ngāti Kahungunu ki Te Wairoa	369	438	20,982	2.3%	3.3%
Ngāti Kahungunu, region unspecified	405	435	18,462	2.5%	3.3%

Notes: Queenstown Lakes area is counted within the Otago Regional Council

MĀORI POPULATION AGE DISTRIBUTION

Table 3 compares the age distribution for Māori and non-Māori in the Southern DHB, highlighting the significant differences in the age structure of the populations. The Māori population is a relatively young population group, with fewer people living greater than 65 years of age. Children comprise a much higher proportion of Māori populations compared to non-Māori.

- In Otago, 33 percent of Māori are aged under 15 years compared to 17 percent of non-Māori.
- Only four percent of Otago Māori are aged 65 and over, compared to 15 percent of non-Māori.
- In Southland, 34 percent of Māori are aged under 15 years compared to 19 percent of non-Māori.
- Only five percent of Southland Māori are aged 65 and over, compared to 14 percent of non-Māori.

Table 3 Otago and Southland populations by age group, Māori and non-Māori, Statistics NZ, 2006

Age Group	Otago Māori		Otago Non-Māori		Southland Māori		Southland Non-Māori	
	n	%	n	%	n	%	n	%
0-14	3,699	33%	28,224	17%	3,828	34%	17,973	19%
15-24	2,682	24%	29,004	17%	2,109	19%	11,583	12%
25-44	2,895	26%	42,189	25%	2,988	27%	28,086	30%
45-64	1,608	14%	43,125	26%	1,746	16%	24,615	26%
65+	399	4%	25,494	15%	537	5%	13,326	14%
Total	11,283	101%	168,036	100%	11,208	99%	95,526	101%

The significant differences in the age structure of these populations are highlighted in pictorial representations (Figures 1 and 2). The triangular shape of the pyramid for Māori indicates a large proportion of the population tends to be younger, with steadily diminishing proportion of the population in the older age groups, and few in the 60 years and older age group. In contrast, the more pear-shaped pyramid for non-Māori is comprised of relatively small younger age groups due to lower reproductive fertility rates, along with larger proportions within older age groups.

Figure 1 Age distribution of Otago population by Māori and non-Māori, Statistics NZ, 2006

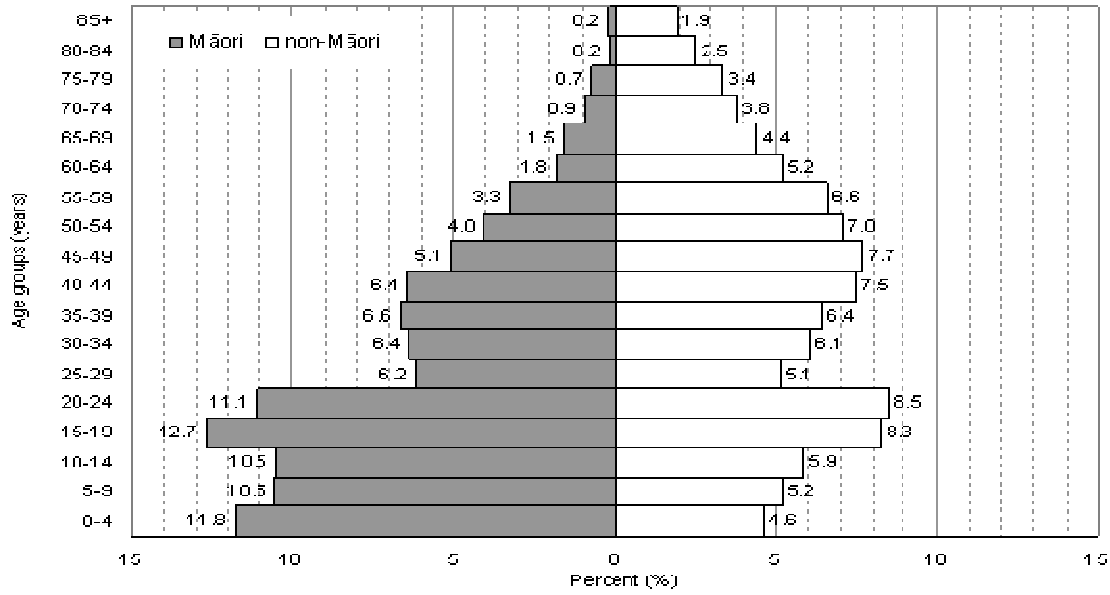
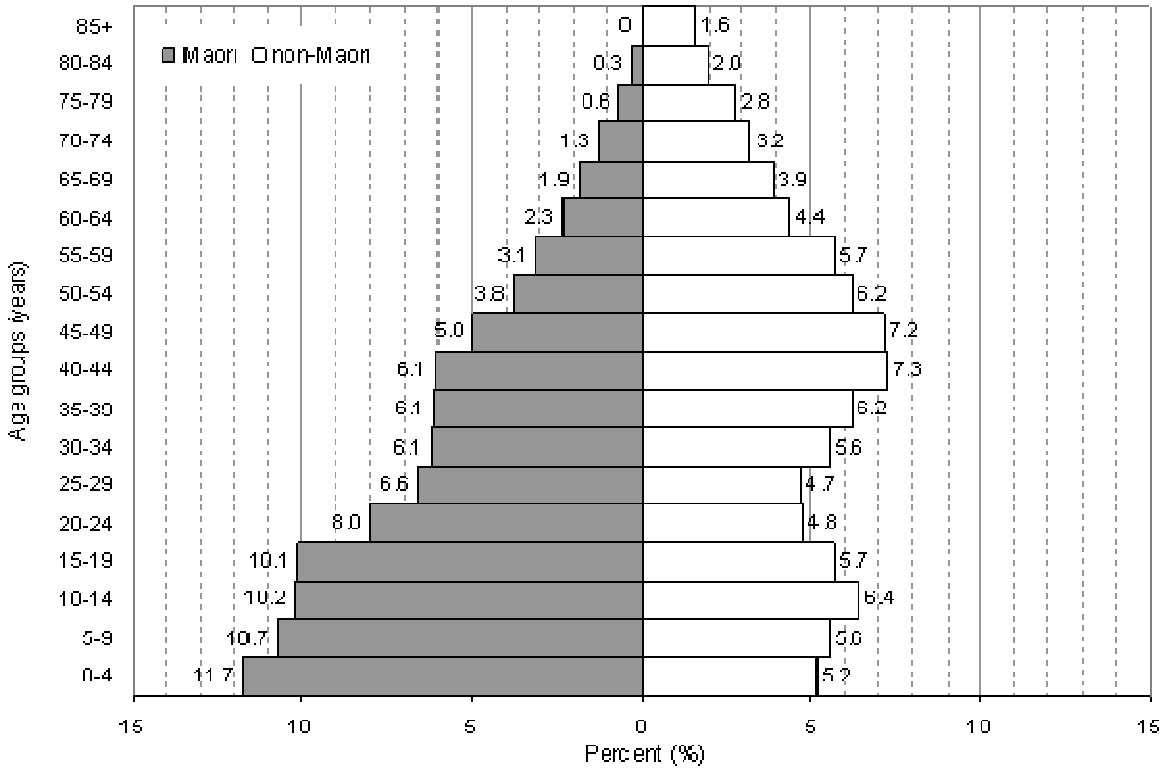


Figure 2 Age distribution of Southland population by Māori and non-Māori, Statistics NZ, 2006



Projected population growth

Statistics New Zealand develops population projections, basing assumptions on medium fertility, mortality, migration and inter-ethnic mobility for Māori and other populations. The 2006 Census enumerated 12,500 Māori who resided in Otago. Population projections predict this will increase to 16,900 by 2026, demonstrating an increase of 35.9 percent over this twenty year period.

Projected population age structure

Much of the population growth for Māori in Otago and Southland will be amongst those aged 15 or younger, but there will also be significant growth in those aged 65 plus. In 2006 the proportions of the Māori population in Otago aged under 15 years and over 65 years were 35 percent and three percent respectively. In 2021 the respective proportions are projected at 35 percent and seven percent, representing no change in the younger age group and more than doubling of the older age group.

In 2006 the proportion of the Māori population in Southland under 15 years and over 65 years were 35 percent and four percent respectively. In 2021 the respective proportions are projected as 36 percent and eight percent, representing a small increase in the younger age group and a doubling of the older age group.

In Otago, the proportion of Māori is projected to increase from seven percent in 2006 to 9 percent in 2026. In Southland, the proportion of Māori is projected to increase from 11 percent of the total population in 2006 to 14 percent in 2026. The DHB will need to take this expected population growth into account in terms of service planning, prioritisation processes and service delivery, especially in relation to services for young people and services for the elderly.

Table 4 Projected populations 2006-2026, Otago and Southland, HDIU/Statistics New Zealand, 2006

Year	Otago					Southland				
	Māori		European/Other*		Total	Māori		Non-Māori		Total
	n	%	n	%		n	%	n	%	
2006	12,500	7%	172,100	93%	184,600	12,240	11%	97,735	89%	109,975
2011	13,630	7%	173,760	93%	187,390	12,970	12%	98,200	88%	111,170
2016	14,700	8%	174,710	92%	189,410	13,730	12%	98,050	88%	111,780
2021	15,800	8%	175,100	92%	190,900	14,380	13%	97,305	87%	111,685
2026	16,990	9%	174,910	91%	191,900	15,030	14%	95,970	86%	111,000

Note: Total includes Pacific populations

4. NATIONAL MĀORI HEALTH PRIORITIES

For New Zealand/Aotearoa

The following priorities and associated indicators for Māori health have been identified nationally. Identified for each are the key actions and activity Southern DHB is undertaking to address the priority areas and reach the targets set.

DATA QUALITY

RATIONALE

Ethnicity misclassification is a problem that has been identified for a number of years. For Māori, this has largely led to undercounting in health data sets. This leads to numerator/denominator bias when census population data is used as denominator data and impacts on the calculation of rates and examination of inequalities in health between Māori and non-Māori.

Reference: Robson B, Harris R. (eds). *Hauora Māori Standards of Health IV. A study of the years 2000-2005.* Wellington: Te Roopu Rangahau Hauora and Eru Pomare.

OBJECTIVE

The accurate, consistent and complete collection of ethnicity data is important. Collecting good quality ethnicity data is essential for service planning and decision-making. The development of ethnicity data protocols across primary and secondary care is a significant step towards understanding the health care needs of all ethnicities including Māori.

HOW OUR PLAN WILL MAKE A DIFFERENCE

The development of the Primary Care Ethnicity tool will assist us to assess the quality of ethnicity data and systems within primary care settings therefore, improving the quality of data being collected.

Actions over the next 12 months (2013/14)

Improving data collection systems and procedures, to ensure quality data is available to enable informative decisions to be made to address health disparities. This plan will:

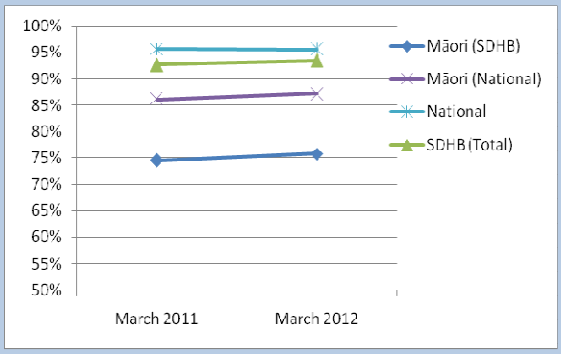
- Support Southern PHO to develop a training package to implement the Primary Care Ethnicity Data Audit Toolkit
- Develop agreed pathways to improve access and consistency of service.
- Southern PHO will provide quarterly reports to identify ethnicity data and issues.
- Improve understanding of the importance of quality data collection.
- Southern PHO will actively encourage uptake of Ethnicity data collection workshops (provided by Southern DHB), these will be provided quarterly.
- Southern PHO will investigate opportunities to match ethnicity data to identify areas of discrepancy between inpatient and primary care.

EVIDENCE

ACCURACY OF ETHNICITY REPORTING IN PHO REGISTERS

The percentage of the population enrolled in Southern PHO

Percentage of Maori enrolled in PHOs				
	Mar-11	Mar-12	Mar-13	Target 13/14
Māori	74.6%	75.8%		98%
Non- Māori	94.4%	95.2%		98%
DHB (Total)	92.7%	93.5%		98%
Māori (National)	86.1%	87.2%		98%
National	95.7%	95.6%		98%



Data sourced from Ministry of Health Enrolment Capitation Data (numerator) and Statistics NZ (denominator)

Note: March 2013 unavailable

ACCESS TO CARE

RATIONALE

There are a number of admissions to hospital for conditions which are seen as preventable through appropriate early intervention and a reduction in risk factors Ambulatory Sensitive Hospitalisation (ASH). As such, these admissions provide an indication of the access and effectiveness of screening, early intervention and the continuum of care across the system. A reduction in these admissions will reflect better management of and treatment of people across the whole system and will free up hospital staff and resources for more complex and urgent cases.

OBJECTIVE

Primary care is the first point of continuity in health, increasing Māori enrolments within General Practices as well as improving access to primary care services will ensure conditions are detected and treated earlier, therefore, reducing avoidable hospital admissions.

The Southern DHB plans to monitor particular conditions through the PHO Performance Programme Plan (PPP) and current service plans which address conditions contributing to high ASH rates for Māori.

HOW OUR PLAN WILL MAKE A DIFFERENCE

Improved access to primary care will lead to reductions in the ambulatory sensitive hospitalisation (ASH) rate. Data will inform development of action plans. Resources will be targeted towards leading ASH conditions. Interventions will lead to improved access to primary care for ASH-related conditions. Interventions will address barriers to access and management.

Actions over the next 12 months (2013/14)

There are a number of conditions that we intend to monitor and address which contribute to high ASH rates.

Programmes and incentives are being rolled out via Māori Providers – Southern PHO will continue to contract with 11 accredited providers across the region to engage with patients around their long term conditions, improving health literacy and providing support to access medical care as and when necessary.

- Southern PHO will actively work with practices to identify patients 0–14 years coded in their Patient Management System as Asthmatic, to ensure appropriate health plans are in place. This will in time help reduce some of the hospital admissions.
- Southern PHO will progress the 'Year on Year' project designed to support practices to work with patients with high health needs with frequent hospital and ED admissions. In collaboration with the Otago University, outcome measures are to be developed by the 1st July 2013.
- Oral Health programme commenced in May 2013 providing free dental care to high needs patients with urgent dental care needs. This programme will be monitored and reviewed.
- Regularly monitor PHO data with a particular focus on Māori enrolment in practices and identify areas for improvement.

EVIDENCE

Ambulatory sensitive hospitalisation (ASH) rates per 100,000 for the 0-4, 45-64, and 0-74 age groups.

Southern DHB Ambulatory sensitive (avoidable) hospital admissions baseline and targets.

Age Group	Baseline (Dec 12)	Target 2013/14
Age 0-4 years	199%	115%
Age 45-64 years	130%	< 95%
Age 0-74 years	180%	85%

CHILD HEALTH

RATIONALE

Breastfeeding helps lay the foundations of a healthy life for a baby, contributing positively to infant health and wellbeing and reducing the likelihood of obesity later in life. Breastfeeding benefits the health of both mother and baby as well as reduce the risk to infants of SUDI, infections, eczema, asthma and obesity.

OBJECTIVE

To increase the number of Māori mothers who breastfeed their pepi. Extensive health promotion and education initiatives are needed to is to increase mothers confidence to breastfeed.

HOW OUR PLAN WILL MAKE A DIFFERENCE

Reviewing breastfeeding rates by ethnicity will allow resources to be targeted toward those groups and areas with highest need, in order to target areas for improvement.

Increasing breastfeeding rates will enhance physical and emotional wellbeing for both mother and baby. Breastfeeding will also help reduce the risk to infants of SUDI, infections, eczema, asthma and obesity.

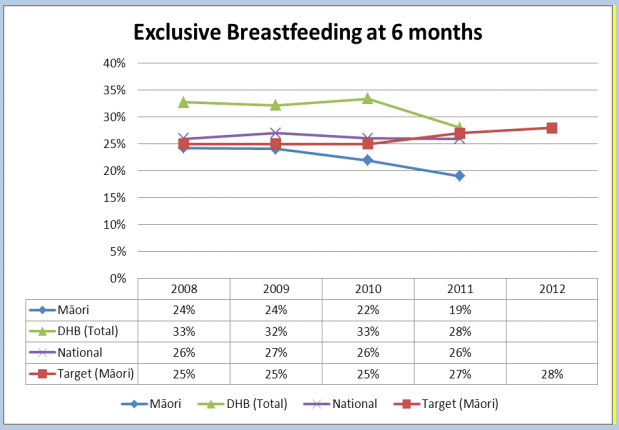
Actions over the next 12 months (2013/14)

Improve the uptake of exclusive breastfeeding at six weeks, three months and six months.

- Continue working with maternity facilities and alongside Tamariki Ora providers to identify strategies that will enhance service delivery pathways.
- Monitor breastfeeding rates against national DHB performance targets, and identify any gaps or trends that may require future attention and support.
- Southern PHO will increase community and institutional capacity to support breastfeeding by coordinating and funding peer counsellor programmes. Ethnicity information will be collected for all new enrolments as trained peer counsellors.
- Southern PHO will run a Kaupapa Māori Peer counsellor programme.
- Supporting networks to develop and implement initiatives which promote, protect and support breastfeeding.
- Public and private settings will be supported to develop and implement breastfeeding initiatives and policies to encourage normalisation of breastfeeding.
- Promote breastfeeding and increase access to appropriate antenatal education. This will include contracts with Māori and Well Child providers to deliver Antenatal breastfeeding classes.
- Continue to achieve 'Baby Friendly Hospital' accreditation.

EVIDENCE

The percentage of infants exclusively breastfed at 6 months[1]



	2008	2009	2010	2011	2012
Māori	24%	24%	22%	19%	
DHB (Total)	33%	32%	33%	28%	
National	26%	27%	26%	26%	
Target (Māori)	25%	25%	25%	27%	28%

Note: data for 2012 (Dec 2012) is not yet available.

CARDIOVASCULAR DISEASE (CVD)

RATIONALE

Cardiovascular disease is a leading cause of death in New Zealand, with Māori having worse outcomes than non-Māori.

Heart attacks and strokes are substantially preventable with lifestyle advice and treatment for those at moderate or higher risk. Stroke mortality is particularly high for Southern Māori women (who are more likely to die of stroke) and heart attacks are high in Māori men. The difference is more marked for the population over 25 years than for just the population over 65 years, indicating that stroke affects Māori at younger ages than it affects non-Māori.

OBJECTIVE

Improve early detection of cardiovascular disease through monitoring the proportion of the eligible population who have had the blood tests for CVD risk assessment (CVDRA), including the blood tests to screen for diabetes, in the preceding five year period.

Improve access to cardiac diagnostic including angiography, echocardiograms and exercise tolerance tests.

HOW OUR PLAN WILL MAKE A DIFFERENCE

Increasing the proportion of cardiovascular risk assessments (CVDRA) performed in the eligible population will reduce morbidity and mortality through improved cardiovascular health.

Actions over the next 12 months (2013/14)

To increase the number of eligible Māori to have a cardiovascular disease risk assessment.

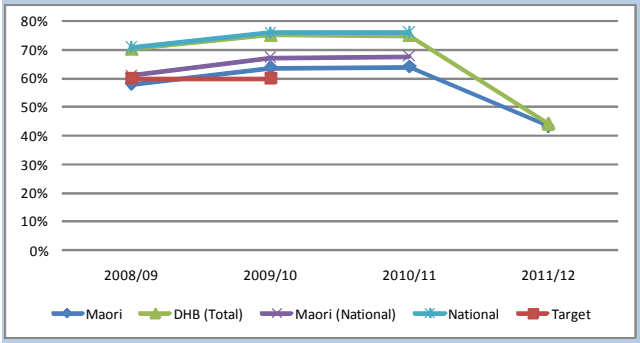
- Southern PHO contracted practices will be supported to offer CVDRA checks to eligible patients. Practice support teams will add additional resource to support this work in identified practices. A clinical quality strategy around long term condition will be implemented.
- CVDRA checks will be offered outside of general practices where opportunities arise, supported by SPHO practice support teams.
- Improve patient journey across the cardiac continuum of care. Southern PHO will enable practices to manage and fully utilise their diabetes registers including recalling patients.
- Continue to support cardiac and stroke rehabilitation, with the aim for people to recover and regain independence.
- Investigate ways to increase the uptake of Cardiovascular checks assessments.
- Work with primary and community health care providers to achieve improvement in CVD target.
- We will monitor the 'More health and diabetes checks' to ensure progress towards reaching the 90% target is on track.
- Develop systems to measure waiting times for cardiac diagnostics.

EVIDENCE

Percentage of the eligible population who have had their CVD risk assessment within the past 5 years

	2009/ 10	2010/ 11	2011/ 12	Target 13/14
Māori	63.7%	64.0%	43.3%	90%
Non- Māori	76.0%	75.8%	44.2%	90%
DHB (Total)	75.1%	74.9%	44.1%	90%
Māori(National)	67.3%	67.7%		90%
National	76.0%	76.0%		90%

Note: Expectation to achieve 60% by 30th June 2012, 75% by 30th June 2013, 90% by 30th June 2014.



Data sourced from Southern PHO. DHB Health Target.

Note: The measure calculation was changed from Jan 2012.

Number of tertiary cardiac interventions

Acute Coronary Syndrome (ACS), new measures:

- 70% of high risk patients will receive an angiogram within 3 days of admission
- 80% of Acute Coronary Syndrome (ACS) patients receiving a risk assessment and classification within 24 hours of presenting.
- 80% of ACS patients undergoing further risk stratification tests within 2 days of admission.

CANCER

RATIONALE

Cancer is a significant cause of death. Mortality from most cancer types is relatively high nationally. Māori have higher cancer mortality rates and worse outcomes than non-Māori.

The risk of developing breast cancer increases with age and is the most commonly diagnosed cancer.

Cervical cancer usually develops slowly, often taking up to ten years to develop. If abnormal cells are not detected or treated early enough there is an increased risk of developing cancer.

OBJECTIVE

Improve early detection and reduce the disease burden of cancer amongst Māori.

HOW OUR PLANS WILL MAKE A DIFFERENCE

Improved breast and cervical cancer screening rates will reduce cancer morbidity and mortality. Actions will be implemented to increase screening coverage for Māori populations. On-going monitoring will identify areas of high and low performance, in order to target areas for improvement.

Actions over the next 12 months (2013/14)

Increase the proportion of Māori Women aged 45-69 years who receive a breast screen

- Implement current service plans, these have been developed in collaboration with Māori input. They are aimed to improve service collaboration and Māori women participation in breast screening programmes.
- Southern PHO will work closely with its contracted providers to ensure all eligible women are enrolled onto the national breast screening programme.
- Monitor Cancer screening rates for the national programmes, and identify areas of significance for Māori to support future service planning and delivery.
- Work in collaboration with primary and community health care providers to encourage the participation of Māori women in screening programmes.

Increase the proportion of Māori women aged 20-69 years who receive a cervical screen.

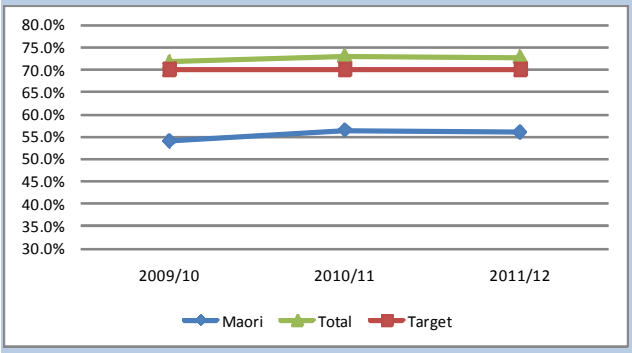
- Support current service plans, these have been developed in collaboration with Māori input. They are aimed to improve service collaboration and Māori women participation in cervical screening programmes.
- Southern PHO will continue to work in partnership with Public Health South to promote uptake of funded cervical smears in targeted populations including Māori, and under screened women.
- Southern PHO will utilise its practice to support clinicians as an additional resource to its contracted and accredited providers, to offer clinics in settings outside of General practice or outside of normal hours to encourage uptake.
- The NCSP District Coordination Steering Group will continue to monitor Māori women's screening coverage and up take of funded cervical smears.

EVIDENCE

Breast screening

The percentage of women aged 45-69 screened under the BreastScreen Aotearoa (BSA) programme.

Breast Screening				
	2009/10	2010/11	2011/12	Target 13/14
Maori	54.0%	56.5%	56.0%	70.0%
Total	71.6%	73.0%	72.8%	70.0%

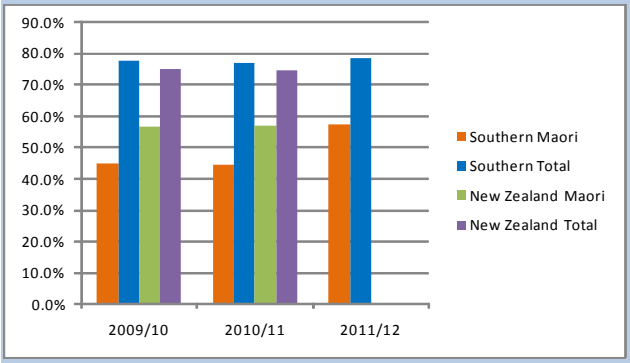


Data sourced from National Screening Unit

Cervical Screening

The percentage of women aged 25-69 screened under the National Cervical Screening Programme (NCSP).

Cervical Screening				
	2009/10	2010/11	2011/12	Target 13/14
Southern Maori	44.9%	44.5%	57.4%	80.0%
Southern Total	77.9%	77.2%	78.5%	80.0%
NZ Maori	56.5%	56.9%		80.0%
NZ Total	75.0%	74.6%		80.0%



Data sourced from National Screening Unit

SMOKING CESSATION

RATIONALE

Tobacco smoking is a well-known cause of death and ill health. It contributes to a number of preventable illness and conditions *(cancers, CVD, diabetes, lack of physical activity, poor nutrition)* that are often irreversible.

OBJECTIVE

Reduce the prevalence of smoking and smoking-related harm amongst Māori.
Working in collaboration with key stakeholders to provide brief interventions and develop resources will equally be effective.

HOW OUR PLANS WILL MAKE A DIFFERENCE

Providing brief advice to smokers is shown to increase the chance of smokers making a quit attempt. Brief advice works by triggering a quit attempt rather than by increasing the chances of success of a quit attempt. The chances of this quit attempt being successful are increased if nicotine replacement therapy or cessation support is also provided. By encouraging and supporting more smokers to make supported quit attempts there will be an increase in successful quit attempts, leading to a reduction in smoking rates and a reduction in the risk of the individuals developing smoking related diseases. This will promote and protect good health and independence.

Actions over the next 12 months (2013/14)

Support Auahi Kore (Smokefree) public places, such as schools, early childhood centres, Kohanga Reo and marae.

Carry out controlled purchase operations to identify retailers selling tobacco products to minors and provide education to retailers to increase compliance rates.

Continually improve the implementation of ABC in our hospitals:

- Continue to implement the ABC brief intervention tool for smoking cessation in Southern DHB hospitals.
- Support the monitoring and feedback processes, including weekly monitoring by wards and charge nurses, coding department feedback and ward audits.
- Daily audits are undertaken in areas that are not meeting the target and information is fed back to the relevant Charge Nurse Manager to enable timely feedback to staff.
- Developing a new referral form for cessation providers across the district for secondary care. This will include all providers listed so patients in any facility have contact details of their closest provider.

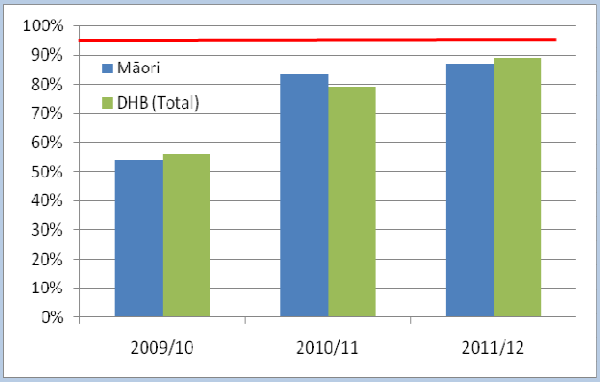
Support the implementation of ABC in primary care

- Establish GP Smokefree Champions in SPHO to support primary care. The SPHO has been funded to recruit three primary champions to provide clinical leadership to embed ABC as an essential element of clinical practice throughout primary care.
- Provide support for GPs through providing on-going education and workshops with keynote presenters. Seminars were held in Invercargill and Dunedin for health professionals in both Primary and Secondary care, Māori Providers, NGO's and the wider community.

EVIDENCE

The percentage of hospitalised smokers who are provided with advice and help to quit.

	09/10	10/11	11/12	Target 13/14
Māori	54%	83.3%	87.2%	95%
Non- Māori	56%	78.6%		95%
SDHB (Total)	56%	79.2%	89.0%	95%
National	57%			95%



Data sourced from Southern DHB reporting and Ministry of Health Target.

The percentage of current smokers enrolled in a PHO who are provided with advice and help to quit

Actual 12/13	Target 13/14
NA	90%

Data is dependent upon availability from MoH, and confirmed ethnicity data has not yet been supplied.

SMOKING CESSATION (Continued)

- Southern PHO, utilising its practice support clinicians, will work with general practice and pharmacy providers to increase cessation support to smokers.
- Provide targeted community-based cessation support to Māori through the Aukati Kaipaipa cessation programme - with increased enrolments onto the programme. New Aukati Kaipaipa smoking cessation services have been contracted for South Otago, North Otago and Central Otago. Referral pathways have been promoted to all GP's and a new cessation form listing all providers has been developed.
- Training provided for providers in the community and clinical settings on how to effectively deliver group-based smoking cessation treatment.
- Opportunities will be sought to offer smoking cessation to vulnerable communities via health days, workplace visits and similar events. Where possible Māori providers will be involved in these targeted events.

Support the implementation of ABC in community settings:

- Work with general practice and LMCs to ensure a maternity smokefree champion has been appointed.
- Support pregnant women to stop smoking through providing advice, information and resources.
- Provide targeted resources for Māori and Pacific Communities "Smoking Affects Lives" Campaign. Public Health South staff are working with local Government agencies to promote AB refer to C as a model of practice with their clients. Sessions will continue to happen within the community.

The percentage of women who identify as smokers at the time of confirmation of pregnancy who are provided with advice and help to quit

Actual 12/13	Target 13/14
New	90%

Data method to collect information for this unofficial target still to be decided.

IMMUNISATION

RATIONALE

Immunisation can protect people against harmful infections which can cause serious complications, including death. It is one of the most effective and cost efficient medical interventions to prevent disease.

High coverage and 'on time' immunisation are important to protect not only the health of an individual but to protect the community as well. High coverage reduces the spread of disease to those who have not been vaccinated either by choice or because of medical reasons, such as children with leukaemia whilst receiving treatment. The complications of influenza and diseases in the elderly can also be serious or life threatening.

OBJECTIVE

Achieve Māori immunisation coverage rates equal to or in excess of total population coverage; and at rates that achieve the Immunisation Health Target to reduce the prevalence and impact of vaccine-preventable diseases.

HOW OUR PLANS WILL MAKE A DIFFERENCE

Assessment of immunisation rates will allow resources to be targeted toward those groups and areas with high need. On-going monitoring will identify areas of high and low performance, in order to target areas for improvement.

Actions over the next 12 months (2013/14)

- Undertake health promotion activities around immunisation, with high priority given to Māori populations.
- Monitor immunisation rates against the national health target to identify areas for improvement in service delivery and future planning.
- Ensure all new-born babies are enrolled with the PHO by 2 weeks of age. The NIR will identify that all babies have a nominated GP, and that the GP accepts the birth nomination.
- Continue to roll out the Paediatric Project where all children admitted to Paediatric Services, or seen in Outpatient Clinics have their immunisation status reviewed. Capacity already exists for opportunistic immunisation to be delivered as appropriate
- Māori representative on the VPD Steering Group. Each representative feeds back to their affiliated providers
- Continue to encourage the "On time Every time' message, as low coverage at the milestone ages is related more to late vaccinations than to high decline rates
- Undertake health promotion activities around immunisation, with high priority given to Māori populations, especially in the Antenatal period, e.g. working with Mother and Pepi groups
- Monitor immunisation rates against the national health target to identify areas for improvement in service delivery and future planning.

EVIDENCE

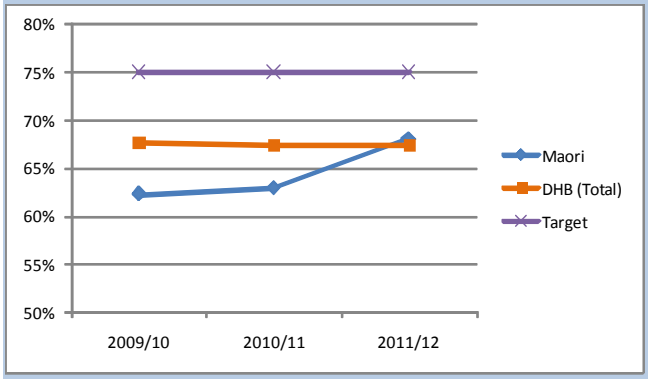
Percentage of fully immunised children at age 8 months

This is a new measure. The following data is for quarter 3 2012/13.

	Māori	Total SDHB	Target 13/14
2012/13	91%	93%	90%

Seasonal influenza immunisation rates in the eligible population (65 years and over)

Seasonal influenza immunisation rates in the eligible population (65 years and over)				
	2009/10	2010/11	2011/12	Target 13/14
Māori	62.3%	63.0%	68.1%	75%
DHB (Total)	67.7%	67.4%	67.4%	75%



Data sourced from PHO Performance Programme.

IMMUNISATION (Continued)

Achieve the immunisation Health Target of 90% by focusing on eligible Māori children to be fully immunised by eight months of age. We intend to:

- Increase immunisation education through general practices, antenatal education, Whānau Ora Services, Well Child Tamariki Ora services, Early Childhood Education, Kohanga reo and other services as appropriate.
- Focus on "on time" immunisations.
- Southern DHB and SPHO will work together to immunise hard to reach children and families through outreach services.

Increase the number of Māori aged 65 years and older who receive an annual flu immunisation.

- Work in collaboration with Māori providers on increasing numbers of Māori aged 65+ to receive an influenza vaccine.
- Southern PHO practice support teams will work with practices and accredited providers to identify patients.
- Invest in (and widely promote) free flu vaccinations for those under 18, as well as for those over 65 eligible for funded influenza vaccine, and support them to provide clinics as appropriate.

RHEUMATIC FEVER

RATIONALE

Rheumatic fever occurs when the body produces a strong immune response to a throat infection caused by a particular type of bacteria – Group A Streptococcus ('strep throat' or 'GAS' infection): Ministry of Health 2012.

It is a growing concern in New Zealand especially amongst Māori and Pacific Island children and young people. If left undetected or untreated it can cause damage to the mitral and/or aortic valves causing rheumatic health disease or death.

OBJECTIVE

To continue to have zero incidence of acute Rheumatic Fever.

HOW OUR PLAN WILL MAKE A DIFFERENCE

Increasing awareness of Rheumatic fever symptoms will ensure throat infections are treated in a timely and effective manner. Early intervention and prevention strategies will contribute to the continuation of zero incidence of Rheumatic Fever in children and young people.

Addressing key risk factors such as inadequate housing will help prevent ARF and also improve health generally.

Actions over the next 12 months (2013/14)

- Working with other South Island DHB's on a joint register for any cases to ensure prophylaxis management.
- To explore programmes that address risk factors for rheumatic fever and responds appropriately to communities.
- Improve access to primary care services, through collaboration with primary care teams around notifiable diseases and sore throat management.
- Monitor rheumatic fever rates against the national health target to identify areas for improvement in service delivery and future planning.
- Southern DHB and SPHO to work in collaboration to identify Māori whānau with children living in poor conditions who may be at risk of rheumatic fever.

EVIDENCE

Rheumatic fever notifications in Southern DHB, all ages

NOTE: There have been no notifications of acute rheumatic fever in the last 10 years in Southern DHB. (Refer to South Island Health Plan)

5. LOCAL MĀORI HEALTH PRIORITIES

For Southern DHB

In addition to those priorities already identified at a national level, Southern's Māori Provider Forum has identified the following local priorities for Māori health service improvement in Southland and Otago. Identified for each are the key actions and activity Southern DHB is undertaking to address the priority areas and reach the targets set

RESPIRATORY CONDITIONS

RATIONALE

Respiratory conditions are any condition that affects the respiratory system such as: Asthma, allergies, chronic obstructive pulmonary disease (COPD), emphysema, chronic bronchitis, lung cancer etc.

Chronic respiratory diseases are becoming an increasing cause of morbidity and mortality for all groups in New Zealand. Mortality from COPD is high for both Māori men and women within Southern.

Southern Māori rates of hospitalisation (for males and the combined male-female population aged over 14 years) due to asthma were significantly higher than rates for non-Māori. Asthma is the most common cause of admission to hospital for children; admissions are twice as common for Māori as for non-Māori.

OBJECTIVE

Southern DHB to work in collaboration with primary and community health providers to reduce the incidence of respiratory disease.

HOW OUR PLAN WILL MAKE A DIFFERENCE

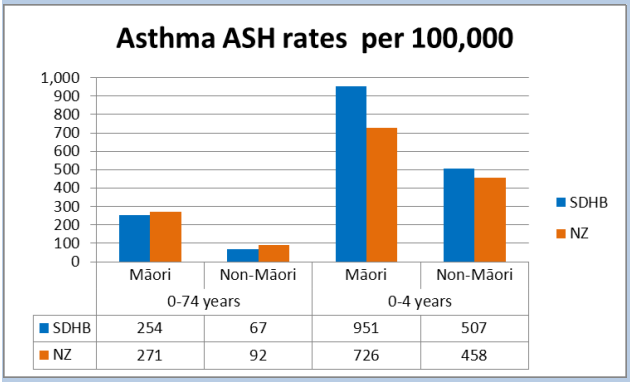
Enhancing communication and collaboration across the health care continuum will give understanding of respiratory disease and optimise management strategies. Sharing information will help to standardise practice and assist in the best possible health care being delivered across the continuum.

Actions over the next 12 months (2013/14)

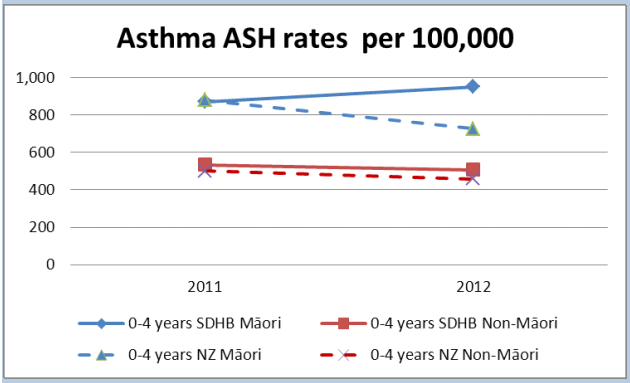
- Southern DHB and SPHO to ensure early detection and intervention to reduce the impact of respiratory illness on one's wellbeing. Number of referrals will be monitored.
- Early diagnosis of conditions that cause respiratory problems and environmental triggers should be addressed and managed sooner rather than later. All patients will be flagged with any form of respiratory condition and followed up.
- Raise awareness and reduce the incidence of respiratory disease through disease prevention and health promotion strategies. This will be achieved through the development of resources.
- To ascertain the number of Asthmatic patients across Southern PHO.
- Southern PHO will actively work with practices to identify patients coded in their PMS as Asthmatic, and explore ways to work with them.
- Education for the primary workforce will be highlighted as a priority for our Workforce development team.

EVIDENCE

Avoidable Hospital Admissions for Asthma



Avoidable Hospital Admissions for Asthma 0-4 years



Data sourced from Ministry of Health. Asthma specific information is provided as part of the DHB Performance Measure SI-1.

DIABETES

RATIONALE

Diabetes contributes to ill health and premature death. Within the Southern district, diabetes is a major issue for Māori, especially women. The prevalence of chronic conditions such as both Type 1 and Type 2 diabetes is increasing, but it is the rapid increase in Type 2 diabetes that is of great concern, particularly amongst Māori and Pacific people.

Improved diabetes care will reduce morbidity and mortality. Improving the management of diabetes will reduce long-term avoidable complications which require hospital-level intervention, such as amputation, kidney failure and blindness, and will improve people's quality of life. Diabetes is also an underlying causative factor for cardiovascular and circulatory diseases (heart attacks and stroke) and respiratory disease. As such it contributes significantly to the top causes of death in the Southern DHB.

OBJECTIVE

Improve early detection of diabetes with the aim to reduce inequalities and the disease burden of diabetes amongst Māori.

HOW OUR PLAN WILL MAKE A DIFFERENCE

Southern DHB has recently developed the Diabetes Care Improvement Plan (DCIP) which will utilise a rewards based funding model focused on improving clinical outcomes for people with diabetes. With annual evaluation and amendment to drive continuous improvement in the provision of primary care services to people with diabetes. Māori with diabetes will be seen more regularly, decreasing the risk of diabetes related complications.

Actions over the next 12 months (2013/14)

The aim of The DCIP is to ensure consistent diabetes care in primary care which meets best practice standards and guidelines.

- Establish a web-based online diabetes education resource for practice nurses.
- Practices will utilise IT tools to deliver high quality care, including disease registers, intervention prompting and clinical decision support.
- Practices can regularly monitor activity and attainment through IT reporting.
- Performance will be reviewed every six months as part of the SPHO practice support and at the 12 month review attainment markers will indicate the level of payment for the practice.
- Southern PHO to work with general practices to improve coding of diabetes and improve the accuracy of individual practice diabetes registers.
- Conduct a clinical review of the 9 main components of diabetes care: BMI, HbA1c, BP, ACr, eGFR, Cholesterol, eye examination, foot examination and smoking status.
- Monitor to ensure that enrolled patients who are diabetic are coded correctly.

EVIDENCE

New Measure:

Percentage of enrolled patients coded as diabetic who are Māori that have an HbA1c ≤ 64mmol/mol.

DIABETES (Continued)

- Southern PHO will work with its accredited providers to develop capacity in both the areas of clinical delivery and data management.
- To ensure consistent diabetes care in primary care which meets best practice standards and guidelines.
- General Practices will utilise IT tools to deliver high quality care, including disease registers, intervention prompting and clinical decision support.
- Improve the patient journey across the diabetes continuum of care.
- Southern PHO will work with its accredited providers to develop capacity in both the areas of clinical delivery and data management.
- Southern DHB and PHO will ensure that patients are involved in activities which support the continuum of care in diabetes management.

EVIDENCE

New Measure:

The number of people identified as Māori on the VDR (Virtual Diabetes register) who have had an HbA1c in the last 12 months

ACCURACY OF ETHNICITY DATA COLLECTION IN HOSPITAL SETTINGS

RATIONALE

Much emphasis is put on quality data, especially ethnicity data collection. Ethnic data is useful for the elaboration of policies, to influence funding for health, social and education services etc. It is important for taking measures to preserving identity as well as identifying those less fortunate. Many users require data for specific purposes and censuses are the most important sources of such data. However, the data that is held by censuses is only as good as the data being entered and the systems that collate it.

A recent report by Te Roopu Rangahau and Eru Pomare noted that ethnicity misclassification is a problem that has been identified for a number of years. For Māori, this has largely led to undercounting in health data sets. This leads to numerator/denominator bias when census population data is used as denominator data and impacts on the calculation of rates and examination of inequalities in health between Māori and non-Māori.

OBJECTIVE

The Southern DHB is aiming to achieving at least 90% accuracy of ethnicity data collection in DHB databases.

HOW OUR PLAN WILL MAKE A DIFFERENCE

Improving the accuracy of ethnicity data in DHB databases will lead to more accurate health profiles reflecting health needs and outcomes. This will enable the DHB to more accurately monitor the effectiveness of programmes and services and more efficiently target resources to achieve maximum health benefits for Māori.

Actions 2013/14

- On-going reports of areas of ethnicity data collection will identify areas of high and low performance, in order to target areas for improvement.
- Improved systems to ensure accurate and detailed ethnicity data information is captured, particularly on groups of policy interest.
- Departments and specialist services will be comfortable asking the ethnicity question.
- Work with the Southern DHB provider arm to provide education on the use of the MoH ethnicity data protocol.
- Support the Southern DHB provider arm to integrate the standardised ethnicity question into relevant patient information forms throughout the DHB.
- Identify best-practice approaches to auditing baseline ethnicity data accuracy in hospital databases.
- Determine baseline ethnicity data accuracy in DHB databases.
- Set ethnicity data accuracy performance targets for DHB databases.
- Southern DHB will continue to be involved in the project to develop an ethnicity data audit tool that can be used in public hospitals. The project has three phases: 1) a review of hospital ethnicity data quality and processes; 2) development of an ethnicity data audit tool; and, 3) piloting and revision of the audit tool.

EVIDENCE

ACCURACY OF ETHNICITY DATA REPORTING IN HOSPITAL DATABASES

Information Only.