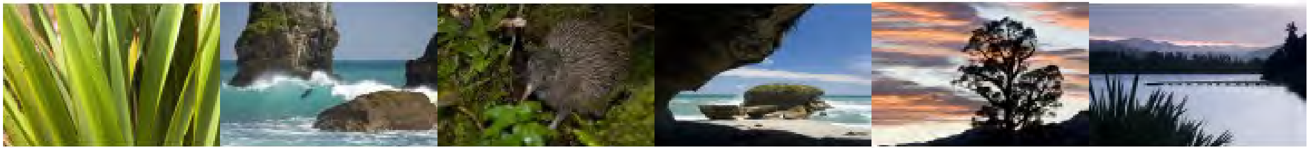
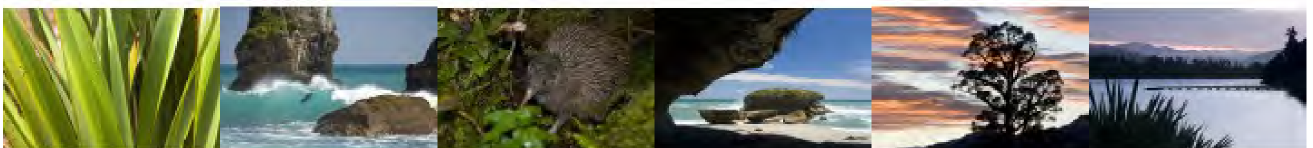


West Coast District Health Board
Te Poari Hauora a Rohe o Tai Poutini

# MĀORI HEALTH PLAN

## 2013-14



MĀORI HEALTH PLAN

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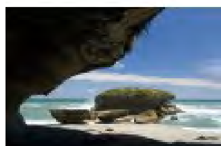

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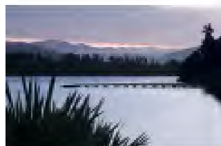
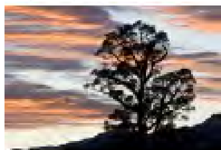


# SUMMARY OF INDICATORS

| National Priorities | Indicators | | | Baseline Māori | Non-Māori | Target |
|---|---|---|---|---|---|---|
| Data Quality | 1 | Accuracy of ethnicity reporting – (ethnicity not stated) | | To be established | | ≤10% |
| Access to care | 2 | % of Māori enrolled in the PHO<br>% of Māori enrolled in clinical programmes | | 85.4% | 94.6% | 95% |
| | 3 | ASH rates per 100,000 | 0-74 yr<br>0-4 yr<br>45-64 yr | 1,746<br>3,953<br>1,773 | 1,558<br>4,087<br>1,577 | <1,883<br><5,359<br><1,578 |
| Maternal health | 4 | Percentage of Māori infants fully and exclusively breastfed | 6 weeks<br>3 months<br>6 months | 67%<br>46%<br>24% | 69%<br>57%<br>39% | 74%<br>57%<br>40% |
| Cardiovascular disease | 5 | %of Māori who have had their cardiovascular risk assessed within the past five years | | 54% | 57% | 90% |
| | 6 | % of high-risk ACS patients accepted for coronary angiography who receive an angiogram within 3 days of hospital admission | | new [1] | new | 70% |
| | 7 | % of patients presenting with ACS who undergo coronary angiogram and are captured on the ANZAC QI Register | | new | new | 95% |
| Cancer | 8 | Breast screening rate | | 85.1% | 78.6% | >75% |
| | 9 | Cervical screening rate | | 59.3% | 75.9% | 80% |
| Smoking | 10 | % of hospitalised smokers provided with cessation advice | | 86% | 84% | 95% |
| | 11 | % of smokers seen in primary care and provided with cessation advice | | 39% | 39% | 90% |
| Immunisation | 12 | % of infants fully immunised by eight months of age | | New | New | 90% |
| | 13 | % of the eligible population immunised against influenza (flu) | | 65.7% | | >65% |
| Rheumatic Fever | 14 | Reduce rheumatic fever rates in the South Island | | 0 cases | 1 case | N/A [2] |
| **Local Priorities** | **Indicators** | | | **Baseline Māori** | **Non-Māori** | **Target** |
| Oral health | 15 | Pre school dental enrolment rates (2011 calendar year)<br>5-year-old Māori caries-free (2011 calendar year) | | 52%<br>47% | 68%<br>61% | 77%<br>63% |
| Access to services | 16 | Reduction in hospital readmission rates for Māori | | TBC [3] | TBC | TBC |

*[1] Implementation of the ANZACS QI Register is dependent on national contracts being agreed. Data will be provided for the ACS measure via the South Island Alliance until the ANZACS Register is up and running.*
*[2] Because of the very low numbers of rheumatic fever cases, the West Coast does not have a local rheumatic fever target. Instead, the South Island DHBs are taking a regional approach, outlined in the South Island Regional Health Services Plan.*
*[3] A new national definition is currently under development and we intend to use to measure and monitor performance once the data and definitions have been confirmed.*



# OVERVIEW

This plan describes West Coast District Health Board's (WCDHB) priorities for Māori health for the 2013-2014 year. This plan aligns with the requirements of the New Zealand Public Health and Disability Act (2000) which directs District Health Boards (DHBs) to reduce disparities and improve health outcomes for Māori. The format of this plan and the indicators listed within it follow the guidelines given in the 2013-2014 Operational Policy Framework provided by the Ministry of Health.

Over the coming year we will work closely within an alliance framework to achieve the outcomes described in the Māori Health Plan. The partners within the alliance will consist of the West Coast PHO, Rata Te Awhina Trust working alongside key clinicians and managers within secondary and community services as well as key partners such as Community and Public Health.

Our 2012-2013 Māori plan has laid a solid foundation from which we will continue to build on in 2013-2014. In the past several years real gains have been made in improving Māori health:

- More Māori are enrolled with primary care. 85% of Māori are now enrolled with the West Coast Primary Health Organisation – up from 79% in 2009/2010.
- More Māori with diabetes are accessing free annual checks. 94% of Māori with diabetes accessed free annual checks in 2011/2012 – a significant improvement from 53% in 2009/2010
- More Māori with diabetes are better managing their diabetes. 71% of Māori with diabetes who accessed free annual checks have satisfactory or better diabetes management in 2011/2012 – up from 67% in 2009/2010
- More Māori have had their cardiovascular (CVD) risk assessed. 42% of eligible Māori adults have had CVD risk assessment in the last five years in 2011/2012 – up from just 19% in 2009/2010.
- More Māori are being supported to quite smoking. 86% of hospitalised Māori smokers were offered advice and help to quit in 2011/2012 – well up from only 46% in 2009/2010.
- Fewer Māori are going to hospital for preventable illnesses. Avoidable hospitalisation rates for Māori (aged 0-74) have dropped to 1746 per 100,000 in 2011/12 – down from 2102 in 2009/2010.
- Māori Health Provider services have been reconfigured to align more closely to the Ministry's Better, Sooner More Convenient health and Whānau Ora strategy including Māori Health positions within Integrated Family Healthcare Services.

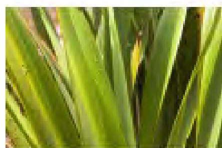
Through work undertaken we have identified the key areas where further investment is required to ensure that we are achieving the targets set and continuing to build on the momentum created in 2012-2013.

We will continue to work alongside our Māori Provider on the West Coast to more closely align services to the Ministry's 6 Health targets and the indicators within the Māori Health Plan and also to integrate some of their services within Integrated Family Healthcare Services.

We will continue to focus on improving the capacity and capability of the West Coast health system to provide appropriate, accessible and integrated health services for Māori on the West Coast. This includes improving the responsiveness and effectiveness of mainstream service providers, reorienting and integrating Māori health services and delivering on the national Whānau Ora initiative.

Following the review of mainstream service effectiveness for Māori, our service priorities include child and maternal health, long term conditions, smoking cessation, and oral health. We anticipate that Māori will benefit from the establishment of clear patient pathways and targeted initiatives that are aimed specifically at increasing Māori uptake of services such as immunisation programmes, breastfeeding support, and school-based health services and reducing inequalities. Additionally we will focus on improved discharge pathways to better support patients on discharge from hospital to improve their recovery and reduce readmissions.

Delivery on Whānau Ora and improving access and health outcomes for our population by supporting interconnectedness and the provision of seamless services between providers and sectors will continue to be a priority. We will work alongside providers to support the organisational transformation required for the delivery of a Whānau Ora Integrated model that is clinically sound, culturally robust and empowers patients while recognising the strengths within Whānau and encourages Whānau to be self-managing.



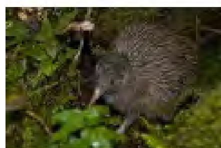
## Performance Reporting

In addition to the alliance group quarterly performance results for the Māori Health Plan indicators will be disseminated to four key audiences.

First, results will be submitted to the Board for review and discussion in the same manner that annual Plan and Health Target results are presented. Second, quarterly performance reports will be reviewed by the Mana Whenua Health Board – Tatau Pounamu. Third, quarterly performance results will be presented at the DHB's executive management meetings and Fourth the DHB's Māori Health Plan performance will be presented in the DHB's Annual Report.

## Abbreviations

| | |
|---|---|
| ABC | An approach to smoking cessation requiring health staff to ask, give brief advice, and facilitate cessation |
| AP | Annual Plan |
| ARF | Acute rheumatic fever |
| ASH | Ambulatory sensitive hospitalisation |
| BFHI | Baby friendly hospital initiative |
| WCDHB | West Coast District Health Board |
| COPD | Chronic obstructive pulmonary disease |
| CVD | Cardiovascular disease |
| CVRA | Cardiovascular Risk Assessment |
| DAR | Diabetes Annual Review |
| DHB | District Health Board |
| DMFT | Decayed, Missing or Filled teeth |
| DNA | Did not attend |
| ENT | Ear Nose and Throat |
| GM | General Manager |
| HbA1c | Glycated haemoglobin |
| IGT | Impaired Glucose Tolerance |
| IHD | Ischaemic heart disease |
| ISDR | Indirectly standardised discharge rate |
| MoH | Ministry of Health |
| NSU | National Screening Unit |
| WCPHO | West Coast Primary Health Organisation |



# SECTION 1 – POPULATION PROFILE & HEALTH NEEDS

## 1. Geographic Distribution

The West Coast DHB has a total population of 32,900[4], of which 10% (3320) identify as Māori – an increase of 5% from the 2006 estimated resident population.

WCDHB comprises three territorial authorities. In the 2006 census, the proportion of the population indicating Māori ethnicity increased across all three territorial local authorities.

| District | Buller | Grey | Westland |
|---|---|---|---|
| Māori (number) | 804 | 1098 | 1014 |
| Māori (%) | 8.3% | 8.3% | 12.1% |

## 2. Health Service Providers

Key health service providers in the DHB include:

- 3 public hospitals within the West Coast DHB
- General Practice – 2 privately owned, 4 DHB owned
- West Coast Primary Health Organisation
- Rata Te Awhina Trust Māori Health Provider
- Multiple local and national non-profit and private health and social providers

## 3. Iwi within the WCDHB

**Poutini Ngāi Tahu**
Under section 9 of the Te Rūnanga O Ngāi Tahu Act 1996 the two rūnanga who hold such status on the West Coast are Te Rūnaka O Ngati Waewae and Te Rūnanga O Makaawhio.

**Te Rūnanga O Makaawhio**
The takiwa (tribal area) of Te Rūnanga o Makaawhio centres on Mahitahi (Bruce Bay) and extends from the south bank of the Pouerua River to Piopiotahi (Milford Sound) and inland to the Main Divide together with a shared interest with Te Rūnanga o Ngati Waewae in the area situated between the north bank of the Pouerua River and the south bank of the Hokitika River.

**Te Rūnanga O Ngati Waewae**
The takiwa (tribal area) of Te Rūnanga o Ngāti Waewae centres on Arahura and Hokitika and extends from the north bank of the Hokitika River to Kahuraki and inland to the Main Divide, together with a shared interest with Te Rūnanga o Makaawhio in the area situated between the north bank of the Pouerua River and the south bank of the Hokitika River

**Tatau Pounamu Manawhenua Health Group**
The West Coast District Health Board has Treaty-based relationships with Te Rūnanga o Ngāti Waewae and Te Rūnanga o Makaawhio, and supports and regularly consults with Tangata Whenua and the Māori community both directly and through Tatau Pounamu, its manawhenua consultative group

## 4. Age Distribution of the Māori Population

Similar to the national Māori population, West Coast Māori have a younger population age structure. Almost half of West Coast Māori (45% are under twenty years of age, compared to 24% of non-Māori population. In contrast, 9% of Māori on the West Coast are aged 60 years and over compared to 24% of non-Māori in the same age band.

| Age Group | 0-9 | 10-19 | 20-39 | 40-69 | 70-79 | 80+ |
|---|---|---|---|---|---|---|
| Māori (%) | 23.05 | 24.79 | 24.39 | 25.61 | 1.75 | 0.41 |
| Non-Māori (%) | 11.47 | 13.07 | 22.81 | 42.43 | 6.49 | 3.73 |

[4] *Estimated Resident Population at June 2011: Statistics NZ updated November 2011*

### 5. Population Growth Projections

Over the period 2006-2026, the young (aged 0-14 years) and working age (15-64 years) Māori populations are predicted to increase by 7.0 percent and 18.7 percent respectively. The greatest population increase occurs in the elderly population for Māori (261.5%). This is predicted to lead to an overall increase in the Māori population of 24.5 percent while the non-Māori population is expected to decrease by 2.7 percent.

### 6. Deprivation Distribution

The West Coast population is relatively deprived overall, as defined by the New Zealand Deprivation Index 2006. West Coast Māori have a similar deprivation profile to the total West Coast population, and this is in contrast to the national picture, in which Māori have a more deprived profile. However, data from the 2006 Census indicate that West Coast Māori have higher levels of deprivation than the total West Coast population on a number of measures including income, education, access to a car and telephone and home ownership.

### 7. Leading causes of hospitalisations

**Leading causes of hospitalisations for children 0-4 years by ethnicity, 2007-09**

| | West Coast DHB | | New Zealand | |
|---|---|---|---|---|
| | Condition | Rank | Condition | Rank |
| Māori | Respiratory Infections | 1 | Respiratory Infections | 1 |
| | Disorders related to length of gestation and foetal growth | 2 | *Persons encountering health services in other circumstances | 2 |
| | Persons encountering health services in other circumstances* | 3 | Disorders related to length of gestation and foetal growth | 3 |
| | Gastro-oesophageal reflux disease | 4 | Gastro-oesophageal reflux disease | 4 |
| | Dental conditions | 5 | ENT Infections | 5 |
| Non-Māori | Respiratory Infections | 1 | Persons encountering health services in other circumstances | 1 |
| | Persons encountering health services in other circumstances | 2 | Respiratory infections | 2 |
| | Gastro-oesophageal reflux disease | 3 | Disorders related to length of gestation and foetal growth | 3 |
| | Disorders related to length of gestation and foetal growth | 4 | Gastro-oesophageal reflux disease | 4 |
| | Respiratory and cardiovascular disorders specific to the perinatal period | 5 | ENT infections | 5 |

Note: ENT infections = ear, nose and throat infections

*Persons encountering health services in other circumstances (Z70-Z76). For example, health supervision and care of other healthy infant and child.

**Leading causes of avoidable hospitalisations, ethnicity, 0-74 years, 2007-09**

| | West Coast DHB | | New Zealand | |
|---|---|---|---|---|
| | Condition | Rank | Condition | Rank |
| Māori | Respiratory Infections | 1 | Respiratory Infections | 1 |
| | Dental conditions | 2 | Dental conditions | 2 |
| | Asthma | 3 | Asthma | 3 |
| | ENT infections | 4 | ENT infections | 4 |
| | Diabetes | 5 | Angina | 5 |
| Non-Māori | Respiratory infections | 1 | Respiratory infections | 1 |
| | Gastroenteritis | 2 | Gastroenteritis | 2 |
| | Dental conditions | 3 | ENT infections | 3 |
| | Obstructed hernia | 4 | Dental conditions | 4 |
| | ENT infections | 5 | Angina | 5 |

**8. All-Cause Mortality, 1996-2004 (Source: New Zealand Health Information Service)**

| | West Coast | | New Zealand | |
|---|---|---|---|---|
| | Māori | Non-Māori | Māori | Non-Māori |
| Mean annual rate per 100,000 | 410.0 (334.1-498.0) | 236.6 (225.6-248.0) | 475.8 (469.6-482.0) | 201.3 (200.3-202.3) |

Note: Small numbers prevent the calculation of an avoidable mortality rate for West Coast Māori females, and contribute to wide 95% confidence intervals around the rate for West Coast Māori males.

**9. Primary Care – PHO Enrolment**

Over the past 26 quarters, enrolments in the West Coast PHO by Māori and Pacific Island people have grown by 52%, while those by people of all other ethnicities have grown 15%

**Enrolled population as at30 June 2012**

| | WCPHO |
|---|---|
| Total Enrolled | 31,114 |
| Māori | 2,869 |
| Māori (%) | 9.2% |

**10. Social Determinants of Health (Source: Statistics New Zealand 2006 Census data)**

| | WCDHB | | New Zealand | |
|---|---|---|---|---|
| | Māori | Non-Māori | Māori | Non-Māori |
| Income more than $50,000 | 4.6% | 9.1% | 5.9% | 12.7% |
| Income less than $20,000 | 29.3% | 35.2% | 27.7% | 30.4% |
| Degree or higher qualification | 1.9% | 5.3% | 4.1% | 11.1% |
| No qualification | 23.4% | 25.5% | 23.0% | 17.6% |
| No access to telephone | 20.7% | 12.1% | 23.3% | 10.9% |
| No access to car | 8.0% | 4.6% | 8.2% | 4.7% |
| Home not owned | 39.5% | 23.9% | 49.0% | 29.9% |

# SECTION 2 – NATIONAL INDICATORS

| Health Issue: | Data Quality |
|---|---|
| Indicator 1: | Accuracy of ethnicity reporting in PHO registers |
| Baseline: | To be established. |
| Target: | Less than 10% of enrolled people are identified as 'ethnicity not stated' |
| Current Actions: | 1. WCDHB has provided training for PHO and primary care providers aimed at increasing the accuracy of ethnicity data<br>2. WCDHB has promoted use of the MoH's ethnicity data collection protocol in PHO enrolment process<br>3. PHO Administration Road Shows target accurate data collection |

## Action Plan:

| Outcome:<br><br>To help achieve this outcome we will: | Accurate population health information<br><br>Decrease the number of enrolled people with 'ethnicity not stated' on their enrolment and limit misclassification of ethnicity in primary care | | |
|---|---|---|---|
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| Support the PHO to deliver training for ethnicity data collection | 75% of practices have completed data collection training | 50% complete by Dec 2013<br>75% by June 2014 | WCDHB Māori Health<br>West Coast PHO |
| Work with the PHO to use the Primary Care ethnicity Data Audit Toolkit to assess the quality of ethnicity data and systems for data collection, recording and output within primary health care settings. | The DHB will participate in the national RFP for the implementation of a Primary Care Ethnicity Data Audit Toolkit | RFP released May 2013 | WCDHB Māori Health<br>West Coast PHO<br>General Practice teams |
| Decrease the number of misclassification of ethnicity | Reducing number of 'ethnicity not stated' | Baseline data confirmed by Oct 2013<br>First report June 30 2014 | West Coast PHO |

| **Health Issue:** | **Access to care** |
|---|---|
| **Indicator 2:** | **Percentage of Māori enrolled in the PHO** |
| **Baseline:** | 85.4% of West Coast Māori were enrolled with a PHO at 30 June 2011/2012 |
| **Target:** | 95% Māori PHO enrolment rates by 30 June 2014 |
| **Current Actions:** | 1. WCDHB has attained high PHO enrolment rates for Māori compared with national figures and Māori enrolment rates continue to increase at a faster rate than any other ethnicity. The West Coast DHB and the West Coast PHO will work together to maintain the Māori enrolment rates for the West Coast. |

## Action Plan:

| **Outcome:** | Improved access to primary care | | |
|---|---|---|---|
| **To help achieve this outcome we will:** | Increase the PHO enrolment rate for Māori | | |
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| Implement the newborn PHO enrolment process | All newborns are enrolled with a primary care provider by 6 weeks of age | Process in place by Dec 2013<br>100% enrolment by June 30 2014 | West Coast PHO<br>Child Youth Health Workstream |
| Māori Provider Kaimahi support Māori to enrol with the PHO | Quarterly reports are provided by the<br>Māori Provider that give evidence of whānau who are supported to enrol with the PHO | Reported on each quarter | Rata Te Awhina Trust |
| Recruitment of specific Māori health positions within Integrated Family Healthcare Care Services | Buller recruitment commenced<br>Grey recruitment commenced<br>Westland recruitment commenced | July 2013<br>Nov 2013<br>Nov 2013 | Rata Te Awhina Trust<br>West Coast DHB Māori |
| Māori Provider clients supported to participate in appropriate clinical programmes | Number of Rata Te Awhina Trust clients participating in;<br>- Long Term Conditions Programme<br>- Diabetes Annual Review<br>- CVRA<br>- Cardiac Rehabilitation programmes | Quarterly reports provided by PHO and Rata Te Awhina Trust | Rata Te Awhina Trust<br>West Coast PHO |

| Health Issue: | Access to care |
|---|---|
| Indicator 3: | **Ambulatory Sensitive Hospitalisations rates per 100,000**<br>for the 0-74, 0-4, and 45-64 age groups |
| Baseline: | 0-74 yr age group Māori 1,746; Non-Māori 1,558 per 100,000<br>0-4 yr age group Māori 3,953; Non-Māori 4,087 per 100,000<br>45-64 yr age group Māori 1,773; Non-Māori 1,936 per 100,000 |
| Target: | 0-74 yr age group: maintain at <95% of national average (<1,883 per 100,000)<br>0-4 yr age group: maintain at <95% of national average (<5,359 per 100,000)<br>45-64 yr age group: maintain at <95% of national average (<1,578 per 100,000) |
| Current Actions: | 1. Improvement in pre-school dental enrolment rates<br>2. Māori positions within Integrated Family Health Care Services |

## Action Plan:

| Outcome: | Improved access to primary care<br>Reduced readmission rates | | |
|---|---|---|---|
| To help achieve this outcome we will: | Reducing the ambulatory sensitive hospitalisation (ASH) rate | | |
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| Develop and implement an action plan to facilitate improved management of ASH conditions in primary care | Identification of the top five ASH conditions for Māori and a plan in place to raise awareness and facilitate improved management of these conditions | Action Plan Q1<br>Q1 - Q4 Monitor ASH admissions rates through the West 2014 | WCDHB Māori health<br>WCPHO<br>WCDHB<br>Rata Te Awhina Trust |
| the implementation of Māori positions within the IFHS will enable improved management of Long Term Conditions in primary care | Reduction in ASH admissions relating to Long Term Conditions | Dec 2013<br>June 30 2014 | West Coast DHB Māori Health<br>West Coast PHO<br>Rata Te Awhina Trust<br>WCDHB Nurse Specialists |
| A review of Tamariki ora well child services and identification of how well these services provide for the needs of pepe and Tamariki will be completed and provide recommendations on the provision of future services[5] | Review and recommendations available<br>Improved access to Tamariki ora well child services<br>Reduction in number of Tamariki accessing hospital services | Review complete by Q2 | West Coast DHB Māori Health |
| Develop a collaborative model with the Māori Provider and the PHO to Improve the interface between primary and secondary care when patients are discharged | Whānau Ora workers and Kaimahi are notified when Māori discharged from hospital require comprehensive support services | Model Dec 2013<br>Review June 30 2014 | WCDHB Māori health<br>Chronic Conditions Nurse Specialist<br>GP Practices |
| Work with the Clinical Complex Care team and Rata Te Awhina Trust to identify Māori referrals to the service | 10 goal based care plans will be developed using InterRAI | Process developed by Q1 and monitored at the end of each quarter | CCCN<br>Rata Te Awhina Trust<br>WCDHB Māori Health |

[5] *Refer to the local indicators to see specific actions relating to oral health which is a leading ASH cause for Tamariki on the West Coast*

| Health Issue: | Child Health |
|---|---|
| Indicator 4: | **Percentage of Māori infants exclusively breastfeeding**<br>at 6 weeks, 3 months, and 6 months |
| Baseline: | 6 weeks – 67%<br>3 months – 46%<br>6 months -24% |
| Target: | 6 weeks – 74%<br>3 months – 57%<br>6 months – 40% |
| Current Actions: | 1. Breastfeeding health promotion activities continue to be delivered by the West Coast PHO<br>2. Breastfeeding support has been facilitated through lactation consultants, Tamariki Ora providers, Māori Health Providers, Mum4Mum Peer Supporters and Plunket nurses |

## Action Plan:

| Outcome: | Improved health amongst mothers and their babies | | |
|---|---|---|---|
| To help achieve this outcome we will: | Increase the number of mothers who have fully and exclusively breastfed their baby to six months | | |
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| Continue to provide health promotion activities which support breastfeeding | Number of mums with Māori babies graduating from the Mum 4 Mums breastfeeding support group<br>Increase proportion of Māori mothers referred to lactation support in community.<br>Breastfeeding pathway live on Health Pathways to help providers refer mothers to the most appropriate support | Ethnicity baselines for Mum-4-Mum and lactation referrals Q2<br>Reporting on progress Q4<br>Breastfeeding pathway established Q2 | Health Pathways Co-ordinator<br>West Coast PHO<br>Child and Youth Health Workstream<br>West Cost DHB |
| Work with WCDHB to integrate Māori Provider Mothers and Pepe service more effectively within Maternity services with a focus on breastfeeding support | >85% of mothers with Māori babies are breastfeeding on hospital discharge.<br>Mothers and Pepe service is available to all Mothers with Māori babies | Six monthly | West Coast DHB Māori Health<br>West Coast DHB Maternity Services<br>Rata Te Awhina Trust |
| Continue Māori involvement in Breastfeeding Interest groups | Number of meetings attended by Māori Kaimahi | Six monthly | West Coast DHB Māori Health<br>Rata Te Awhina Trust |

| Health Issue: | Cardiovascular disease |
|---|---|
| Indicator 5: | **Cardiovascular risk assessment (CVRA) completion within the past 5 years**<br>(percentage of the eligible population) |
| Baseline: | 54% at June 2012 |
| Target: | 90% by June 2014 |
| Current Actions: | 1. Heart Respiratory Team responsible for monitoring results for CVD<br>2. CVRA performance targets incorporated into Māori Provider Service delivery contracts |

## Action Plan:

| Outcome:<br><br>To help achieve this outcome we will: | Reduced mortality through improved cardiovascular health<br><br>Increase the proportion of cardiovascular risk assessments (CVRA) performed in the eligible population | | |
|---|---|---|---|
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| Work with the PHO to review CVRA rates in general practices | Identification of high and low-performing clinics. Shared strategies to improve rates implemented | Dec 2013<br>June 2014 | West Coast DHB Māori Health<br>West Coast PHO |
| Training and tools are provided to Māori Provider clinicians to ensure clinical guidelines are met | Rata Te Awhina Trust clinical staff are up-skilled in clinical best practice | Dec 2013<br>June 2014 | West Coast DHB Māori Health<br>West Coast PHO<br>Rata Te Awhina Trust |
| Hold CVRA clinics for Māori in collaboration with Nurse Specialists, PHO, Māori Provider and general practice teams | 6 CVRA clinics held | Quarterly | West Coast DHB Māori Health<br>West Coast PHO<br>Rata Te Awhina Trust<br>WCDHB Nurse Specialists |
| Delivery of Te Whare Oranga Pai physical activity and healthy eating programme | Number of health plans developed<br>Base line data established | Quarterly reports | |
| Continued involvement by Māori in the Heart and Respiratory quarterly meetings | Number of meetings attended | Quarterly | Rata Te Awhina Trust<br>West Coast DHB Māori Health |
| Develop a process for data capture from Māori Provider back to the practices | All screening completed in community settings is fed in to the relevant practice | Meetings held and process decided by December 2013 =- process implemented by June 2014 | Rata Te Awhina Trust<br>West Coast DHB Māori Health<br>West Coast PHO<br>General Practice Teams |

Note: Further detail on actions to deliver on the More Heart and Diabetes Checks Health Target can be found in the DHB's Annual Plan www.westcoastdhb.org.nz.

| Health Issue: | Cardiovascular disease |
|---|---|
| Indicator 6: | Improved quality of tertiary and specialist care |
| Baseline: | New |
| Target: | 70% of high risk patients will receive an angiogram within 3 days of admission<br>95% of patients presenting with ACS who undergo coronary angiogram are captured on the ANZAC QI Register [6] |
| Current Actions: | 1. WCDHB will work with CDHB Cardiology to measure progress in relation to Māori outcomes within this indicator throughout the year. |

## Action Plan:

| Outcome: | improved quality of tertiary and specialist care for Māori patients with cardiac conditions | | |
|---|---|---|---|
| To help achieve this outcome we will: | Monitor the number of Acute Coronary interventions for Māori and non-Māori in the WCDHB | | |
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| Support the implementation of the Regional Cardiac Services Plan to improve the quality of tertiary and specialist care for patients with cardiac conditions<br>Implement regionally agreed protocols and clinical pathways for patients with Acute Coronary Syndrome (ACS). | 70% of high risk patients will receive an angiogram within 3 days of admission<br>95% of patients presenting with ACS who undergo coronary angiogram are captured on the ANZAC QI Register. | Results will be measured in Quarter 4 | WCDHB<br>CDHB<br>Monitor intervention rates regionally via the Cardiac Workstream. |

[6] *Implementation of the ANZACS QI Register is dependent on national contracts being agreed. Data will be provided for the ACS measure via the South Island Alliance until the ANZACS Register is up and running.*

| Health Issue: | Cancer |
|---|---|
| Indicator 7: | Breast screening rate among the eligible population |
| Baseline: | 85.1% at 30 June 2012 |
| Target: | Maintain performance above 75% |
| Current Actions: | 1. Māori participation in the Local Cancer Team Meeting<br>2. Promotion of Breast screen Aotearoa by primary care providers<br>3. Breast screening attendance data reviewed on a regular basis |

## Action Plan:

| Outcome: | Reduced cancer mortality and morbidity | | |
|---|---|---|---|
| To help achieve this outcome we will: | Improve breast screening rates | | |
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| Work with the regional Breastscreen Aotearoa co-ordinator to continue to ensure support services are engaged and co-ordinated effectively | Meetings held and agreed best practice models for breast screening service delivery models developed for the West Coast | Dec 2012<br>June 2013 | West Coast DHB Māori Health<br>Breastscreen Aotearoa<br>Local Cancer Team |

| **Health Issue:** | **Cancer** |
|---|---|
| **Indicator 8:** | **Cervical screening rate among the eligible population**<br>(three year cycle, age 25-69) |
| **Baseline:** | 59.3% at June 30 2012 |
| **Target:** | 80% by June 2014 |
| **Current Actions:** | 1. 0.4 FTE Māori Cervical Screening Nurse employed by the DHB<br>2. Collaborative initiatives between the WCDHB, WCPHO and the Māori Provider to better co-ordinate and improve screening rates |

## Action Plan:

| **Outcome:** | Reduced cancer mortality and morbidity | | |
|---|---|---|---|
| **To help achieve this outcome we will:** | Improve cervical screening rates | | |
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| Increased referrals to Māori Cervical Screener through promotion and integration of service in primary care | Monthly reports from the WCDHB including referral from primary care and number of Māori women accessing the service | Quarterly reports<br>Additional reports to Tatau Pounamu as required | West Coast DHB Māori Health<br>West Coast DHB Cervical Screener<br>West Coast PHO<br>GP practice teams |
| Work with the PHO to highlight mainstream responsiveness to inequalities in cervical screening rates | Inclusion in PHO quality training | June 2014 | West Coast DHB Māori Health<br>West Coast PHO<br>GP Practice teams |
| Work with the Māori Provider and the PHO to identify opportunities for outreach clinics and screening to occur | Number of clinics held<br>Number of outreach screening occurred | Quarterly reports | West Coast DHB Māori Health<br>West Coast DHB Cervical Screener<br>West Coast PHO |
| Develop a process to facilitate improved coordination between services<br>Engage key stakeholders in identifying a system approach to improve cervical screening rates for priority women | Process facilitated and embedded in the pathway | Dec 2012<br>June 30 2013 | West Coast DHB Māori Health<br>West Coast DHB Cervical Screening services<br>West Coast PHO |

| **Health Issue:** | **Smoking** |
|---|---|
| **Indicator 9:** | **Percentage of hospitalised smokers provided with brief advice and offer of referral for cessation support** |
| **Baseline:** | 86% as at June 2012 |
| **Target:** | 95% by June 2014 |
| **Current Actions:** | 1. Māori targets identified within the West Coast Tobacco Control Plan implementation<br>2. Aukati Kaipaipa programme implemented on the West Coast<br>3. Monthly reporting is provided for WCDHB by ward and stratified by ethnicity |

## Action Plan:

| **Outcome:**<br><br>**To help achieve this outcome we will:** | Improved respiratory health and reduction in cardiovascular risk<br><br>Increase the proportion of hospitalised smokers who are given brief advice and offered referral for cessation support | | |
|---|---|---|---|
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| ABC training provided to all Māori Kaimahi who interface with hospital services including Kaiawhina, navigators, and Māori provider Kaimahi | 100% of Māori Provider staff trained in ABC | June 30 2014 | WCDHB Māori Health<br><br>West Coast PHO Smoking Cessation Co-ordinator |
| WCDHB will developed standardised systems for brief advice and referral to smoking cessation services during discharge planning for current smokers | Discharge planning tools and processes include smoking cessation options | June 30 2014 | WCDHB Māori Health<br><br>West Coast Smokefree Services Co-ordinator<br><br>WCDHB<br><br>WCDHB Smoking Cessation Co-ordinator<br><br>WCDHB discharge Planning services |
| Aukati Kaipaipa services and Coast Quit smoking cessation services are promoted to all wards and a process for referrals developed and implemented<br><br>Provide targeted community-based cessation support to Māori and whānau through the Aukati Kaipaipa cessation programme. | $\geq$100 people enrol with the Aukati Kaipaipa smoking cessation programme. | Quarterly | WCDHB<br><br>Community and Public Health<br><br>Aukati Kaipaipa<br><br>WCPHO |
| Work with LMCs and primary care to ensure ABC smoking cessation interventions are provided to pregnant wahine Māori who smoke | Progress is made towards providing 90% of women who identify as smokers at the time of confirmation of pregnancy advice and support to quit | Quarterly | WCDHB<br><br>Community and Public Health<br><br>Aukati Kaipaipa<br><br>Rata Te Awhina Trust |
| Support hospital based monitoring and feedback processes, monitoring by Clinical Nurse Managers, coding department feedback to wards, ward audits and analysis of care pathways where no intervention is being recorded. | ABC Ward reports continue to be distributed to all West Coast DHB staff quarterly showing results for all wards | Quarterly | WCDHB |

Note: Further detail on actions to deliver on the Hospital Smoking Health Target can be found in the DHB's Annual Plan at www.westcoastdhb.org.nz.

| Health Issue: | **Smoking** |
|---|---|
| Indicator 10: | **Percentage of smokers seen in primary care and provided with brief advice and offer of referral for cessation support** |
| Baseline: | 39% as at 30 June 2013 |
| Target: | 90% by June 30 2014 |
| Current Actions: | 1. Implementation of Māori objectives within the West Coast Tobacco Control Plan<br>2. System improvements in primary care to enable increases in the quantity and quality of coding information for Māori and non-Māori<br>3. ABC deliverables within Māori Provider contracts<br>4. Māori Provider training opportunities being coordinated or delivered by the West Coast Smokefree Services Co-ordinator |

## Action Plan:

| Outcome: | Improved respiratory health and reduced cardiovascular risk | | |
|---|---|---|---|
| To help achieve this outcome we will: | Increasing the proportion of smokers in primary care who are given brief advice and offered referral for cessation support | | |
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| Support implementation of ABC training in community settings | Number of primary care health workers trained in ABC | Dec 2013<br>June 30 2014 | WCDHB Māori Health<br>WC Smokefree Services Co-ordinator |
| Provide targeted community based cessation support to Māori through the Aukati Kaipaipa cessation programme | Number of Māori supported through Aukati Kai Paipa<br>Regular reports from Community & Public Health on the AKP programme | Quarterly reporting | WCDHB Māori Health<br>Community & Public Health - AKP |
| Māori Provider clients are provided with smoking cessation advice and referred to the appropriate service | Number of Rata Te Awhina Trust whānau provided with cessation advice<br>Number of Rata Te Awhina Trust whānau referred to cessation services | Quarterly reporting | Rata Te Awhina Trust |
| Develop performance reports and dashboards in primary care which enable targeting of practices where performance is low, and monthly monitoring of individual practice performance. | Number of Māori referred to cessation support services from primary care | Quarterly reporting | WCDHB Māori Health<br>WC Smokefree Services Co-ordinator |
| Buller Youth Smokefree project continues to provide targeted advice to youth in the Buller | Number of Māori who are provided with cessation advice through the Buller Youth Smokefree project | Q2<br>Q4 | Buller REAP<br>Healthy West Coast Governance Group |

Note: Further detail on actions to deliver on the Primary Care Smoking Health Target can be found in the DHB's Annual Plan at www.westcoastdhb.org.nz.

| **Health Issue:** | **Immunisation** |
|---|---|
| **Indicator 11:** | **Percentage of infants fully immunised by eight months of age** |
| **Baseline:** | new |
| **Target:** | 90% of all eight-month-olds will be fully vaccinated by 30th June 2014 |
| **Current Actions:** | 1. Outreach Immunisation Services focused on locating and vaccinating hard to reach children and reducing inequalities for Tamariki Māori and children.<br>2. Immunisation deliverables within Māori Provider contracts |

## Action Plan:

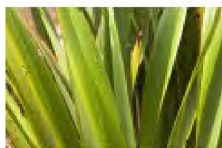
| **Outcome:** | Improved child health | | |
|---|---|---|---|
| **To help achieve this outcome we will:** | Increase the proportion of Māori children fully immunised by 8 months of age | | |
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| Review systems for seamless handover between maternity, general practice and WCTO services and NIR services | 95 % of newborn babies are enrolled on the NIR at birth<br>100% of newborns are enrolled with a primary care provider by 6 weeks of age<br>Identify the immunisation status of children in hospital and refer them for immunisation. | Registration system review completed Q1<br>Enhancements embedded into services by June 2014<br>Quarterly reports | Māori Health WCDHB<br>Child Youth Health work-stream<br>Maternity Services |
| Focus Outreach Immunisation Services on locating and vaccinating hard to reach children and reducing inequalities for Tamariki Māori and children. | OIS Referrals show ethnicity and are reported on quarterly<br>Three outreach clinics are held in community settings during 2013/14 | Quarterly reporting<br>Clinics held by June2014 | Māori Health WCDHB<br>West Coast PHO<br>Outreach Immunisation<br>Rata Te Awhina Trust |
| Develop a DHB-wide Immunisation Promotion programme linking with the Canterbury DHB's Immunise for Life Programme. | Immunisation Promotion Campaign launched.<br>Immunisation promoted during immunisation week.<br>Immunisation information available for patients through antenatal education. | Campaign Q2.<br>Quarterly reporting. | Māori Health WCDHB<br>West Coast PHO<br>Outreach Immunisation<br>Rata Te Awhina Trust |

Note: Further detail on actions to deliver on the Immunisation Health Target can be found in the DHB's Annual Plan at www.westcoastdhb.org.nz.

| Health Issue: | Immunisation |
|---|---|
| Indicator 12: | Percentage of the eligible population immunised against seasonal influenza |
| Baseline: | 65.7% as at 30 June 2012 |
| Target: | >75% by 30th June 2014 |
| Current Actions: | 1. Māori Provider collaboration with the PHO in the delivery of outreach clinics for 65+ Seasonal Influenza<br>2. Immunisation Advisory Group prioritises Māori Immunisation |

## Action Plan:

| Outcome: | Reduced communicable disease | | |
|---|---|---|---|
| To help achieve this outcome we will: | Increasing the proportion of eligible Māori who have received the seasonal influenza vaccine | | |
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| Provide Outreach clinics in a community setting targeting 65+ seasonal influenza vaccinations | Three outreach community clinics held targeting Māori before June 2014. | 30 June 2014 | WCDHB Māori Health<br>WC PHO<br>Rata Te Awhina Trust |
| Ensure 65+ Seasonal influenza is included in Māori provider contracts | Data provided quarterly in Māori Provider contract | Quarterly reports<br>30 June 2014 | WCDHB Māori Health<br>Rata Te Awhina Trust |



# SECTION 3 - LOCAL INDICATORS

| Health Issue: | Oral health |
|---|---|
| Indicator 13: | Pre-school dental enrolment rates<br>5-year-old Māori caries-free |
| Baseline: | 52% enrolled as at 2011 (calendar year)<br>47% caries-free as at 2011 (calendar) |
| Target: | 77% enrolled<br>61% caries-free |
| Current Actions: | 1. Barriers to care survey being developed<br>2. Working with pre-school and Te Kohanga Reo to provide education<br>3. Reviewing information and resources |

## Action Plan:

| Outcome: | Improved oral health among children | | |
|---|---|---|---|
| To help achieve this outcome we will: | Focus on increasing preschool dental clinic enrolment rates | | |
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| A review on the way all dental services are offered to Māori children and whānau<br>Implement ;barriers to care' survey<br>Based on the survey results develop a plan for change | Results of survey indicates:<br>- issues with enrolment or attendance<br>- opportunities for improvement<br>Plan for change is developed and implementation commenced | Survey completed by January 2014 and changes implemented by June 30 2014 | WCDHB Māori Health<br>WCDHB Dental Services |
| Provide education and information to Māori Provider staff<br>Oral health data included in Māori Provider contracts | 100% of Māori provider staff are trained in lift the lip and provided with appropriate resources<br>85% of Māori Provider Tamariki are enrolled in the dental service | Training and resources delivered by August 2013<br>Quarterly reports provided | WCDHB Māori Health<br>WCDHB Dental services<br>Rata Te Awhina Trust |
| Work with the Māori Provider on ways to introduce the level one mobile screening unit in primary care settings | Number of Mobile screening services delivered in Māori settings | Dec 2013<br>June 30 2014 | WCDHB Māori Health<br>WCDHB Dental services<br>Rata Te Awhina Trust |
| Work with Public Health Nurses to ensure Māori whānau are being provided with oral health information and education | Number of Māori whānau visited by the Public Health Nurses and provided with oral health information and education | Numbers of whānau reported on quarterly | WCDHB Community services |

| Health Issue: | Access to services |
| --- | --- |
| Indicator 14: | Reduction in hospital readmission rates for Māori |
| Baseline: | Ethnicity Baselines to be established in 2013/14[7] |
| Target: | Ethnicity Baselines to be established in 2013/14 |
| Current Actions: | 1. Long Term Conditions programme<br>2. Māori Provider Whānau Ora contract includes deliverables around LTC |

## Action Plan:

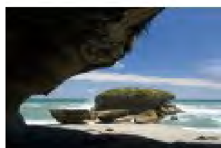
| Outcome:<br><br>To help achieve this outcome we will: | A reduction in the number of Māori readmitted to hospital<br><br>Focus on discharge planning and rehabilitation processes for Māori<br>Focus on reducing inequalities in readmission rates | | |
| --- | --- | --- | --- |
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| Work with the WCDHB discharge planning team to develop appropriate discharge pathways for Māori<br>Process developed for post discharge care working with the Māori Provider | A pathway is developed for Māori discharges from hospital and embedded in discharge planning services<br>Māori Provider Kaimahi are included in the discharge planning process where appropriate<br>Number of inpatients referred to the Māori Provider for post discharge care | Planning complete by Dec 2013<br>Embedded into services by June 30 2014 | WCDHB Māori Health<br>WCDHB discharge planning<br>WCDHB Social work dept<br>Rata Te Awhina Trust |
| Comprehensive support services for Māori discharged from the hospital | Participation by Māori Provider services in discharge planning and post discharge support<br>A reduction in readmissions to hospital | June 30 2014 | WCDHB Māori Health<br>WCDHB discharge planning<br>WCDHB Social work dept<br>Rata Te Awhina Trust |

[7] *A new national definition is currently under development and we intend to use to measure and monitor performance once the data and definitions have been confirmed.*

| **Health Issue:** | **Disease prevention**<br>by improving nutrition, increasing physical activity and reducing obesity |
|---|---|
| **Indicator 15:** | - Number of Māori participating in Te Whare Oranga Pai<br>- Number of Māori Participating in Green Prescription<br>- Number of Māori participating in Appetite for Life |
| **Baseline:** | Ethnicity Baselines to be established in 2013/14 |
| **Target:** | Increase number of Māori engaged in nutrition and physical activity programmes |
| **Current Actions:** | 1. Te Whare Oranga Pai<br>2. Green Prescription<br>3. Appetite for Life |

## Action Plan:

| **Outcome:** | Reduction in the onset of chronic illness | | |
|---|---|---|---|
| **To help achieve this outcome we will:** | Focus on supporting iwi Māori to lead healthier lifestyles | | |
| **Activity/Action** | **Evidence** | **Timeframe** | **Responsibility** |
| Actively engage primary care practitioners in obesity prevention and referral to services that support improved nutrition and increased physical activity | Number of referrals to nutrition and physical activity programmes from primary care practitioners reporting by ethnicity:<br>- Green prescription<br>- Te Whare Oranga Pai<br>- Appetite for Life<br>- WCDHB dietician | Dec 2013 | Healthy West Coast<br>WCDHB Māori Health<br>WC PHO<br>Rata Te Awhina Trust |
| Support the sustained growth of the Te Whare Oranga Pai initiative by developing pathways for clinical and professional support | - Stakeholder relationships created<br>- Referral pathways developed | Dec 2013 | Healthy West Coast<br>WCDHB Māori Health<br>WC PHO<br>Rata Te Awhina Trust |



# SECTION 4 – DELIVERING WHĀNAU ORA

| Objective | Activity/Actions | Evidence |
|---|---|---|
| Building capacity and capability. | Enhance the capacity and capability of provider collectives through support of the Canterbury DHB funded Māori Development Organisation - He Oranga Pounamu.<br>Continue to support the agreed Māori appointment process across the system (led by He Oranga Pounamu) to enhance the capability of advisory boards and working groups. | Renewal of He Oranga Pounamu service agreement. |
| Supporting the sector to be outcomes focused. | Identify opportunities for the introduction of Integrated Contracts across government agencies to support the implementation of the Whānau Ora models.<br>Provide advice around outcomes based monitoring and evaluation frameworks that have proved successful in alliance work streams. | At least one meeting held with other government funders by Q1. |
| Support the Implementation of the Whānau Ora programmes of action. | Support the Whānau Ora collectives to move into Phase 2 of the national programme and develop Whānau Ora models including advice and expertise in the following areas:<br>- Service planning and the provision of information and trend data for analysis;<br>- Analysis of Census 2013 returns, identifying significant population changes that might influence demand;<br>- Development of organisation infrastructure; and<br>- Support for research and professional development within Whānau Ora collectives. | Complete and distribute Māori and Pacific Health Profiles by Q1<br><br>Analysis of 2013 Census Māori and Pacific data, and distribution to Whānau Ora collectives by Q2. |
| Supporting Strategic Change. | Participate in the Whānau Ora Regional Leadership Group.<br>Work with other government agencies at a local and regional level to actively support the implementation of Whānau Ora and improve cross-sector collaboration.<br>Seek opportunities for the WCDHB to become more informed and updated on the national MOH contribution to Whānau Ora and help to share that information across the sector:<br>- Formalise relationships between the Whānau Ora Collectives, DHB and Māori and Pacific Provider Forum.<br>- Engage with Whānau Ora Collectives should there be any high level Māori or Pacific health planning that will result in changes to<br>- Share regular updates on progress received as part of the Whānau Ora Regional Leadership Group.<br>- Support continued engagement with the Māori and Pacific Health Provider Forum to enhance relationships with providers outside of the Whānau Ora Ccollective | Formalisation of relationship between WCDHB and Whānau Ora collectives (include ensuring consistency of regional distribution of information through Te Herenga Hauora and SI General Managers Network) by Q2. |