Māori Health Plan 2013-2014

Mihimihi

E ngā mana, e ngā reo, e ngā kārangarangatanga tāngata

E mihi atu nei ki a koutou

Tēnā koutou, tēnā koutou, tēnā koutou katoa

Ki wā tātou tini mate, kua tangihia, kua mihia kua ēa

Rātou, ki a rātou, haere, haere, haere

Ko tātou ēnei ngā kanohi ora ki a tātou

Ko tēnei te kaupapa, 'Oranga Tika', mo te iti me te rahi

Hei huarahi puta hei hapai tahi mō tātou katoa

Hei oranga mō te katoa

Nō reira tēnā koutou, tēnā koutou, tena koutou katoa

To the authority, and the voices, of all people within the communities

We send greetings to you all

We acknowledge the spirituality and wisdom of those who have crossed beyond the veil

We farewell them

We of today who continue the aspirations of yesterday to ensure a healthy tomorrow, Greetings

This is the Plan

Embarking on a journey through a pathway that requires your support to ensure success for all

Greetings, greetings, greetings

"Kauā e mahue tētahi atu ki waho

Te Tihi Oranga O Ngati Whatua"

Foreword

This plan for Māori health will be the catalyst for driving Māori health gain within our district, and supporting Māori health gain activity across the northern region. It provides Auckland DHB and our local health services with a guide to priority areas for action to achieve demonstrable Māori health gain in twelve months and provides more discipline and accountability for measuring results. One of the key functions of a District Health Board is to reduce the unacceptable disparities in health status by improving the health outcomes of Māori. This means collective action right across the health sector to achieve this, keeping Māori health at the very fore of planning, funding and service delivery activities.

Whānau Ora will be a key platform on which activities to improve health outcomes and reduce health inequities for Māori through quality prevention, assessment and treatment services will be based. The principles that will underpin this work will be;

- Commitment to manawhenua
- Health equity
- Self-determination
- Indigeneity
- Ngā kaupapa tuku iho
- Whole-of-DHB responsibility
- Evidence-based approaches

Orienting the health sector to respond effectively to Māori health needs will require the commitment of the wider health workforce, and advanced competencies for health practitioners. Such an approach will also contribute positively to opportunities of potential that a Māori-led health focus brings. It will also inherently require a shift in thinking and practice.

By 2020 we want to see Māori in our region living longer, enjoying a better quality of life with fewer avoidable problems and hospitalisations. We want to see a system that is responsive, integrated, well resourced, and sustainable so that gains we make today can be used and built upon by future generations. These ambitions are certainly achievable and will be one of the key ways in which our success as a District Health Board and as health professionals will be measured in years to come.

Auckland District Health Board has a key Māori Memorandum of Understanding (MoU) partner, Te Runanga o Ngāti Whātua. Te Runanga o Ngāti Whātua have endorsed the content of the Auckland District Māori Health Plan and will be key to partnering the District Health Board to engage key stakeholders for increased Māori health gain.

Primary health care organisations also have a critical role to play in achieving Māori health gain. Auckland PHO, Alliance Health PHO, ProCare PHO, The National Hauora Coalition PHO, have provided formal letters of endorsement of this plan.

Contents

Introduction

In response to and in support of the collaborative environment that the Auckland and Waitemata DHB's are working in, the Māori health plan for 2013-14 is developed to reflect that partnership. This built on work that began in 2011 with the development of a *Joint Māori Health Action Plan* (Auckland and Waitemata DHB 2011) which synthesised activities across both DHB's to achieve Māori health gains. This has been undertaken and enabled via the establishment of a new joint Māori health team for planning and funding across Auckland and Waitemata DHB's.

We have developed the Māori health plans for both DHB's collaboratively. This has allowed us to synthesise Māori health gain activities where possible, whilst highlighting instances where the two DHBs have differed in approach, focus, starting point, or data. As a result, the two Māori health plans contain identical activities for the majority of the priority areas. As well, the local priorities are aligned.

The purpose of the Māori health plans is to document the DHB's direction for improving health outcomes and reducing inequities for Māori residents, and those who chose to access health services, within both regions. In addition to the Māori health plans, the Auckland and Waitemata DHB's annual plans for 2013/14 contain activities to address inequities and health gain for Māori. Increased collaboration between Auckland and Waitemata DHB's has also occurred at the planning and funding level and a closer alignment of annual plans (priorities and activities) is a result of this. Strategies to improve the health of Māori are woven throughout the annual plans, which our Māori health plans align to.

Within the northern DHB region (made up of Northland, Waitemata, Auckland and Counties Manukau DHB's), the Northern Region Health Plan also contains actions for Māori health gain. In particular, the regional strategy focuses on enablers like workforce development that are crucial for achieving and maintaining any gains made.

Both DHB's remain committed to Māori health, and all of these strategic documents should be read in conjunction to gain a good understanding of what each DHB is doing to meet this commitment.

Te Tiriti o Waitangi

Auckland District Health Boards recognise and respect the Te Tiriti o Waitangi as the founding document of New Zealand. Te Tiriti o Waitangi encapsulates the fundamental relationship between the Crown and Iwi. It provides a framework for Māori development, health and wellbeing. The New Zealand Public Health and Disability Act 2000 requires DHBs to establish and maintain processes to enable Māori to participate in, and contribute towards, strategies to improve Māori health outcomes.

Te Tiriti o Waitangi serves as a conceptual and consistent framework for Māori health gain across the health sector and the articles of Te Tiriti provide four domains under which Māori health priorities for the Auckland DHB can be established. The framework recognises that all activities have an obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

- Article 1 – Kawanatanga (governance) is equated to health systems performance. That is, measures that provide some gauge of the DHB's provision of structures and systems that are necessary to facilitate Māori health gain and reduce inequities. It provides for active partnerships with manawhenua at a governance level.

- Article 2 – Tino Rangatiratanga (self-determination) is in this context concerned with opportunities for Māori leadership, engagement, and participation in relation to DHB's activities.

- Article 3 – Oritetanga (equity) is concerned with achieving health equity, and therefore with priorities that can be directly linked to reducing systematic inequities in determinants of health, health outcomes and health service utilisation.

- Article 4 – Te Ritenga (right to beliefs and values) guarantees Māori the right to practice their own spiritual beliefs, rites and tikanga in any context they wish to do so. Therefore, the DHB has a Tiriti obligation to honour the beliefs, values and aspirations of Māori patients, staff and communities across all activities.

Guiding Principles

It is proposed that the following nine principles underpin the Auckland DHB work streams and approaches and provides practical direction for the identification of Māori health priority areas and associated activities and indicators.

Health partnership with manawhenua

This principle is reflected in the Memoranda between Auckland DHB and Te Rūnanga o Ngāti Whatua, which outlines the partnership approach to working together at both governance and operational levels. These MOU arrangements establish a treaty based health partnership enabling joint collaboration between the Crown and Ngati Whatua in key areas such as funding and planning. To this extent the relationship is designed to ensure the provision of effective health and disability services for Māori resident within the Ngati Whatua tribal rohe (area).

Commitment to Māori communities

The commitment to Māori communities is given expression through manaaki tangata obligations which are central in the provision of manawhenua responsibilities being delivered in conjunction with the kawanatanga obligations of Auckland DHB. Commitment to Māori communities therefore demonstrated through their engagement and input into decisions affecting the health and independence of Māori communities.

Whānau ora

Whānau ora, in the context of this plan, is concerned with an intra- and inter-sectoral strength-based approach to supporting whānau to achieve their maximum potential in terms of health and wellbeing during their interaction with health services. The approach is whānau-centred and involves providing support to strengthen whānau capacities to undertake functions that are necessary for healthy living and contributing to the wellbeing of whānau members and the whānau collective.

Health equity

As a principle, health equity is concerned with eliminating avoidable, unfair and unjust systematic disparities in health between Māori and non-Māori. The concept of health equity acknowledges that different types and levels of resources may be required in order for equitable health outcomes to be achieved for different groups. Improving Māori access to health services will be a key contribution towards achieving health equity.

Self-determination

This principle is concerned with the right of Māori patients/individuals and collectives to be informed and exert control over their health. This is consistent with full involvement in health care decision-making, increased capacity for self-management, higher levels of autonomy and reduced dependence.

Indigeneity

Indigeneity is concerned with the status and rights of Māori as indigenous peoples. The value placed on Indigeneity should be reflected in health policies and programmes that support the retention of Māori identity, the participation of Māori in decision-making, and health development based on the aspirations of Māori.

Ngā kaupapa tuku iho

As a principle, ngā kaupapa tuku iho requires acknowledgment and respect for distinctly Māori values, beliefs, responsibilities, protocols, and knowledge that are relevant to and may guide health service planning, quality programming and service delivery for Māori.

Whole-of-system responsibility

Achieving best health outcomes for whānau and health equity for Māori is a whole-of-system responsibility. Therefore, contributing to Māori health gain and reducing ethnic inequalities in health between Māori and non-Māori is an expectation of all health activities through the whole of the health system.

Evidence-based approaches

The evidence-based approach is a process through which scientific and other evidence is accessed and assessed for its quality, strength and relevance to local Māori. An understanding of the evidence is then used in combination with good judgement, drawing on a Māori development perspective and social justice ethic, to inform decision-making that maximises the effectiveness and efficiency of Māori health policy, purchasing, service delivery and practice.

Auckland Population

Profile and Health Needs

1. Geographic Distribution

- Auckland DHB's population was estimated to be 469,400 in 2013/2014. At the 2006 Census Auckland DHB had a population of 428,310, 7.8% of ADHB's population identified as Māori compared with 14.6% nationally;
- The newly created Auckland "super city " established a ward based system for all of greater Auckland including Auckland City, North Shore City, Rodney District Council, Manukau City, Papakura City and Franklin District Council. The previous District Health Board boundaries now no longer align with the newly created wards of Auckland City.
- A third of the Auckland DHB population resides in Albert-Eden-Mt Roskill area. Auckland DHB's population is ethnically diverse with greater proportions of Asian and Pacific peoples than in New Zealand as a whole, and a smaller proportion of Māori.
- More Māori reside within the Maungakiekie -Tamaki and Albert-Eden-Mt Roskill areas.

2. Health Service Providers

Key health service providers in ADHB include:

- Three public hospitals; Auckland City Starship Children's and Greenlane Clinical Centre.
- Two PHO's (which had enrolled 79% of the eligible Māori population and 93% of the non- Māori in 2012/13 Q2);
- Contract with 5 Māori providers totalling $3.5 million
- Multiple local and national non-profit and private health and social providers.

3. Age Distribution of the Māori Population

- It is predicted that in 2013-14, ADHB's over-65 population will be approx 11% of the total population, Māori over-65 will be less than half at 4.9%. Other age categories remain similar to the rest of the country;
- The ADHB Māori population is skewed towards younger age groups with higher proportions in the 0-14, 15-24 and 25-44 age groups, but fewer older adults and elderly:

Table 2: Age distribution of the ADHB population predicted 2013-14

Age Group	**0-14**	**15-24**	**25-44**	**45-64**	**65+**
Māori (%)	29.0	17.3	29.9	18.9	4.9
Non-Māori (%)	16.1	14.9	35.1	23.2	10.9

4. Population Growth Projections

From 2006 to 2026 ADHB's Māori population will grow but at a lesser rate (16%) than non Māori (30.7%), and the national Māori population (29.9%).

5. Deprivation Distribution

Auckland DHB's population is spread reasonably evenly across the NZDep categories, there is however distinct difference between Māori and Non-Māori. Non Māori are represented evenly across all deciles, Māori representation increases with each deprivation decile (from least deprived to most deprived). Twice as many Māori (22%) are represented compared to non-Māori (11%) in Decile10.

6. Leading Causes of Mortality and Avoidable Hospitalisation

The leading causes of avoidable mortality by gender are ranked in Table 3 below. Similar issues ranked highly for Māori and European/Other populations locally and nationally. However there were differences between gender with suicide and self-harm in the leading five causes for males.

Table 3: Leading five causes of mortality by gender for those aged 0-74 years, 2007-2009

	Males		Females	
	ADHB	**NZ**	**ADHB**	**NZ**
Māori	Ischaemic Heart Disease	Ischaemic Heart Disease	Lung Cancer	Lung Cancer
	Lung Cancer	Unintentional Injury	Ischaemic Heart Disease	Ischaemic Heart Disease
	Unintentional Injury	Lung Cancer	Diabetes	COPD
	Stroke	Diabetes	COPD	Breast Cancer
	Suicide and self-harm	Suicide and self-harm	Breast Cancer	Unintentional Injury
Non Māori	Ischaemic Heart Disease	Ischaemic Heart Disease	Breast Cancer	Breast Cancer
	Lung Cancer	Unintentional Injury	Lung Cancer	Lung Cancer
	Suicide and self-harm	Lung Cancer	Ischaemic Heart Disease	Ischaemic Heart Disease
	Colorectal Cancer	Colorectal Cancer	Stroke	Colorectal Cancer
	Stroke	Suicide and self-harm	Diabetes	COPD

The leading causes of avoidable hospitalisation are ranked in Table 4 below. Similar issues ranked highly for Māori and European/Other populations locally and nationally, with the exception of ENT infections locally and Dental conditions nationally. However there were differences between gender with Kidney/urinary Infections in the leading five causes for females.

Table 4: Leading five causes of avoidable hospitalisations (excluding preventable injury) by gender for those aged 0-74 years, 2012

	Males		Females	
	ADHB	**NZ**	**ADHB**	**NZ**
Māori	Cellulitis	Respiratory infections	Cellulitis	Respiratory infections
	Respiratory infections	Cellulitis	Respiratory infections	Cellulitis
	COPD	Dental conditions	Asthma	Dental conditions
	Angina and Chest pain	Diabetes	Kidney/urinary Infections	Angina and Chest pain
	ENT infections	Angina and Chest pain	Angina and Chest pain	COPD
Non Māori	Angina and Chest pain	Angina and Chest pain	Respiratory infections	Angina and Chest pain
	Cellulitis	Respiratory infections	Angina and Chest pain	Respiratory infections
	Respiratory infections	Cellulitis	Cellulitis	Cellulitis
	ENT infections	Ischaemic Heart Disease	ENT infections	Kidney/urinary Infections
	Ischaemic Heart Disease	Road-Traffic Accidents	Asthma	Dental conditions

Success to date in ADHB

1. The ADHB and WDHB collaboration for Māori Health Gain has been completed, with a combined team and focus ensuring Māori health continues to be a priority across both DHB's.

2. The eight month immunization target has been met by ADHB. Māori childhood immunisation levels at 24 months continue to be high. In July 2009 Māori (2 year old) immunisations were at 67%, increasing to 91% by July 2012 91%.

3. Performance on the Before School Checks programme, continues to improve significantly with increased coverage of high deprivation populations, which will have positive implications for Māori.

4. Breast screening coverage for Māori has risen from 45% seven years ago to 68.4% (ADHB). Inequalities in this indicator have essentially been eliminated.

5. Smoking cessation advice in hospital is above the target (95%) in ADHB (95.8%).

6. 17 new Māori nursing graduates were employed at ADHB in 2013.

7. Ethnicity data quality improvement activities in primary care and cervical screening are on-going.

8. Investigation of outcomes of coronary artery bypass graft at ADHB has been completed.

9. Continued collaboration with local schools to develop "Health Academies", to increase the Māori workforce growth across clinical disciplines and to feed into the current Rangatahi Workforce Development Programme.

10. Dedicated resources are in place to give effect to the MOU between ADHB and Te Runanga o Ngati Whatua.

11. Development of accountability based balanced score card and regular reporting to Māori Health Gain Advisory Committee.

12. Development of tikanga Strategy completed for ADHB.

National Priority Area Summary

National Health Priority Area		Indicators	Baseline Māori	Non- Māori	Target
Data Quality	**1**	Ethnicity Data Accuracy	No data available.		
Access to Care	**2**	Percentage of Māori enrolled in PHO's	78.7%	92.1%	97-103%
		ASH Rates per 100,000 0-74 Years	201%	85%	171%
		0-4 Years	136%	60%	115%
		45-64 Years	269%	100%	228%
Child Health	**3**	Rates of exclusively breastfed at:			
		6 weeks	60%	75%	62%
		3 months	51%	66%	53%
		6 months	22%	33%	24%
Cardiovascular Disease	**4**	Percentage of eligible Māori who have had their CVD risk assessed within the last five years	53.1%	51.3%	75%
Tertiary cardiac		70% of high risk Acute Coronary Syndrome patients accepted for coronary angiography having it within 3 days of admission (Day of admission=Day 0).	Baseline TBC	Baseline TBC	70%
		95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within one month.	Baseline TBC	Baseline TBC	95%
Cancer	**5**	Breast screening rate.	68.4%	67.1%	70%
		Cervical screening rate.	57.1%	88.3%	80%
Smoking	**6**	Percentage of hospitalized smokers provided with cessation advice	95.8%	96.8%	95%
		Percentage of smokers presenting to primary care provided with cessation advice	36%	35%	90%
Immunisation	**7**	Percentage of infants fully immunised by 8 months of age	A 86%	A 90%	85%
		Percentage of population (<65 Years) who received the seasonal influenza immunisation.	* 64%	61%	70%
Rheumatic Fever	**8**	Number and rate reductions, 10% below 3-year average.	** 3.5		** 3.2

I) Breastfeeding data is from Plunket and does not include Well Child providers, or Māori Well Child Providers.

*Data by Māori ethnicity was unavailable from District Health Board Shared Services (DHBSS), data available pertains to High Needs Population category, which includes Māori, Pacific or NZDep quintile 5 and has been included as a proxy.

**Rheumatic fever rates are total population rates (provided by MoH), but it should be noted that 95% of cases are Māori and Pacific.

Data Quality

Indicator 1):	**Accuracy of Ethnicity Data**
Baseline Māori:	NA
Baseline non- Māori:	NA
Target:	Coverage of all three stages of the ethnicity data audit toolkit.
Current Activity:	Waitemata DHB has co-developed the Audit Toolkit developed by Otago School of Medicine Te Roopu Rangahau Hauora a Eru Pomare Māori Health Research unit in conjunction with the University of Auckland, MoH Māori Health Business Unit and Waitemata PHO.
Planned Activity:	Implement the (MoH) Ethnicity Data Audit Toolkit across PHO enrolled populations.
Rationale for Activity:	The ethnicity data audit tool comprehensively assesses the quality of general practice ethnicity data. It also provides information and guidance regarding actions that can be implemented to improve ethnicity data quality.
Issues:	There is a significant discrepancy between the proportion of the Māori population enrolled with PHO's and the proportion of Māori who stated they were enrolled in the NZ Health Survey. This suggests significant under-counting of Māori in GP and PHO enrolment databases. A comparison of NIR ethnicity data and PHO registers in WDHB found 37.1% discordance/misclassification of Māori ethnicity data (Bramley and Latimer 2007). Improvements in the quality of GP ethnicity data (national priority 1.1) will correct misclassification of Māori as non-Māori in PHO enrolment data.

What are we trying to do? Improve Data Quality responsiveness to reducing health inequalities and improving Māori health outcomes.

To achieve this we will focus on: Improving accuracy of ethnicity reporting in PHO registers.

What are we going to do?	Where do we want to get to?	Timing	Responsibility
RFP Ethnicity Data Audit Toolkit	RFP Submitted.	Q1-Q2	Māori Health Gain Team
Collaborate with PHO's to implement the Primary Care Ethnicity Data Audit in general practices.	Agreement about process and PHO deliverables for practices undertaking audit.	Q1-2	Primary Care Health Service Group
	Implement audit in 50% of practices.	Q2-4	PHOs

Access to health care

Indicator 1):	**Increasing <u>percentage of Māori enrolled in PHO's</u>.**
Baseline Māori:	ADHB 78.7%
Baseline other:	ADHB 92.1%
Target:	97-103%
Rationale for Activity:	Addressing the ethnicity data accuracy as outlined in NP 1.1 is expected to increase the % of Māori enrolled in PHO's. Routine monitoring of ethnicity stated at enrolment and reporting to the board to ensure consistent improvement in PPP measure. Significant and consistent increases in the % of ethnicity not-stated at enrolment will be required to implement quality improvement process to ameliorate regular business.
Issues:	Misclassification of ethnicity on Primary Healthcare Organisation (PHO) registers is a significant problem that affects our ability to address inequalities in health outcomes.

What are we trying to do? Ensure <u>access to health care,</u> to reduce inequalities in health status for Māori and improve Māori health outcomes.

To achieve this we will focus on: <u>Increasing percentage of Māori enrolled in PHO's.</u>

What are we going to do?	Where do we want to get to?	Timing	Responsibility
Implement the (MoH) Ethnicity Data Audit Toolkit (As above NP1.1). Work with PHO's to ensure that the quality of ethnicity data at PHO level is high.	(As above)	Q4	Māori Health Gain Team, PHOs Primary Care Health Service Group, PHO's
PHO Māori health plans to include HP/SIA specific strategies to increase PHO enrolment. Quarterly monitoring of PHO ethnicity enrolment and reported to Māori Health Gain Advisory Committee/Manawa Ora as per PPP.	100% of MHP submitted and approved which address minimum Māori health requirements.	Q1-4	Māori Health Gain Team, ADHB primary care team; PHOs
Conduct analysis to identify the number of people not enrolled and associated demographics including age, domicile. Use this information to develop and implement other strategies to increase Māori enrolment	Appropriate identification and targeting of population sub-groups not currently enrolled.	Q1 Q2-3	

Quarterly monitoring of PHO ethnicity enrolment and reporting to Māori Health Gain Advisory Committee/Manawa Ora as per PPP.	Target for % Māori enrolled in PHO met. 100% of ethnicity stated at enrolment (ppp measure)	Q1-4	Māori Health Gain Team, WDHB primary care team and PHOs
Undertake a project to contact Māori with discordant ethnicities on NHI and PHO enrolment databases to clarify their ethnic affiliations and, where indicated, amend recorded ethnicities.	Reduce misclassification of Māori as non-Māori on PHO enrolment databases leading to more accurate reporting of Māori PHO enrolment.	Q2	Primary Care Health Service Group, PHO's

Indicator 2):	**<u>Reducing Ambulatory Sensitive Hospital</u> admission rates for Māori.**
Baseline Māori: from Q2 2012/13	0-74 years ADHB 201% 0-4 years ADHB 136% 45-64 years ADHB 269%
Baseline non- Māori: from Q2 2012-13	0-74 years 85% ADHB 0-4 years 60% ADHB 45-64 years 100% ADHB
Target:	0-74 years 171% 0-4 years 115% 45-64 years 228%
Rationale for Activity:	A Whānau Ora Centre is under development in the ADHB region. Te Hononga o Tamaki me Hoturoa (THTH) provides a Toitu Child heath programme. The Primary Options Acute Care (POAC) programme continues to be delivered.
Issues:	Not all ASHs can be prevented. Reasons for ASH are complex.

What are we trying to do? <u>Reduce ASH rates in all three age groups.</u>

To achieve this we will focus on: The following conditions are the leading causes of ASHs in the 0-74 year age group: cellulitis, dental conditions, gastroenteritis, asthma, and respiratory infections.

What are we going to do?	Where do we want to get to?	Timing	Responsibility
Support the implementation of a Whānau Ora health centre in ADHB region and monitor its impact on ASHs. Support the Toitu child health	Reduce ASHs in all three age groups.	Q1-4	Māori health gain team,

programme and monitor impact on ASH's. .	Reduce ASHs in 0-4 age group		
Review POAC programme to assess effectiveness for Māori. Identify, if indicated, strategies to improve Māori access to, and outcomes from, POAC programme.	Reduction in ASHs due to increased effectiveness of POAC for Māori. On-going monitoring of POAC to assess impact of any strategies that are implemented.	Q1-4	Māori Health Gain Team, primary care team; PHOs
Understand reasons people are admitted with ASH conditions: using current activity (e.g. re-hospitalisation risk prediction tool work); and collecting information about pre-hospitalisation primary care from those admitted		Q1-4	
In collaboration with DHB primary care team and PHOs identify strategies to reduce ASHs for cellulitis and asthma.	Monitor impact on hospitalisations for cellulitis and asthma.	Q1-4	Māori Health Gain Team, primary care team; PHOs and Māori providers
Investigate possibility of including cellulitis detection and management in school sore throat programmes being implemented as part of rheumatic fever prevention programme.	Reduced cellulitis ASH in children aged 5 – 14 years.	Q1-4	Māori Health Gain Team, rheumatic fever team; school throat swabbing teams
Monitor ASHs for Māori by age and condition. Regular reporting to Manawa Ora (Māori health gain advisory committee).	Regular reporting and feedback of performance to DHB, PHO, and providers		

Cardiovascular Disease

Indicator 1):	**5 year <u>CVD Risk Assessment</u>**
Baseline Māori:	Auckland 53.1%
Baseline non- Māori:	Auckland 51.3%
Target:	90%

Rationale for Activity:	CVD is a major cause of morbidity and mortality for Māori and makes a substantial contribution to the inequalities between Māori and non-Māori in all-cause mortality and life expectancy. Risk assessment is the first step in implementing evidence-based prevention and management of CV disease. Māori specific performance is monitored and reported back to Manawa Ora – Māori health gain advisory committee.
Issues:	The CVD targets in the PPP and the national health plans differ. The PPP has an interim target for July – Dec 2013/14 of 75% and 90% for Jan – June 2014. The national target is 90%. Current ADHB performance for coverage of 5 year CVD risk assessments is low. There is likely to be ethnic misclassification in this indicator with Māori who have been risk assessed being recorded as non-Māori.

What are we trying to do? Reduce Māori morbidity and mortality via improved cardiovascular access and care.

To achieve this we will focus on: increasing the percentage of eligible Māori population who have had their CVD risk assessed within the past 5 years**.**

What are we going to do?	Where do we want to get to?	Timing	Responsibility
Support PHO activities to increase CVD risk assessment.	On target by end of 2013-14 year.	Q4	Primary care. Chief funding and planning officer Marty Rogers Kerry Hiini
Review CVD contracts to include specific targets for Māori.	Strategies used to achieve the target are embedded into contracts and 'business as usual' for the DHB's and PHO's.	Q1	Māori Health Gain team/ Kerry Hiini
Opportunities for outreach CVD risk assessment services to be identified. Business plan for outreach service developed and submitted.	The most effective CVD risk assessment service outreach opportunities identified, resourced and implemented.	Q2	Funding LTC
Investigate feasibility of implementing CVD risk assessment in hospital with feedback to GPs.	Targets are met through a combined approach of business as usual, increased monitoring, effective outreach and	Q3	Māori Health Gain team/ Kerry Hiini, CVD GM and programme

	opportunistic risk assessment.		manager.
Reduce ethnicity data misclassification.	This will occur as a result of the actions outlined in the 'Accuracy of Ethnicity Data' indicator	Q1-4	Primary care and Māori health gain team.

Indicator 2):	**<u>Tertiary Cardiac Interventions</u>** High risk Acute Coronary Syndrome patients accepted for coronary angiography having it within 3 days of admission (Day of admission=Day 0). Patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within one month.
Baseline Māori:	Awaiting information about definition of indicators to allow calculation of current baseline
Baseline non- Māori:	ADHB: 1,205
Target:	70% of high risk Acute Coronary Syndrome patients accepted for coronary angiography having it within 3 days of admission (Day of admission=Day 0). 95% of patients presenting with Acute Coronary Syndrome who undergo coronary angiography have completion of ANZACS QI ACS and Cath/PCI registry data collection within one month.
Current Activity:	This activity currently occurs within ADHB.
Planned Activity:	Once baseline data is obtained and analysed by ethnicity and targeted activity will be indentified and developed if required.
What are we trying to do? Reduce Māori morbidity and mortality through improved access to <u>cardiovascular care</u>.	
To achieve this we will focus on: Monitor and investigate Rate of Tertiary Cardiac Interventions and any ethnic disparities between Māori and others.	

What are we going to do?	**Where do we want to get to?**	**Timing**	**Responsibility**
Monitor indicator performance by ethnic group through regular performance reporting to	Accurate reporting of indicator performance by ethnic group	Q1 - 4	Māori health gain team,
	Identify whether inequality in performance for these indicators by ethnic group.	Q2	ADHB cardiology CVD GM and Programme

Quarterly reporting to Manawa Ora (Māori health gain advisory committee).	No inequalities in performance	Q1 - 4	Manager.
If performance below target work with cardiology services to identify reasons for poor performance and implement strategies to improve performance.	Performance on target or better.	Q1 - 4	Māori health gain team, ADHB cardiology cardiology CVD GM and Programme Manager.
If inequalities in performance identified	Audit and investigation into reasons for inequalities and implement strategies to address.	Q2 - 4	Māori health gain team, ADHB cardiology cardiology CVD GM and Programme Manager.

Cancer

Indicator 1):	**Breast Screening**
Baseline Māori:	Auckland 68.4%
Baseline non- Māori:	Auckland 67.1%
Target:	70% of breast screening coverage for eligible population.
Rationale for Activity:	The data sharing protocol will improve identification of unscreened Māori women, facilitate communication between BreastScreen provider and PHOs and support PHOs/GPs to contact women and discuss participation in breast screening with them. The DHB needs to be assured of the quality of ethnicity data in mammography screening and, if problems are identified, work with providers to improve ethnicity data quality/reduce misclassification.
What are we trying to do? Reduce Māori breast cancer morbidity and mortality.	
To achieve this we will focus on: Improving breast screening coverage rates for Māori women and reducing ethnic disparities in screening rates.	

What are we going to do?	Where do we want to get to?	Timing	Responsibility
Continue to support BSA provider to provide screening service to	Monitoring of screening participation through PPP data	Q1-4	Māori health

eligible women. Continue to monitor performance.	(quarterly).		gain team
Data sharing protocol to be developed and confirmed for data sharing to enhance recruitment and referral between PHO's and BSA.	Enhanced recruitment and referral, to achieve 70% of breast screening coverage for eligible population.	Q1-Q4	BSA/ PHOs
Review the quality of ethnicity data within mammography screening programme.	Agreed data sharing protocol.	Q2	BSA/PHO's
	Data review.	Q3	Megan Tunks/Sue Crengle

Indicator 2):	Cervical screening
Baseline Māori:	Auckland 57.1%
Baseline other:	Auckland 88.3%
Target:	80% of eligible women have received a three yearly cervical screen.
Rationale for Activity:	Cervical cancer is one of the most preventable cancers with regular smear tests. In ADHB ethnicity data misclassification in the NCSP-R has been shown to adversely affect the reporting of Māori women's participation in cervical screening (under-reports). Activities to improve the quality of ethnicity data have been commenced and are on-going. There is some evidence to suggest that funding used to increase access to cervical smears may be benefitting women already engaged with the programme rather than those who are not regularly engaged at the moment.
Issues:	The cervical screening rate for Māori women in Auckland is much lower than for non-Māori women. Misclassification of ethnicity data has been identified as a contributor to the low coverage rate.
What are we trying to do? Reduce Māori cervical cancer morbidity and mortality.	
To achieve this we will focus on: Improving cervical screening coverage rates for Māori women and reducing ethnic disparities in screening rates.	

What are we going to do?	**Where do we want to get to?**	Timing	Responsibility
ADHB Lead -Work with established Auckland Metro Cervical Cancer Coordination service to implement	3 year plan implemented. Measured by Coverage rates,	Q1-2	Megan Tunks

3 year strategic plan, focused on improving Māori screening. Improve the quality of ethnicity and other information recorded on the NCSP – R for Māori women.	Bi-monthly reports to Manawa Ora Comparison with Non Māori Women eligible and enrolled but not participating e.g. 12% of eligible women within Waitemata PHO. PPP data by ethnicity	Q1-Q2	Sue Crengle/Megan Tunks
Develop a consumer co-design quality improvement project to improve the cervical screening pathway for Maori. Project will look at screening pathway, screening eligibility, invitations and recalls for screening participation and provider processes and capacity.	Implement recommendations for optimal cervical screening pathways for Māori, informed by Māori and whanau.	Q1-Q4	Megan Tunks
Continue to support free screening for priority group women.	Discuss with NSU how the use of this funding can be enhanced to ensure that it increases participation by women currently not participating in the programme. PHOs to report priority screening by ethnicity. Review effectiveness of priority screening funding for reaching women who are unscreened or overdue screens.	Q1-4	Marty Rogers/ PHO/Māori health gain team
Continue to address ethnicity data quality issues in cervical screening information. (GPs, PHO's, labs, NSU)	All lab forms from all GPs include ethnicity data information	Q2	Sue Crengle/Marty Rogers/Karen Bartholemew/ PHOs
Extend the activities to improve ethnicity data quality to ADHB. DHB and PHO's to collaborate to correct discordant ethnicity data (women who have different ethnic groups recorded in NCSP-R, PHO and NHI databases)	Discordant ethnicities corrected in practice and PHO databases.	Q2	Māori and planning public health physicians and Māori Team

Smoking

Indicator 1):	Current smokers enrolled in a PHO and provided with advice and help to quit.
Baseline Māori:	Auckland 36%
Baseline Total:	Auckland 35%
Target:	90% of identified current smokers enrolled with a PHO and provided with advice and help to quit.
Rationale for Activity:	A substantial proportion of the Māori population continues to smoke. Smoking is an important issue among pregnant Māori women. A large proportion of Māori are enrolled with general practices and should receive smoking cessation advice and help to quit when they attend general practices.
Issues:	Further work is required to ascertain the quality of advice and accessibility of help to quit.

What are we trying to do? Reduce cancer morbidity and mortality, and improve respiratory health through reduced smoking rates.

To achieve this we will focus on: Identified current Māori smokers enrolled in a PHO and provided with advice and help to quit.

What are we going to do?	Where do we want to get to?	Timing	Responsibility
Develop a wraparound campaign with maternity services for pregnant Māori mothers to include smoking cessation as a part of holistic health lifestyle programme.	Feasible opportunities to engage with Māori mothers re: smoking cessation and other priorities identified.	Q1	Māori Health Gain Team/Wai Vercoe
PHO Smoke free coordinators will develop smoke free plans with specific activity to decrease Māori smoking rates. Ideally these plans will go beyond the advice to quit and include recording of activity regarding help to quit.	PHO Smoke free plans approved and implemented with specific activity identified which targets Māori.	Q2	Māori Health Gain Team
Work with PHO Smoke Free Coordinators to survey a sample of Māori smokers who have received cessation advice, to establish quality and appropriateness of advice.	Survey results and any resulting recommendations will be addressed in future smoke free plans.	Q3	Māori Health Gain Team/Smoke Free Coordinators.
Plans will be monitored and reviewed quarterly and successful strategies highlighted and promoted and key learning's among PHO's.	Quarterly monitoring of smoke free plans.	Q1-4	Māori Health Gain Team

Ensure that new contracts have a requirement for smoke free policy development.	Half yearly reporting on the number of contracted providers with Māori smoke free policies.	Q3	Smoke Free Coordinator/Healthy Lifestyle Programme Manager

Indicator 2):	**<u>Hospitalised Māori</u> smokers provided with advice and help to quit.**
Baseline Māori:	Auckland 96%
Baseline non- Māori:	Auckland 94.95%
Target:	95% of hospitalised Māori smokers provided with advice and help to quit.
Current Activity:	Brief advice is given currently.
Planned Activity:	Further work will look at the quality and impact of advice and linkage to quit support services.
Rationale for Activity:	To support simple referral pathways for Māori who smoke to ensure access to timely support to quit. A broader group of champions is required to support and deliver quit smoking messages.
Issues:	Further work is required to ensure quality advice is given and optimal accessibility to quit help services.

What are we trying to do? Reduce cancer morbidity and mortality, and improve respiratory health through <u>reduced smoking rates</u>.

To achieve this we will focus on: Hospitalised Māori smokers provided with advice and help to quit.

What are we going to do?	Where do we want to get to?	Timing	Responsibility
Provide training to Māori Health Service/He Kamaka Waiora Registered Staff to be smoking cessation leads using the STEPS programme with ongoing support through the ADHB Smokefree Team. Continue with current activity including reporting, monitoring and corrective action programmes each week.	A smoke free lead within He Kamaka Waiora team. Maintain target levels.	Q3	Smokefree Coordinator Māori Services Manager
If maternal smoking indicator is implemented obtain baseline data from booking forms about 1) Number of women smoking by ethnicity	Obtain baseline data. Set target. Work with providers who are not undertaking the activity (or not reporting it) to	Q2 Q4	Māori health gain team/Smoke Free Coodinator/Womens Health GM and Director Child Health.

2) Number of smokers offiered quit advice	improve performance.

Child health

Indicator 1):	**<u>Exclusive and fully breastfeeding rates</u>** (combined)
Baseline Māori:	Auckland 6 weeks 60%, 3 months 51%, 6 months 22%
Baseline non-Māori:	Auckland 6 weeks 75%, 3 months 66%, 6 months 33%
Target:	Exclusive breast feeding at 6 weeks 62%, 3 months 57% and 6 months 27% (targets TBC)
Rationale for Activity:	Research shows that children who are exclusively breastfed for the early months are less likely to suffer adverse effects from childhood diseases, less risk of SUDI and long term less likely to get diabetes.
Planned Activity:	A regional maternal nutrition and physical activity RFP was successfully submitted to MoH, by a regional collective, led and supported by ADHB/WDHB. Text messaging support services and face to face workshops which include promotion of breastfeeding messages will be implemented as a part of this regional project (see related activity below).
Issues:	Integration between perinatal, postnatal and well child and primary care providers needs strengthening. Access to community based lactation consultants.

What are we trying to do? Increase the numbers of exclusively/fully breastfed <u>babies at 6 weeks, 3 months and 6 months.</u>

To achieve this we will focus on: Strengthening relationships and creating community based opportunities' for education and support.

What are we going to do?	Where do we want to get to?	Timing	Responsibility
Continue to work with Well Child providers to promote and support increased breast feeding rates.			
Analysis of breast feeding rates by ethnicity on discharge for hospital antenatal bookings.	Inequalities in breasfeeding rates on hospital discharge to be examined and addressed.	Q2	Megan Tunks/Wai Vercoe
Analysis of hospital based lactation consultant utilisation by ethnicity.	Appropriate Māori uptake of hospital-based lactation consultant services.	Q3	Megan Tunks/Wai Vercoe
Establish text messaging support		Q2	Megan

service, in partnership with Auckland University to establish a Text messaging support service to promote breastfeeding and other healthy lifestyle related messages.	Increased access and targeted support service options for breast feeding support for pregnant Māori mothers.	Q1-Q4	Tunks/Wai Vercoe Megan Tunks/Wai Vercoe
Work with regional 'collective' to engage pregnant Māori women in; text messaging support service to promote breastfeeding and face to face workshops. Engage Māori women in the testing and development of key messages for text support service. Monitor and analyse Māori uptake of text messaging service to promote maternal health (including breastfeeding) and face to face workshops by Māori.	Māori specific and appropriate messaging within text support programme for pregnant women. Equitable uptake of new maternal nutrition and physical activity service options to support increased breastfeeding coverage for Māori.	Q2 Q4	Megan Tunks/Wai Vercoe Megan Tunks/Wai Vercoe

Immunisation

Indicator 1):	**Percentage of <u>8 month olds fully immunised</u> at 8 months.**
Baseline Māori:	Auckland 86%
Baseline non- Māori:	Auckland 90%
Target:	90% of 8 month olds fully immunised at 8 months.
Rationale for Activity:	The planned activity for 2013-2014 will be continued from 2012-2013 as the process has shown the ability to eliminate disparities in immunisation rates.
Issues:	Immunisation can prevent a number of diseases and is a very cost-effective health intervention. It provides not only individual protection, but for some diseases also population-wide protection by reducing the incidence of diseases and preventing them from spreading to vulnerable people. The timeliness is the focus of the 8 month immunisation at 8 months. Coverage based on a 3 month average 23/03/13 has identified 3 key points in: ADHB • Sustained progress against 8 month target – Māori rates are low 79% • 24 month improving - NZE 92%

	A recent and new OIS contract for service to cover both Auckland and Waitemata DHBs has been awarded to Healthwest NGO located in West Auckland. The transition to cover both DHB districts will be realised over the coming months and will be monitored closely. A PHO assessment is currently underway to identify and determine GP fee for service and bulk funding systems. Misclassification and the translation of systems to record appropriate ethnicity data collection is being investigated. NIR status reports continue to be an ongoing issue.

What are we trying to do? Improve child health by improving immunisation coverage.

To achieve this we will focus on: Increased the percentage of pēpi Māori fully immunized at 8 months.

What are we going to do?	Where do we want to get to?	Timing	Responsibility
Monthly analysis of the 10 practices with majority high needs populations and/or those struggling to meet targets (within each PHO), for immunisation coverage are collated, and includes poorest coverage by ethnicity. Those practices are identified and the immunisation quality team provides support to increase the immunisation coverage and implement strategies for improved coverage among Māori. Continue with current programme of activity as this target is on track and achieved.	Quality improvement initiatives implemented across all practices to reduce the need for the monthly quarterly monitoring and reach all immunisation targets. This approach was the approach developed and utilised which enabled WDHB (as one of the largest DHB populations) to reach the 24 month old immunisation target).	Monthly	Immunisation Programme Manager/ Māori Health Gain Team/ Wai Vercoe

Indicator 2):	**Seasonal Influenza immunisation rates in the eligible population 65+**
Baseline Māori:	Auckland 64%*
Baseline non- Māori:	Data Not Yet Available

Target:	70% immunisation rate for the eligible population 65+
Current Activity:	This is currently part of the PPP programme.
Planned Activity:	Regular business via PPP in addition to community based initiatives
Rationale for Activity:	The numbers of older Māori in this group are as low as 3 to 5% of the population. Targeting this group via established networks may be an effective and cost efficient strategy to increase rates of immunization for this group.
Issues:	The complications of influenza in older people can be serious or life threatening.

What are we trying to do? Improve the health of kaumatua.

To achieve this we will focus on: Increase the rates of seasonal influenza among Māori 65+

What are we going to do?	Where do we want to get to?	Timing	Responsibility
Ensure that PHO Māori health plans have specific activity to promote seasonal influenza coverage for Māori 65+.	PHO Māori health plans with approved focus on 65+ Māori immunisations.	Q2	PHO's
Kaumatua strategy to include a range of community based awareness activities.	Community based & driven initiatives for change in behaviour and outcome.	Q3	Māori Health Gain Team/Hone Hurihanganui
Identify eligible patients who have not had 'flu vaccine and offer vaccination	Work with primary care (DHB) and PHO's to develop process for identifying those who are not vaccinated. Develop programme to increase vaccination of these people through PHO's, Māori providers and the development or outreach immunisation for 'flu vaccination'.	Q1-Q4	Māori Health Gain Team HOP/Immunisation Programme Manager

*Data was unavailable from District Health Board Shared Services (DHBSS), * indicates High Needs Population category, which includes Māori, Pacific or NZDep quintile 5 and has been included as a proxy.

Rheumatic Fever

Indicator 1):	Rheumatic fever rate per 100,000
Total Population:	ADHB 3.5:100,000
Total Population:	Māori, non-Māori data is not available. % Rheumatic fever cases pertain to Māori and Pacific poulations.
Target:	ADHB 3.2:100,000
Current Activity:	RF programme being developed and implemented. Six strategies have been identified: systematic throat swabbing in high risk schools, opportunistic throat swabbing, health literacy / education/ awareness, health professional

	engagement, 'no cost for primary care' for target group, and an outreach strategy. Geographic localities have been stratified according to ARF risk and the strategies used will vary depending on the level of risk. All six strategies will be used in high risk areas. Low risk area will receive health professional training and health literacy activities
Planned Activity:	Systematic throat swabbing will be rolled out in 15 schools in high risk areas. Miscoding of RF in hospital discharge data has been identified and a solution will be identified and implemented. Prospective case reviews will be undertaken for all children diagnosed with acute RF. The findings of these reviews will be used to refine the programme. Specific actions to deliver improved performance • Ensure all cases of acute rheumatic fever are notified to the Medical Officer of Health within 7 days of hospital admission by June 2014 • Develop a rheumatic fever prevention plan by 20 October 2013 and implement as agreed with the Ministry of Health • A sore throat swabbing is implemented in 16 schools within the Auckland district by 30 June 2014 • 95% of GP practices are following the National Heart Foundation Sore Throat Management Guidelines by 30 June 2014 • A process is in place by 30 June 2014 that ensures people identified through the sore throat swabbing programme with Group A Streptococcal infections receive appropriate treatment within 7 days of being symptomatic • A process is in place by 30 June 2014 to ensure that all people with a history of rheumatic fever receive monthly antibiotics no more than 5 days after the due date How will we know we've achieved it? Measured by • Achieve a 10% reduction on the Auckland DHB current rate of 3.5:100,000 to 3.2 per 100,000 population • 95% of GP practices are following the National Heart Foundation Sore Throat Management Guidelines by 30 June 2014 • All new cases of acute rheumatic fever are subject to a 'significant event' review Quarter 1 reports will be submitted by ADHB to: 1. Identify geographic localities for the delivery of throat swabbing programmes according to ARF risk.

	2. Provide quantitative uptake data from school roll out. 3. Provide qualitative data on collaborative approach taken with local Māori and Pacific providers, PHOs and GP practice done
Rationale for Activity:	RF is a 'better public service' target. Systematic school based throat swabbing is not cost effective in moderate and low risk areas.
Issues:	In order to reduce rheumatic fever rates in Auckland, a collaborative response from health (primary and secondary care), housing, education, the Ministry of Social Development and the Auckland City Council is required.

What are we trying to do? Achieve a reduction in incidence of acute rheumatic fever.

To achieve this we will focus on: Achieve a 10% reduction on the ADHB current rate 3.5:100,000 to 3.2 per 100,000 population.

What are we going to do?	Where do we want to get to?	Timing	Responsibility
ADHB plan developed and implemented Support the implementation of the ARF programme.	Māori involvement in all aspects of development and delivery.	Q2 (20/10/13) Q1-4	ADHB staff Wai Vercoe/Sue Crengle
Support the capacity of Māori providers to participate in the delivery of the programme. Develop appropriate process to ensure coverage by Māori providers of outreach services.	Māori providers are a key link in the implementation and success of the programme.	Q1-4	Wai Vercoe

Access to outpatient services

Indicator 1):	**Outpatient processes** (Qualitative).
Baseline Māori:	NA
Baseline non- Māori:	NA
Target:	NA
Rationale for Activity:	Understanding of the options available for setting and or rebooking of appointments is low amongst Māori whānau. Hospital services are not always responsive to the reality of Māori whānau

	when setting appointments. The cost to hospital services and Māori whānau is high because of the Did Not Attend rates.
Issues:	Lack of active participation by Māori whānau in outpatient clinic appointment processes. Limited engagement by existing clinic appointment processes with Māori whānau.

What are we trying to do? Ensure optimal access to outpatient services for Māori.

To achieve this we will focus on: Existing booking and scheduling processes.

What are we going to do?	Where do we want to get to?	Timing	Responsibility
Raise health literacy of whānau to ensure aware of options for booking and attending outpatient clinics.	Appropriate participation in use of outpatient bookings options by Māori whānau.	Q4	Māori Health Gain Team/John Paterson
Support hospital based services develop appropriate responses to Māori patients when setting recall appointments.	Any required booking system changes implemented.	Q1-Q4	Ambulatory Services
Dedicate a resource to address the DNA rate for the following outpatient services at Waitemata and ADHB's within remit of: • Cancer Hematology - Auckland • Paediatric Surgery - Auckland	Increased uptake of outpatient appointments in the diabetes clinics and paediatric clinics.	Q4	General Managers and Clinical Heads of Department for General Medicine and Child, Women and Family Services, Māori Health
Evaluation of current intervention model to identify and implement strategies to roll out across other clinics.	DNA model evaluated, effective interventions inform future planning.	Q4	Māori Health Gain Team/John Paterson

Improve the health of older Māori

Indicator 1):	**Māori Health of Older People Strategy (Qualitative).**
Baseline Māori:	NA
Baseline non- Māori:	NA
Target:	NA
Rationale for Activity:	Currently Māori make up only 4% of the aged population in Auckland and Waitemata DHB areas, however with the changing demographics the size

	of this population group will increase. The excess burden of disease experienced by the Māori population requires careful planning and service development it is timely therefore that the DHB's develop an overarching strategy to inform service modeling for the future.
Issues:	The Māori population, as well as the overall population, is aging. Therefore an increased emphasis on this population is required in order to prepare for increased strain and expectations on kaumatua.

What are we trying to do? Increase the quality and quantity of life for Kaumatua.

To achieve this we will focus on: Development of a strategy across the continuum of healthcare to inform DHB planning, funding and service delivery activities.

What are we going to do?	Where do we want to get to?	Timing	Responsibility
Develop Kaumatua Strategy for Waitemata and Auckland DHB. Strategy will include a focus on: Dementia care pathway, Influenza immunization, Diabetes & CVD risk assessment & management, Palliative care, NASC, Whānau Ora, and HBSS.	Kaumatua strategy approved. Business cases for alternative delivery models developed and approved.	Q2 Q1 & Q4	Māori Health Gain Team/Hone Hurihanganui
Pilot the IMAP tool at two older adult services with the highest Māori utilization/readmission rates in Primary and secondary care settings.	Pilot report and recommendations.	Q4	Manager MHG, HSG OP, HSG Primary Care
Evaluate the effectiveness of the IMAP	Evaluation report	Q4	Manager MHG

Whānau Ora

Indicator 1):	**ADHB contribution to "Whānau Ora"**
Baseline Māori:	NA
Baseline non- Māori:	NA
Target:	NA
Rationale for Activity:	Whānau Ora provides the catalyst for improving the capability of health providers and hospital-based services to deliver high quality, integrated and responsive services to whānau and the communities they live in. We will work closely with the whānau ora collectives to support the implementation of their priorities. This activity is listed in detail within the

	annual plans for Auckland DHB and Waitemata DHB. In addition to our work with the whānau ora collectives, we will also work with our MoU partners, Māori health providers and service units within the DHB's to achieve and support the aspirations of whānau ora.
Issues:	A key issue for both Auckland DHB and Waitemata DHB is an understanding of whānau ora, the outcomes being sought, the approaches to be used and the processes for change. There is currently a wide variation in responses to whānau ora. From a whānau ora perspective, this is ok however it has hindered planning efforts in the development of whānau ora centres and networks.

What are we trying to do? Implement a whānau ora system

To achieve this we will focus on: coherent approach to whānau ora within ADHB and WDHB.

What are we going to do?	Where do we want to get to?	Timing	Responsibility
Planning and Funding Develop a "whānau ora" approach to inform planning and funding activities.	Tool completed and approved by Auckland DHB and Waitemata DHB	Q1	TRONW, Manager Māori Health Gain/Shayne Wijohn
Develop an outcomes framework to support clarity of actions and gain in each area.	Outcomes framework developed and in place. Contracts integrated among Māori health providers	Q2 Q1 & Q2	
Develop a map of Auckland / Waitemata – where Māori live and what providers (Māori and non-Māori) deliver services to them	Clear knowledge of Māori providers capacity, reach and populations served.	Q1	
Community Based Support the development of whānau ora centres in Auckland and Waitemata DHB districts	Develop plan for location of whānau ora centres Raise one business case at ADHB and submit to Board Develop second business case at WDHB	Q1	

Glossary

ADHB	Auckland District Health Board
AOD	Alcohol Other Drugs
ASH	Ambulatory Sensitive Hospitalisations
BSA	Breast Screen Aotearoa
COPD	Chronic Obstructive Pulmonary Disorder
CVD	Cardiovascular disease
DNA	Did Not Attend
DSME	Diabetes Self Management & Education
EBI	Effective Brief Intervention
He Kamaka Waiora	Māori Health Provider and Planning Arm, WDHB and ADHB
HOP	Health of Older People
HP	Health Promotion
HSG	Health Service Group
HSG Op	Health Service Group Operations
IMAC	Immunisation Advisory Centre
Kaumatua	Elders (both male and female)
Kaupapa	Strategy/Theme
Kawanatanga	Government
LTC/SME	Long Term Conditions/Self Management Education
MHG	Māori Health Gain (Manager)
MHGAC	Māori Health Gain Advisory Committee
Manawhenua	Iwi of the region with Trusteeship of Land
MHP	Māori Health Plan
MoH	Ministry of Health

MOU	Memorandum of Understanding
NCSP	National Cervical Screening Programme
NDSA	Northern DHB's Support Agency
NIR	National Immunisation Register
PAM	Potentially Avoidable Hospital Admissions
PHO	Primary Healthcare Organisation
POAC	Primary Options Acute Care
PPP	PHO Performance Programme
RFP	Request for Proposal
SIA	Services To Improve Access
Te Hā	Te Hā o Te Oranga – Health Provider arm of Te Runanga o Ngāti Whātua
Te Tiriti o Waitangi	Treaty of Waitangi
Tikanga	Correct procedure, custom, habit, lore, method, manner, rule, way, code, meaning, plan, practice, convention.
TRONW	Te Rūnanga O Ngāti Whātua
TWOW	Te Whānau o Waipareira Trust
Whānau	Extended family
Whānau Ora	Families supported to achieve their maximum health and wellbeing

References

Auckland District Health Board. (2012). *Annual Plan 2012 - 2013.* Auckland City: Auckland District Health Board.

Auckland District Health Board. (2011). *Māori health plan 2010-2011*. Auckland: Auckland District Health Board.

Auckland and Waitemata DHBs. (2011). *Joint Māori Health Action Plan*. Auckland City: Auckland and Waitemata District Health Boards.

Auckland and Waitemata DHBs. (2011a). *Community and Public Health Advisory Committee Meeting*. Auckland City: Auckland and Waitemata District Health Boards.

Bramley D, Latimer S. (2007). 'The accuracy of ethnicity data in primary care'. *New Zealand Medical Journal,* 120(1262): U2779.

Loring, Belinda, Ratima, Mihi. (2009). Health Needs Assessment for Māori: Waitemata District Health Board 2009. Auckland: Waitemata District Health Board.

Māori Health Gain Advisory Committee Joint DHB Report, 2012

Ministry of Health. (2010). Ministry of Health's Operational Performance Framework. Wellington: Ministry of Health.

Northland DHB, Waitemata DHB, Auckland DHB, Counties Manukau DHB. (2012). Northern region health plan. Auckland: Northland DHB, Waitemata DHB, Auckland DHB, Counties Manukau DHB.