Māori Health Plan

2011-12

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Abbreviations

ABC	An approach to smoking cessation requiring health staff to **a**sk, give **b**rief advice, and facilitate **c**essation support.
AP	Annual Plan
ARF	Acute rheumatic fever
ASH	Ambulatory sensitive hospitalisation
BFHI	Baby friendly hospital initiative
BOP	Bay of Plenty
BOPDHB	Bay of Plenty District Health Board
CME	Continuing medical education
COPD	Chronic obstructive pulmonary disease
CVD	Cardiovascular disease
CVRA	Cardiovascular risk assessment
DAR	Diabetes annual review
DHB	District Health Board
DMFT	Diseased, missing, or filled teeth
DNA	Did not attend (used in the measurement of outpatient clinic attendance)
EBPHA	Eastern Bay Primary Health Alliance
ENT	Ear, nose, and throat
GM	General manager
HbA1c	Glycosylated haemoglobin
IGT	Impaired glucose tolerance
IHD	Ischaemic heart disease
ISDR	Indirectly standardised discharge rate
MHSG	Māori health steering group
MOH	Ministry of Health
NCHOD	National Centre for Health Outcomes Development
NMO	Nga Mataapuna Oranga (Primary Health Organisation)
NSU	National Screening Unit
NZ	New Zealand
NZHS	New Zealand Health Survey
PHO	Primary Health Organisation
PoPAG	Population Health Advisory Group
RR	Rate ratio
WBOPPHO	Western Bay of Plenty Primary Health Organisation

Overview

The Māori Health Plan describes Bay of Plenty District Health Board's (BOPDHB) Māori health priorities for 2011-2012. The indicators listed in this plan are a subset of many potential options but are linked to the leading causes of mortality and morbidity for Māori. Therefore achieving improvements in the conditions related to these indicators will have a significant impact on improving Māori health in the Bay of Plenty.

These indicators represent areas where BOPDHB can have a direct influence on performance and outcomes by working with stakeholders in the health sector. However, maintaining improvements with these targets requires a population health approach. Sustaining long-term improvement will require BOPDHB to work collaboratively with sectors outside health to address the social determinants which create and maintain inequalities in health outcomes. (1)

Progress toward the targets listed in this plan will be monitored through the Māori Health Steering Group (MHSG). This group will meet regularly to review performance and will be comprised of representatives from key stakeholder groups working on the conditions associated with these indicators. The group is modelled on the monthly health target performance review group which is made up of representatives from BOPDHB, primary health organisations (PHOs), and other key stakeholders.

The action plan listed below each indicator in this document provides a brief summary of selected activities associated with each indicator. Generally these activities align with those described in the BOPDHB Annual Plan (AP). Greater detail on the actions linked with each indicator may be available from the stakeholders associated with the relevant indicator.

The first section of this plan gives a brief summary of demographic, health outcome, and service utilisation information. More detail can be found in the references used in this plan. The methods used to determine local indicators are summarised in Appendix A. The targets and actions described in this plan are aligned with the BOPDHB Annual Plan and the Midland Region Clinical Services Plan. The Māori Health Plan gives a one year subset of actions and aspirational targets related to Māori health; longer term activities (2-5 years) to improve health for Māori and non-Māori are described in the 2011-2012 BOPDHB Annual Plan.

Summary of Indicators

National Priorities		Indicators		Baseline (BOPDHB) Māori	Baseline (BOPDHB) Non-Māori	Target[i]
Data Quality	1	Ethnicity data accuracy		*To be confirmed*		
Access to care	2	Percentage of Māori enrolled in PHOs (1)		93.7%	95.9%	95%
	3	ASH rates per 100,000 (2010 calculations) (2)	0-74 yr	3446	2263	2757
			0-4 yr	8078	6804	6865
			45-64 yr	4421	1822	3758
Maternal health	4	Exclusive breastfeeding (6 mths) (3)		22.9%	35.7%	27%
Cardiovascular disease	5	Percentage of the eligible population who have completed a cardiovascular risk assessment (CVRA) within the past 5 years (4)		58%	72%	90%
	6	Number of tertiary cardiac interventions		*Information only.*		
Diabetes	7	Percentage of diabetics who attended a diabetes annual review (DAR) (5)		67%	75%	75%
	8	Percentage of those with DAR complete and HbA1c <8% (5)		63%	86%	85%
Cancer	9	Breast screening rate (3)		44.7%	64.9%	70%
	10	Cervical screening rate (3)		55.1%	86.4%	80%
Smoking	11	Percentage of hospitalised smokers provided with cessation advice (6)		64.6%	64.6%	95%
	12	Percentage of smokers presenting to primary care provided with cessation advice		*Baseline data unavailable*		90%
Immunisation	13	Percentage of 2 year-olds fully immunised (5)		73%	76%	95%
	14	Percentage of the population (>65 years) who received the seasonal influenza immunisation (3)		63%	69.4%	70%
Workforce	15	Percentage of Māori DHB staff in the following categories: management, clinical, and administrative.		*Information only.*		
Regional Priorities						
Cardiovascular disease	16	Number of tertiary cardiac interventions		*To be confirmed*		
	17	Percentage CVRA completion within the past 5ys (eligible population)		Varies by DHB		90%
Local Priorities						
Respiratory health	18	Asthma hospitalisation rate (0-14 years) (per 100k) (1)		989	371	890
Access to services	19	Did-Not-Attend (DNA) outpatient appointments (% per year) (7)		13.31%	5.11%	10%
Oral health	20	Preschool dental clinic enrolment rates (8)		28%	45%	55%
Cardiovascular disease	21	Proportion of secondary prophylaxis recipients (post-rheumatic fever) who received the appropriate medication within the targeted timeframe		*To be confirmed. Baseline data unavailable.*		

[i] Baseline data sources are cited in the indicators column. Targets are to 30 June 2012 for the BOPDHB Māori population. National targets have been set by the Ministry of Health; local and ASH rate targets have been set by BOPDHB. Baseline rates are for the non-Māori population except where the European population has been stated within the plan.

Section 1 – BOPDHB Māori Population: Profile and Health Needs

1. Geographic Distribution

- BOPDHB had a total population of 194,931 at the 2006 Census (4.8% of New Zealand). (1) 45,561 residents (23%) identified as Māori[ii] compared with 15% nationally;
- BOPDHB comprises five territorial authorities. In 2006 the majority of the total population were based in western areas; over 50% lived in Tauranga City with a tapering population count towards the east;
- Absolute numbers of Māori reflect the total population's pattern, tapering from west to east. However Māori make up a greater *proportion* of each district's population toward the east. (2)

Table 1. Bay of Plenty (BOP) population distribution by territorial authority as at the 2006 Census. (2)

District	Western BOP	Tauranga	Whakatane	Kawerau	Opotiki
Total Pop.	42,075	103,632	33,300	6,921	8,976
Māori (%)	16	16	40	59	54

2. Health Service Providers

Key health service providers in BOPDHB include:

- Two public hospitals; Tauranga (324 beds) and Whakatane (101 beds); (3)
- Three PHOs, which had enrolled 93.7% of the eligible Māori population and 95.9% of the eligible European/Other population in 2006/7 (compared with national levels of 90.9% and 93% respectively). (4) PHO names and enrolment composition are presented in point 8;
- Multiple local and national non-profit or private organisations.

3. Iwi within BOPDHB

Multiple iwi lie within or across BOPDHB's borders including:

- Ngai Te Rangi
- Ngai Tai
- Ngāti Awa
- Ngāti Mākino
- Ngāti Manawa
- Ngāti Pūkenga
- Ngāti Ranginui
- Ngāti Rangitihi
- Ngāti Whakahemo
- Ngāti Whakaue ki Maketū
- Ngāti Whare
- Tapuika
- Te Whānau ā Te Ēhutu
- Te Whānau ā Apanui
- Tūhoe
- Tūwharetoa ki Kawerau
- Waitahā
- Whakatōhea

4. Age Distribution of the Māori Population

- BOPDHB's over-65 population is proportionately larger than the national average (15.9% vs. 12.3%). Other age categories are similar to the rest of the country; (4)
- The BOPDHB Māori population is skewed towards younger age groups with higher proportions in the 0-14 and 15-24 age groups, but fewer older adults and elderly:

Table 2. Age distribution of the BOPDHB population as at the 2006 Census. (4)

Age Group	0-14	15-24	25-44	45-64	65-74	75+
Māori (%)	36	16	26	17	4	1
Non-Māori (%)	18	10	25	28	10	9

5. Population Growth Projections

- From 2006 to 2026 BOPDHB's total population will grow faster than the national average (25.5% vs. 18.1%).The greatest local increase will be in the 65 and older age group which will grow by 84.3% compared with 85.2% nationally; (4)
- Similarly, BOPDHB's Māori population will grow by a greater amount (35.5%) than the local non-Māori/non-Pacific population (21.5%), and the national Māori population (29.9%). (4)

6. Deprivation Distribution

BOPDHB had fewer people in the two least deprived NZDep categories compared with the national average, but had a slightly higher proportion in the three most deprived categories. (4) Deprivation increases toward the east of the DHB where Māori make up more of the population.

7. Leading Causes of Avoidable Mortality and Hospitalisation

The leading causes of avoidable mortality and hospitalisation are ranked below. Similar issues ranked highly for Māori and European/Other populations locally and nationally. (4)

[ii] Based on prioritised ethnicity.

Table 3. Leading causes of avoidable mortality and hospitalisation for BOPDHB 2003-5. (4)

	Avoidable Mortality		Avoidable Hospitalisation	
	BOPDHB	NZ	BOPDHB	NZ
Māori	1 CVD – IHD	CVD – IHD	Respiratory infections	Respiratory infections
	2 Lung cancer	Lung cancer	Cellulitis	Cellulitis
	3 Road traffic injuries	Diabetes	Angina	Angina
	4 Diabetes	COPD	COPD	COPD
	5 COPD	Road traffic injuries	Asthma	Asthma
Euro Other	1 CVD – IHD	CVD – IHD	Respiratory infections	Angina
	2 Lung cancer	Lung cancer	Angina	Respiratory infections
	3 Colorectal cancer	Colorectal cancer	Cellulitis	Cellulitis
	4 Suicide & self harm	Suicide & self harm	Road traffic injuries	Road traffic injuries
	5 Road traffic injuries	Road traffic injuries	Gastroenteritis	ENT infections

8. Health Service Utilisation

8.1 Primary Care – PHO Enrolment

In 2010 the highest number of Māori were enrolled with Eastern Bay Primary Health Alliance (EBPHA) (20,148 people), followed by Western Bay of Plenty PHO (WBOPPHO) (16,391), and finally Ngā Matapuna Oranga PHO (NMO) (7,731 people). (5)

Table 4. Enrolled populations in BOPDHB PHOs as at December 2010. (5)

PHO	EBPHA	WBOPPHO	NMO
Total Enrolees	45,081	142,676	11,409
Māori	20,148	16,391	7,731
Māori (%)	45	11	68

8.2 Secondary Care – Emergency Department Utilisation

The 2006/7 New Zealand Health Survey (NZHS) did not show any difference in Emergency Department presentation rates between Māori and non-Māori (aged 15+ years) at a local or national level. (4)

8.3 Secondary Care – Elective Surgery

Age-standardised rates (per 100,000) for elective surgery discharges over 2005-7 are shown below (with 95% confidence intervals). (4) BOPDHB had a higher rate than the national average. BOPDHB Māori had a higher elective surgery discharge rate than the local European/Other group, and a higher elective surgery discharge rate than Māori and non-Māori nationally.

Table 5. Average age standardised national and BOPDHB elective surgery public hospital discharge rates 2005-7 (95% CI). (4)

	Māori	Euro/Other	Total
BOPDHB	4694.3(4576.2-4814.6)	4137.5(4083.6-4192.0)	4225.1(4176.7-4273.9)
New Zealand	4316.8(4284.4-4349.3)	3567.6(3546.2-3579.2)	3549.8(3528.5-3559.9)

9. Social Determinants of Health

9.1 Home Ownership

A higher proportion of BOPDHB Māori do not own their own home compared with the European/Other group (63.7% vs. 49%). National rates are similar; 66.3% of Māori do not own their own home compared with 48.4% of the European/Other group. (4)

9.2 Education

In 2006 Māori in BOPDHB were less likely to gain Level 2 NCEA (41%) compared with Māori nationally (42%), non-Māori in BOPDHB (60%), and non-Māori nationally (63%). (4)

9.3 Employment

Māori in BOPDHB were almost 2.5 times as likely to be unemployed than the European/Other group at the 2006 census (8.6% vs. 3.6%). The BOPDHB Māori unemployment rate was significantly higher than the national Māori unemployment rate (6.9%). The national European/Other unemployment rate of 3.3% was similar to that in BOPDHB. (4)

9.4 Income

BOPDHB Māori were more likely than the European/Other group to be categorised as low income at the 2006 census (27% vs. 21%). Fewer Māori were classed as low income nationally (24%) whilst the proportion of low income European/Others (21%) was the same. (4)

Section 2 - National Māori Health Priorities

Section 2 summarises BOPDHB's current and planned activities along with targets related to the National Māori Health Priorities. The national priorities and associated indicators are listed below:

National Priorities (9) and Indicators (15)		
Data Quality	1	Ethnicity data accuracy
Access to care	2	Percentage of Māori enrolled in PHOs
	3	Ambulatory sensitive hospitalisation (ASH) rate (0-4y, 45-64, 0-74y)
Maternal health	4	Exclusive breastfeeding at 6 months
Cardiovascular disease	5	Percentage of the eligible Māori population who have completed a cardiovascular risk assessment (CVRA) within the past 5 years
	6	Number of tertiary cardiac interventions
Diabetes	7	Percentage of diabetics who have attended a diabetes annual review (DAR)
	8	Percentage with DAR complete and HbA1c <8%
Cancer	9	Breast screening rate
	10	Cervical screening rate
Smoking	11	Percentage of hospitalised smokers provided with cessation advice
	12	Percentage of PHO smokers provided with cessation advice
Immunisation	13	Percentage of 2 year-olds fully immunised
	14	Percentage of the eligible population who have received the seasonal influenza immunisation
Workforce	15	Percentage of Māori staff in the following categories: • Management • Clinical • Administrative

Health Priority:	Data Quality
Indicator 1:	Accuracy of ethnicity reporting in PHO registers
Baseline:	Baseline levels of PHO ethnicity data accuracy have not been established
Target:	BOPDHB will set targets after assessing PHO enrolment forms
Current Actions:	1. BOPDHB has provided training for PHOs and primary care providers aimed at increasing the accuracy of ethnicity data; 2. BOPDHB has promoted use of the MOH's ethnicity data collection protocol in PHO enrolment forms.

Action Plan:

Population health outcome we desire:	Accurate population health information		
To help achieve this outcome we will focus on:	Increasing the number of PHOs using the Ministry's standardised ethnicity question on enrolment forms		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Advocate for use of the Ministry of Health's ethnicity data collection protocol in PHO enrolment forms.	Use of the standardised ethnicity question on all PHO enrolment forms in the Bay of Plenty.	Ongoing	BOPDHB Planning and Funding
Require use of the Ministry's ethnicity data collection protocol via any new provider contracts.	Add the requirement for use of the Ministry's standardised ethnicity data collection protocol in new provider service contracts which are developed over 2011/12.	Ongoing	BOPDHB Planning and Funding
Work with Te Tumu Whakarae to plan use of the Primary Care Ethnicity Audit Framework when it becomes available.	Planned implementation of the Primary Care Ethnicity Audit Framework in selected areas.	By June 2012	BOPDHB Planning and Funding
Half yearly review of the use of PHO enrolment forms by the Māori Health Steering Group (MHSG).	Support for increased use of the standardised ethnicity question in PHO enrolment forms.	Half yearly	BOPDHB Planning and Funding Māori Health Steering Group

Health Priority:	Access to care
Indicator 2:	Percentage of Māori enrolled in PHOs
Baseline:	93.7% of Bay of Plenty Māori were enrolled with a PHO at the 2006/7 NZHS (2011 enrolment figures will be calculated with Statistics NZ population adjusters during the first quarter 2011-2012)[‡]
Target:	95% Māori PHO enrolment rates by 30 June 2012 (this target may be adjusted once more recent data are obtained)
Current Activities:	1. BOPDHB has attained high PHO enrolment rates for both Māori and non-Māori compared with national figures. BOPDHB is developing a process to enrol newborn babies with a GP to improve immunisation rates.

Action Plan:

Population health outcome we desire:	Increased access to primary care		
To help achieve this outcome we will focus on:	Raising the PHO enrolment rate for Māori		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Update PHO enrolment estimates. Advocate for increased enrolment of Māori where relevant. Work with Te Tumu Whakarae to plan use of the Primary Care Ethnicity Audit Framework.	Up to date estimates of PHO enrolment rates for Māori and non-Māori in BOPDHB using 2011 enrolment data and Statistics New Zealand population estimates. Increased enrolment of Māori. Greater focus on primary care access and accurate collection of ethnicity data. Planned implementation of the Primary Care Ethnicity Audit Framework in selected areas. The framework will be used to highlight under-enrolment or misclassification of ethnicity.	Ongoing Ongoing By June 2012	BOPDHB Planning and Funding BOPDHB Planning and Funding PHOs BOPDHB Planning and Funding
Half yearly review of PHO enrolment figures by the MHSG.	Support for increased focus on increasing Māori enrolment in Bay of Plenty PHOs and/or improved data collection.	Half yearly	BOPDHB Planning and Funding MHSG

[‡] BOPDHB's European/Other enrolment rates were 95.9% at the 2006/7 NZHS. Nationally, 90.9% of Māori and 93% of European/Others were enrolled in a PHO.

Health Priority:	Access to Care
Indicator 3:	Ambulatory sensitive hospitalisation (ASH) rate (0-4y, 45-64y, 0-74y)
Baseline:	Māori indirectly standardised discharge ratios (ISDR) (year ending Sept 2010) were: 138 (0-4yrs), 93 (45-64yrs), 109 (0-74yrs). (6) Age standardised rates[§] in the 0-74 yr age group were **3446.3** and **2263.2** per 100,000 (Māori vs. non-Māori) (Rate ratio(RR)=1.5) Age specific rates in the 0-4yr age group were **8077.5** and **6804.0** per 100,000 (Māori vs. non-Māori) (RR=1.2) Age specific rates in the 45-64yr age group were **4421.3** and **1821.6** per 100,000 (Māori vs. non-Māori) (RR=2.4) (2)
Targets:	ISDR targets (based on MOH guidelines) to 30 June 2012: 120 (0-4yrs), 93 (45-64yrs), 106 (0-74yrs) (6) 0-74 yr age group: **2757** per 100,000 by 30 June 2012 (20% reduction) (Target rate ratio = 1.2) 0-4 yr age group: **6865** per 100,000 by 30 June 2012 (15% reduction) (Target rate ratio = 1) 45-64 yr age group: **3758** per 100,000 by 30 June 2012 (15% reduction) (Target rate ratio = 2.1)
Current Activities:	An enhanced monitoring approach to paediatric ASH indicators is being conducted by Toi Te Ora - Public Health Service.

Action Plan:

Population health outcome we desire:	Improved access to primary care		
To help achieve this outcome we will focus on:	Reducing the ambulatory sensitive hospitalisation (ASH) rate		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Continue to fund services in primary care focused on ASH conditions. Advocate for increased focus on ASH conditions and inequalities through PHO monthly meetings. Facilitate opportunities to learn from DHBs with low ASH rates.	Continued funding for primary care programmes such as intravenous antibiotic treatment of cellulitis. Continued provider funding for community services facilitating improved management of oral health and respiratory conditions. Use the monthly PHO forum to provide baseline rates, identify inequalities and increase attention on Māori ASH rates. Identify service delivery improvements in conjunction with high performing DHBs.	Ongoing Ongoing By March 2012	BOPDHB Planning and Funding PHOs Service providers BOPDHB Planning and Funding PHOs BOPDHB Planning and Funding
Progress will be monitored by the MHSG. ASH reporting will be developed with the MOH.	Half yearly reports of ASH rates.	Half yearly	BOPDHB Planning and Funding MHSG

[§] BOPDHB age standardised & age specific rates are for the year ending September 2010 unadjusted for Māori undercount in BOPDHB data. 2010 BOPDHB population data based on Statistics New Zealand projections. Sources used prioritised ethnicity. Age standardisation based on the 2001 Census New Zealand Māori population.

Health Priority:	Maternal health
Indicator 4:	Percentage of infants exclusively breastfed at 6 months
Baseline:	22.9% at December 2009 (35.7% for non-Māori) (7)
Target:	27% for Māori infants in BOPDHB by 30 June 2012 (target set by the Ministry of Health)
Current Activities:	1. Breastfeeding health promotion activities continue to be delivered through the regional public health unit; 2. Breastfeeding support has been facilitated through lactation consultants, Tamariki Ora providers, and Plunket nurses; 3. Breastfeeding education is provided through antenatal education providers such as midwives.

Action Plan:

Population health outcome we desire:	Improved health among mothers and infants		
To help achieve this outcome we will focus on:	Increasing the number of mothers who have exclusively breastfed to six months		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Continue to provide health promotion activities which support breastfeeding.	Community health promotion initiatives targeted towards Māori mothers.	Ongoing	Toi Te Ora - Public Health Service
Maintain baby friendly hospital initiative (BFHI) accreditation.	Ongoing implementation of best practice principles outlined by BFHI to support breastfeeding in the perinatal period.	Ongoing	Provider Arm
Identify effective interventions at high performing DHBs and disseminate this information to relevant stakeholders.	A summary of the strategies and activities used by high performing DHBs will be shared with relevant stakeholders.	By June 2012	BOPDHB Planning and Funding
Provision of lactation clinic services.	Lactation clinic services will be purchased to deliver postnatal support to mothers.	By June 2012	BOPDHB Planning and Funding
Six-monthly review of breastfeeding rates by the MHSG.	Support for initiatives aimed at increasing 6 month breastfeeding rates among Māori mothers.	Ongoing	BOPDHB Planning and Funding MHSG

Health Issue:	Cardiovascular disease
Indicator 5:	Cardiovascular risk assessment (CVRA) completion within the past 5 years (percentage of the eligible population)
Baseline:	58% at quarter 3 2010/11 (72% for Other) (8)
Target:	90% by 30 June 2012 (for both Māori and non-Māori in BOPDHB)
Current Activities:	1. Monthly CVRA attainment reporting systems have been implemented in parallel with health target reporting; 2. Monthly strategy meetings are held with all PHOs in the Bay of Plenty to review CVRA results and plan improvements; 3. CVRA performance targets have been incorporated into service delivery contracts.

Action Plan:

Population health outcome we desire:	Reduced mortality through improved cardiovascular health		
To help achieve this outcome we will focus on:	Increasing the proportion of cardiovascular risk assessments (CVRA) performed in the eligible population		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Development of an agreed BOP wide CVD management strategic plan.	Strategic Plan outlining: - specific data on breakdown of Māori CVD risk completion; - development of Bay of Plenty wide education to reduce disparities.	Ongoing through 2011/12	PHOs BOPDHB Planning and Funding
Reduction in CVD risk assessment disparities for Māori.	Focus on clinics with the most significant disparities. EBPHA to extend its current CVD risk assessment programme from EBOP PHO practices and extend to whole district and include all risk cohorts.	Ongoing	EBPHA
Progress measurement through quarterly CVRA reporting to the MHSG.	Review of quarterly Māori CVRA rates.	Quarterly	BOPDHB Planning and Funding MHSG

Health Issue:	Cardiovascular disease
Indicator 6:	Number of tertiary cardiac interventions (collection requested for information purposes only)
Baseline:	n/a
Target:	n/a
Current Activities:	1. BOPDHB has been working with other Midland DHBs over 2010/11 to develop a cardiac services plan to improve access to tertiary cardiac care.

Action Plan:

Population health outcome we desire:	Reduced mortality through improved cardiovascular health		
To help achieve this outcome we will focus on:	Monitoring the number of tertiary cardiac interventions for Māori and non-Māori in BOPDHB		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Work with the Ministry of Health to develop a case definition for tertiary cardiac interventions.	A working case definition for tertiary cardiac interventions which encompasses intervention types, readmissions, age, and weighting.	By October 2011	Ministry of Health
Develop data collection systems in association with Information Development services.	Systems and procedures for regular reporting of tertiary cardiac intervention figures will be developed.	By December 2012	BOPDHB Planning and Funding Provider Arm
Measurement of rates of tertiary cardiac interventions for Māori and non-Māori for 2011/12.	An annual result for tertiary cardiac intervention figures complying with the case definition will be produced.	Ongoing	BOPDHB Planning and Funding Provider Arm
Reporting and review of tertiary cardiac intervention results to the MHSG.	Annual report of tertiary cardiac intervention results.	Annual	BOPDHB Planning and Funding MHSG

Health Issue:	Diabetes
Indicator 7:	Percentage of diabetics who have attended a diabetes annual review (DAR)
Baseline:	67% at quarter 2 2010/11 (75% for Other) (9)
Target:	75% by 30 June 2012 (for both Māori and non-Māori in BOPDHB)
Current Activities:	1. Monthly DAR reporting systems have been implemented in parallel with health target reporting; 2. Monthly strategy meetings are held with all PHOs in the Bay of Plenty to review DAR results and plan improvements; 3. Improved diabetic identification systems have been implemented in primary care.

Action Plan:

Population health outcome we desire:	Reduced morbidity and mortality due to diabetes		
To help achieve this outcome we will focus on:	Improved attendance at the annual diabetic review in primary care		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Continue to evaluate service funding initiatives by their impact on inequalities.	New interventions developed to increase DAR rates will also reduce inequalities.	Ongoing through 2011/12	BOPDHB Funding and Planning BOPDHB Funding Management Committee
Advocate with stakeholders for a continued focus on reducing inequalities.	Performance review meetings with stakeholders involved in DAR performance will include an inequalities focus.	Ongoing	BOPDHB Funding and Planning PHOs
Learn from DHBs which have attained high performance whilst also reducing inequalities in the DAR rates.	An educational seminar focused on DAR performance will be provided in conjunction with high performing DHBs.	Ongoing	BOPDHB Māori Health Funding and Planning Other DHBs
Continue to obtain and analyse high quality data which provides accurate diabetes prevalence estimates and DAR rates.	Reliable performance feedback for providers enabling changes to interventions through the year.	Ongoing	BOPDHB Funding and Planning Ministry of Health
Progress measurement through monthly review of Māori DAR rates at PHO meetings. Quarterly reporting to the MHSG.	Quarterly Māori DAR rates.	Quarterly	BOPDHB Planning and Funding MHSG

Health Issue:	Diabetes
Indicator 8:	Percentage of diabetics who have attended the DAR and have HbA1c < 8%
Baseline:	63% at quarter 2 2010/11 (86% for Other) (9)
Target:	85% by 30 June 2012 (for both Māori and non-Māori in BOPDHB)
Current Activities:	1. Monthly HbA1c reporting systems have been implemented in parallel with health target reporting; 2. Monthly strategy meetings are held with all PHOs in the Bay of Plenty to review HbA1c results and plan improvements; 3. Specific diabetes management targets are being incorporated into service provider contracts.

Action Plan:

Population health outcome we desire:	Reduced morbidity and mortality due to diabetes		
To help achieve this outcome we will focus on:	Improved management of those who have attended the DAR		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Ongoing diabetes management. Develop agreed integrated Diabetes Clinical Care Pathways as per the Bay Navigator Project. Ongoing management of funding to ensure targeting towards at risk groups.	Development of Diabetes Care Pathway. Implementation of the Bay Navigator diabetes pathway. Ensure local diabetes team is involved in development, implementation and ongoing management of agreed outcomes. New evidence-based screening options: Link screening to enrolment process; Link screening for diabetes to other health initiatives such as cardiovascular disease (CVD) risk assessments; Annual recall IGT for testing; Use of patient questionnaires.	December 2011 June 2012	Provider Arm/PHOs All PHOs
Progress measurement through monthly review of Māori HbA1c rates at PHO meetings. Quarterly reporting to the MHSG.	Quarterly Māori HbA1c rates.	Quarterly	BOPDHB Planning and Funding MHSG

Health Issue:	Cancer
Indicator 9:	Breast screening rate among the eligible population
Baseline:	44.7% at June 2010 (64.9% for non-Māori) (7)
Target:	70% by 30 June 2012 (NSU national target) (10)
Current Activities:	1. PHOs and clinics are sent breast screening attendance data on a regular basis; 2. The increased number of operations at BOPDHB has led to shorter waiting times for surgical procedures; 3. BOPDHB has achieved shorter waiting times for radiotherapy over the past twelve months.

Action Plan:

Population health outcome we desire:	Reduced cancer mortality and morbidity		
To help achieve this outcome we will focus on:	Improved breast screening rates		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Continue to purchase breast screening services and monitor screening rates by ethnicity.	Ongoing breast screening rate information for Bay of Plenty grouped by ethnicity. Ongoing service delivery from regional providers and local Māori providers.	Ongoing	BOPDHB Planning and Funding
Facilitate opportunities to learn from high performing providers of breast screening services (such as Breast Screen South Ltd).	Identification of best practice models of breast screening service delivery. Identification of improvements to service delivery in Bay of Plenty and the Midland region.	Ongoing	BOPDHB Planning and Funding PHOs Radiology service providers
Continue to monitor waiting times for radiotherapy.	Where waiting time targets are not met analysis by ethnicity will be performed to ensure inequalities are not being created or widened. In parallel we will work to ensure waiting time performance is improved.	Ongoing	BOPDHB Planning and Funding
Progress measurement will be achieved through six monthly review of breast screening results by the MHSG.	Six monthly breast screening rates.	Six monthly	BOPDHB Planning and Funding MHSG

Health Issue:	Cancer
Indicator 10:	Cervical screening rate among the eligible population (three year cycle)
Baseline:	55.1% at June 2010 (86.4% for non-Māori) (7)
Target:	80% by 30 June 2012 (NSU national target) (11)
Current Activities:	1. Performance targets are incorporated into service provider contracts where relevant; 2. Cervical screening is managed regionally by the NSU; BOPDHB provides support for service providers in the area where possible.

Action Plan:

Population health outcome we desire:	Reduced cancer mortality and morbidity		
To help achieve this outcome we will focus on:	Improved cervical screening rates		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Continue to contract cervical screening services for providers focusing on Māori women.	Ongoing support for screening services from specialist providers focussed on increasing rates among Māori in the west and eastern Bay of Plenty.	Ongoing	BOPDHB Planning and Funding Service providers
Work with PHOs to highlight mainstream responsiveness to inequalities in cervical screening rates.	Provide cervical screening rates at monthly meetings with PHOs. Advocate for greater focus on reducing inequalities.	Ongoing	BOPDHB Planning and Funding PHOs
Identify practice models conducive to improved screening rates.	Make contact with representatives from high-performing DHBs. Identify systems improvements which can be implemented at BOPDHB.	By March 2012	BOPDHB Planning and Funding
Work with the MOH to develop information systems which provide regular progress updates on screening rates.	Systems will be developed which facilitate regular reporting of cervical screening rates.	Ongoing	BOPDHB Planning and Funding Ministry of Health
Progress monitoring will be performed by the MHSG.	Half yearly progress reports of screening rates for Māori and non-Māori.	Half yearly	BOPDHB Funding and Planning MHSG

Health Issue:	Smoking
Indicator 11:	Percentage of hospitalised smokers provided with cessation advice
Baseline:	64.6% for quarter 2 2010/11 (64.6% for NZ Europeans in BOPDHB) (6)
Target:	95% by 30 June 2012 (Health Target)
Current Activities:	1. BOPDHB has developed standardised systems for smoking cessation advice during discharge planning for current smokers; 2. Monthly reporting is provided for BOPDHB hospitals by ward and specialty and stratified by ethnicity; 3. A care pathway has been developed at BOPDHB facilitating continued cessation advice in primary care following discharge.

Action Plan:

Population health outcome we desire:	Improved respiratory health		
To help achieve this outcome we will focus on:	Increasing the proportion of hospitalised smokers who are offered cessation advice		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Facilitate systems improvements for patient contact and data collection.	Implementation of an Inreach Patient Smoking Cessation transition service targeting Māori and enabling whānau self-management to quit.	By June 2012	Smokefree Coordinator
Continue to provide and facilitate training for staff in secondary and primary care.	Provide ABC training for nurses, doctors and allied health services staff. Facilitate training in Kaihautu Auahi Kore leadership and peer support roles for ex-smokers.	Ongoing	Smokefree Coordinator
Improved Primary/Secondary Integration.	Ongoing CME sessions to primary clinical staff (GPs and practice nurses) regarding smoking cessation. Increased electronic discharge summary referrals to GP's enabling smoking cessation in primary care.	Ongoing	GP Smokefree Champion
Quarterly reporting and review by the MHSG.	Quarterly Māori cessation advice provision rates.	Quarterly	BOPDHB Funding and Planning MHSG

Health Issue:	Smoking
Indicator 12:	Percentage of smokers seen in primary care and provided with cessation advice
Baseline:	Currently being collected (the first step in this process involved determination of the current level of smoking status coding)
Target:	90% by 30 June 2012
Current Activities:	1. BOPDHB commenced an audit of practice smoking coding rates in January 2011; 2. BOPDHB has incorporated smoking coding and cessation provision targets into new service provider contracts.

Action Plan:

Population health outcome we desire:	Improved respiratory health		
To help achieve this outcome we will focus on:	Increasing the proportion of smokers in primary care who are offered cessation advice		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Perform systems improvements in primary care which enable increases in the quantity and quality of coding information.	Continue to work with PHOs to improve the quality of coding data in general practice patient information management systems.	Ongoing	BOPDHB Planning and Funding PHOs
Facilitate training and support in smoking cessation for primary care.	Facilitate ABC smoking cessation training for doctors, nurses, and allied health staff. Facilitate training for ex-smokers in Kaihautu Auahi Kore leadership-peer support roles. Continue to support a GP champion to provide smoking cessation training for GPs and nurses.	Ongoing	Smokefree Coordinator GP Smokefree Champion
Integrate the requirement for coding improvements and cessation advice provision into service provider contracts.	Primary care contracts to have coding and cessation advice provision targets included where relevant.	Ongoing	BOPDHB Planning and Funding
Progress monitoring will be performed through regular reporting to the MHSG.	Six monthly coding and cessation advice provision rates reported to the MHSG.	Six monthly	BOPDHB Funding and Planning MHSG

Health Issue:	Immunisation
Indicator 13:	Percentage of 2 year-olds fully immunised
Baseline:	73% for quarter 2 2010/11 (76% for BOPDHB total population) (12)
Target:	95% by 30 June 2012
Current Activities:	1. Monthly strategy meetings are held with all PHOs in the Bay of Plenty to review immunisation results and plan improvements; 2. Immunisation education and promotion is being facilitated through midwives and antenatal classes; 3. A GP enrolment initiative has been developed for neonates at BOPDHB hospitals.

Action Plan:

Population health outcome we desire:	Improved children's health		
To help achieve this outcome we will focus on:	Increasing the proportion of Māori children fully immunised by 2 years of age		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Develop and implement improved systems for monitoring and recall of overdue immunisations.	Evaluation of remodelled immunisation service is used to further refine the use of data from the National Immunisation Register (NIR) and GP-based patient management systems. Individualised practice immunisation rates comparing interpractice performance provided to GPs.	October 2011 Monthly from July 2011	BOPDHB Planning and Funding National Immunisation Register PHOs
Increase opportunistic immunisation in a wider range of venues (child assessment unit/paediatric inpatient wards/outpatients/Emergency Departments/hauora clinics/GP clinics).	Staff in different settings are trained to deliver opportunistic vaccinations. Increased numbers of opportunistic immunisations will be delivered in hospital and primary care.	September 2011 Ongoing	BOPDHB Planning and Funding Provider Arm PHOs
Focus on increasing immunisation at age groups earlier than two years of age.	Higher rates at two years through punctual delivery of earlier doses.	Ongoing	PHOs
Progress measurement through monthly review of Māori immunisation rates at PHO meetings. Quarterly reporting to the MHSG.	Quarterly Māori vaccination rates.	Quarterly	BOPDHB Funding and Planning MHSG

Health Issue:	Immunisation
Indicator 14:	Percentage of the eligible population (>65 years) immunised against influenza
Baseline:	62.6% for Jan-June 2010 (69.4% for non-Māori) (7)
Target:	70% for Māori for Jan-June 2012
Current Activities:	1. Seasonal influenza vaccine uptake is promoted through PHOs and clinics.

Action Plan:

Population health outcome we desire:	Reduced communicable disease		
To help achieve this outcome we will focus on:	Increasing the proportion of eligible Māori who have received the seasonal influenza vaccine		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Continue to support workplace and community initiatives to encourage influenza immunisation.	Ongoing support of seasonal influenza vaccination through media promotion, workplace initiatives, and general practice liaison.	Ongoing	BOPDHB – Communications Planning and Funding Provider Arm
Continue to work with primary care providers via PHOs to advocate for seasonal influenza immunisation.	Advocate for increased seasonal influenza vaccination through existing monthly meetings with PHOs.	Ongoing Monthly meetings	BOPDHB Planning and Funding PHOs
Monitor seasonal influenza vaccination rates at selected intervals by ethnicity.	Work with the MOH to gain punctual reporting of seasonal influenza vaccination rates. Facilitate vaccination rate feedback to PHOs and other key stakeholders involved in the vaccination pathway.	Ongoing	BOPDHB Planning and Funding MOH PHOs
Progress monitoring will be performed through regular reporting to the MHSG.	Seasonal influenza vaccination rates reported to the MHSG.	Six monthly	BOPDHB Funding and Planning MHSG

Health Issue:	Workforce
Indicator 15:	Percentage of Māori DHB staff in selected occupation categories (management, clinical, and administrative)
Baseline:	n/a
Target:	n/a
Current Activities:	1. BOPDHB has several educational grants for Māori staff which support graduate and postgraduate training relevant to clinical, administrative, and management roles.

Action Plan:

Population health outcome we desire:	n/a		
To help achieve this outcome we will focus on:	n/a		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Advocate for Māori health workforce development. Advocate use of the Ministry's ethnicity data collection protocol in BOPDHB staff information forms. Measure the percentage of Māori staff in selected occupation categories within BOPDHB.	Work with other Midland region DHBs to advocate for implementation of initiatives from the Kia Ora Hauora Māori workforce development programme. Staff information forms will use a standardised ethnicity collection question and protocol. A cross sectional estimate of staff ethnicity in management, clinical, and administrative fields will be produced.	Ongoing Ongoing By June 2012	BOPDHB Planning and Funding BOPDHB Human Resources and Information Development departments BOPDHB Human Resources and Information Development departments BOPDHB Planning and Funding BOPDHB Human Resources and Information Development departments
The MHSG will be presented with a snapshot of staff ethnicity in management, clinical, and administrative fields.	Annual report of staff ethnicity categorised by selected occupational groups.	Annual	BOPDHB Funding and Planning MHSG

Section 3 – Regional Māori Health Priorities

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

Regional Priority	Indicators		Rationale
Cardiovascular disease	16	Number of tertiary cardiac interventions	1. Despite higher burden of mortality and morbidity from CVD Māori do not access tertiary interventions at a higher rate. 2. Access to tertiary cardiac services is constrained by distance; utilisation may be lower for DHBs which are more distant from Waikato Hospital.
	17	Cardiovascular risk assessment (CVRA) completion within the past 5 years (percentage of the eligible population)	1. Cardiovascular disease is the leading cause of mortality for Māori; 2. Reductions in mortality and morbidity are achievable with appropriate screening and preventative care; 3. All Midland DHBs experience inequalities in cardiovascular risk assessment rates; 4. The CVRA health target has been increased to 90% for 2011/12. This target is more likely to be reached if Midland DHBs share successful models of practice across the region.

Health Issue:	Cardiovascular disease
Indicator 16:	Number of tertiary cardiac interventions
Baseline:	Baseline has not been established. This data will be collected as part of the national indicator set described previously.
Target:	Information only (during 2011/12)
Current Activities:	1. A Midland cardiac services plan was developed in 2006 and has guided cardiac service development over the past five years; 2. A Midland clinical services plan was developed in 2010; reducing inequalities in cardiovascular outcomes and improving access to CVD management are listed as priorities for the Māori Midland population. (13)

Action Plan:

Population health outcome we desire:	Reduced mortality through improved cardiovascular health		
To help achieve this outcome we will focus on:	Monitoring the number of tertiary cardiac interventions for Māori and non-Māori in Midland DHBs		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Work with the Ministry of Health to develop a case definition for tertiary cardiac interventions. Share data collection methods across Midland DHBs. Measure rates of tertiary cardiac interventions for Māori and non-Māori through 2011/12.	A working case definition for tertiary cardiac interventions which encompasses intervention types, readmissions, age, and weighting. Systems and procedures for reporting tertiary cardiac intervention figures will be developed. Regular reporting of tertiary cardiac intervention figures complying with the case definition will be provided.	By October 2011 By December 2012 Ongoing	Ministry of Health Midland DHBs Midland DHBs
Reporting and review of annual cardiac intervention results will be performed by Midland Māori General Managers (GMs).	Annual tertiary cardiac intervention results will be reported.	Annual	Midland Māori GMs

Health Issue:	Cardiovascular disease				
Indicator 17:	Cardiovascular risk assessment (CVRA) completion within the past 5 years (percentage of the eligible population)				
Baseline:	Quarter 3 results 2010/11 (9):	**DHB**	**Māori (%)**	**Other (%)**	**Difference (%)**
		Taranaki	58	74	16
		Waikato	66	79	13
		Lakes	68	81	13
		BOPDHB	58	72	14
		Tairawhiti	66	76	10
Target:	90% by 30 June 2012 (national target for both Māori and non-Māori)				
Current Activities:	1. All Midland DHBs are reporting ongoing improvements in CVRA rates; 2. DHBs are working with PHOs to increase CVRA rates.				

Action Plan:

Population health outcome we desire:	Reduced mortality through improved cardiovascular health		
To help achieve this outcome we will focus on:	Increasing the proportion of cardiovascular risk assessments (CVRA) performed in the eligible population		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Share effective CVRA improvement strategies via the Midland Māori GM network.	Review quarterly CVRA results reported by the MOH for the Midland DHBs. Identify DHBs with high rates and share strategies used to achieve improvement. Share information on effective strategies across Midland DHBs.	Quarterly	Midland DHBs' Māori General Managers
Provide regular reporting for Midland DHBs.	Use quarterly health target reporting from the MOH to provide Midland CVRA performance data to Midland Māori GMs. Identify DHBs with high rates, and high inequalities. Share this information to assist all Midland DHBs improve performance.	Quarterly	Midland DHBs' Māori General Managers MOH
Progress measurement will be performed through discussion among Midland Māori GMs.	Quarterly report of Māori CVRA rates.	Quarterly	Midland DHBs' Māori General Managers MOH

Section 4 – Local Māori Health Priorities

Section 4 summarises BOPDHB's current and planned activities along with targets related to Local Māori Health Priorities. The national priorities and associated indicators are listed below:

Local Priority	Indicator		Rationale
Respiratory health	18	Asthma hospitalisation rate (0-14 years)	1. The hospitalisation rate (2005-7) for BOPDHB Māori with asthma (0-14 years) was almost three times that of the European/Other group (989/100,000 vs. 371/100,000 per year). (4) 2. The rate for BOPDHB Māori is almost 40% higher than Māori nationally. (4) 3. Poor asthma management in children has significant economic and social costs for individuals, families, and society due to absence from school or work, and medical management costs. (14)
Access to services	19	Did-Not-Attend (DNA) rate for outpatient appointments	1. Overall outpatient DNA rates at BOPDHB for Māori (Jan-Dec 2009) were 2.6 times higher than non-Māori (13.31% vs. 5.11%) (doctor and non-doctor appointments). (15) 2. The difference in outpatient DNA rates for appointments with doctors is even higher; Māori DNA rates are 3.25 times those of non-Māori (20.35% vs. 6.27%). 3. Higher disease burden coupled with higher DNA rates will result in ongoing unmet health need.
Oral health	20	Preschool dental clinic enrolment rates	1. The mean number of decayed, missing, or filled teeth (DMFT) for Māori children in Year 8 in BOPDHB in 2006 (non-fluoridated areas) was 3.5 compared with 1.9 for non-Māori/non-Pacific children. These are higher than national DMFT scores of 2.8 and 1.6 respectively. Fluoridated areas have the same ethnic inequalities. (4) 2. 21% of Māori children in Year 8 (2006) were caries-free compared with 38% of non-Māori/non-Pacific children (non-fluoridated areas). These levels are lower than national scores of 28% and 44% respectively. Fluoridated areas have the same ethnic inequalities. (4) 3. Dental conditions are the leading cause of ASH in BOPDHB (0-74 years). (16)
Cardiovascular disease	21	Proportion of secondary prophylaxis recipients who received the appropriate medication within the targeted timeframe	1. The incidence of ARF is higher in BOPDHB than the national average. (20) 2. ARF is significantly higher in Māori children compared with non-Māori in BOPDHB. (2) 3. ARF in BOPDHB is amenable to both targeted interventions and population level initiatives. (21) 4. Secondary prophylaxis offers an opportunity to limit the mortality and morbidity associated with rheumatic fever. (21)

Health Issue:	Respiratory health
Indicator 18:	Asthma hospitalisation rate (0-14 years)
Baseline:	989 per 100,000 (age standardised) per year for Māori (0-14 yrs) compared with 371 per 100,000 per year for European/Other in BOPDHB (4) (RR = 2.7)
Target:	890 per 100,000 per year for Māori (0-14 yrs) by 30 June 2012 (10% improvement)
Current Activities:	1. BOPDHB currently facilitates community respiratory education and home visits via contracted service providers; 2. Increased paediatric inpatient asthma education has been facilitated through greater respiratory specialty nurse time.

Action Plan:

Population health outcome we desire:	Improved respiratory health		
To help achieve this outcome we will focus on:	Reducing the asthma hospitalisation rate for those 0-14 years of age		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Advocate for increased focus on preventative asthma management for Māori children.	Provide baseline asthma hospitalisation figures to PHOs at monthly DHB-PHO meetings.	By September 2011	BOPDHB Planning and Funding
	Translate rate data into absolute hospitalisation figures for PHOs and practices.	Ongoing	BOPDHB Planning and Funding
	Support development of the best practice asthma management clinical pathway for Bay Navigator.	By January 2012	BOPDHB Provider Arm
Perform ongoing measurement of asthma hospitalisation rates.	Work with Information Development services to gain six-monthly updates of hospitalisation data.	Ongoing	BOPDHB Planning and Funding Provider arm Information Development
The MHSG will review asthma hospitalisation data at half year intervals. The group includes representation from PHOs who will be responsible for increased preventative management of asthma.	Half yearly update of hospitalisation results.	Half yearly	BOPDHB Funding and Planning MHSG

Health Issue:	Access to services
Indicator 19:	Did-Not-Attend (DNA) rate for outpatient appointments
Baseline:	13.31% for Māori for 2009 compared with 5.11% for non-Māori (15)
Target:	10% for Māori by 30 June 2012 (25% reduction)
Current Activities:	1. BOPDHB currently provides monthly auditing and reporting of DNA rates to specialty schedulers; 2. Phone call reminders are made prior to appointments for selected specialties; 3. Protocols for follow-up, reminders, contact verification, and communication with GPs have been implemented.

Action Plan:

Population health outcome we desire:	Improved access to secondary care		
To help achieve this outcome we will focus on:	Reducing the Did-Not-Attend (DNA) rate at outpatient appointments		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Provide baseline DNA information to relevant stakeholders.	Work with stakeholders to convey baseline DNA levels, inequalities, and target information. Develop incentive models to reward progress toward the DNA target.	By August 2011	BOPDHB Planning and Funding
Advocate with stakeholders for a focus on improving DNA rates among high needs groups such as Māori.	Encourage stakeholders to focus on inequalities and high needs groups such as Māori. Link stakeholders with tools conducive to improved performance.	Ongoing	BOPDHB Planning and Funding
Identify best practice approaches to improve performance through contact with high-performing DHBs.	Make contact with representatives from high-performing DHBs. Identify systems improvements which can be implemented at BOPDHB.	By January 2012	BOPDHB Planning and Funding
Monitor DNA rates on a half yearly basis.	Work with Information Development services to implement systems for regular reporting of DNA rates.	Ongoing	BOPDHB Planning and Funding Information Development Service
Progress measurement will be performed by the MHSG.	Half yearly progress reports of DNA rates for Māori and non-Māori.	Half yearly	BOPDHB Funding and Planning MHSG

Health Issue:	Oral health
Indicator 20:	Preschool dental clinic enrolment rates
Baseline:	28% of Māori preschool children were enrolled with a dental clinic for the year ending December 2008 (45% of European/Other children were enrolled during that time). (17)
Target:	65% of Māori preschool children will be enrolled with a dental clinic by 30 June 2012 (this target is the same as that set for non-Māori by the National Health Board)
Current Activities:	1. BOPDHB recently completed construction of four new fixed chair dental clinics; 2. Greater coverage of primary schools and kohanga reo is being achieved through the deployment of five new mobile dental units

Action Plan:

L3 - Population health outcome we desire:	Improved oral health among children		
To help achieve this outcome we will focus on:	Increasing preschool dental clinic enrolment rates		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Provide baseline enrolment information to relevant stakeholders.	Work with stakeholders to convey baseline enrolment rates, inequalities, and target information. Develop incentive models to reward progress toward the enrolment target.	By August 2011	BOPDHB Funding and Planning
Work with the provider arm to increase the focus on Māori enrolment rates.	Encourage a focus on inequalities and high needs groups such as Māori. Link stakeholders with tools conducive to improved planning and performance.	Ongoing	BOPDHB Funding and Planning
Identify best practice approaches to improve performance through contact with high-performing DHBs.	Arrange a seminar with representatives from high-performing DHBs. Identify systems improvements which can be implemented at BOPDHB.	By February 2012	BOPDHB Funding and Planning
Monitor enrolment rates on a regular basis.	Develop enrolment rate data collection systems.	Ongoing	BOPDHB Funding and Planning Information Development Service
Progress measurement will be performed by the MHSG.	Half yearly progress reports of enrolment rates for Māori and non-Māori.	Half yearly	BOPDHB Funding and Planning MHSG

Health Issue:	Cardiovascular disease (Rheumatic Fever)
Indicator 21:	Proportion of secondary prophylaxis recipients (post-rheumatic fever) who received the appropriate medication within the targeted timeframe (timeframe to be confirmed)
Baseline:	Baseline levels of secondary prophylaxis delivery within the targeted timeframe have not been established.
Target:	BOPDHB will set targets after establishing baseline levels.
Current Activities:	1. A rheumatic fever action plan has been developed based on recent epidemiological reports for BOPDHB and Lakes DHB; 2. School-based primary prevention initiatives have been implemented at selected sites in the Eastern Bay of Plenty; 3. Increased primary care awareness has been facilitated through education initiatives and promotion of management guidelines particularly in the Western Bay of Plenty and Tauranga where incidence rates do not warrant a school-based intervention. [**]

Action Plan:

Population health outcome we desire:	Improved cardiovascular health		
To help achieve this outcome we will focus on:	Reducing the ARF recurrence rate		
We will undertake these activities and actions	Deliverables	Timing	Responsibility
Measure levels of successful secondary prophylaxis and set targets to attain by June 2012. [**] Continue to support initiatives to prevent rheumatic fever throughout the DHB.	Measurement of the percentage of secondary prophylaxis recipients who successfully receive the required medication within the appropriate timeframe. Review successful models of care. Continue to deliver awareness raising sessions with GPs and other health professionals across the Bay of Plenty. Continue to support the development of a regional rheumatic fever register. Use the regional register to improve secondary prevention throughout the Bay of Plenty.	Ongoing By June 2012	BOPDHB Funding and Planning BOPDHB District Nursing Service Toi Te Ora - Public Health Service Toi Te Ora - Public Health Service
The MHSG will work with stakeholders involved in the rheumatic fever management pathway to develop regular reporting.	Regular reporting of secondary prophylaxis rates.	Ongoing	BOPDHB Funding and Planning MHSG

[**] Actions to address secondary prophylaxis listed in this plan are strategic. More detailed action plans to address rheumatic fever are completed by providers such as Toi Te Ora – Public Health Service which is funded to deliver interventions in areas with high focal incidence rates (e.g. Murupara, Kawerau, Opotiki) and areas with diffusely distributed but high incidence (e.g. Tauranga and the Western Bay of Plenty).

Appendix A

Development of Regional Local Indicators for BOPDHB – Summary of Methods

Regional and local indicators were developed through a five step process involving:

1. Identification of information sources;
2. Identification of leading health issues;
3. Ranking health issues;
4. Scoring the leading health issues;
5. Review and finalisation

1. Identification of Information Sources

External Information Sources
The most useful source of health needs information was a 2008 Health Needs Assessment completed by the MOH. This document provided epidemiological summaries for a range of conditions stratified by age gender, and ethnicity. Health service utilisation was also presented.

Internal Information Sources
Epidemiological and service utilisation reports were gathered from Toi Te Ora – Public Health Service, Funding and Planning, and the DHB's Population Health Advisory Group (PoPAG).

2. Identification of Leading Health Issues

Health conditions and service utilisation issues were collected in a spreadsheet if they met the following criteria:

a) A statistically significant difference between Māori and non-Māori outcomes was present;
b) There were high inequalities between Māori and non-Māori in BOPDHB (a rate ratio of 1.2 or greater was used) – indicating worse health outcomes for Māori compared with non-Māori within the DHB;
c) There were high inequalities between Māori in BOPDHB and Māori nationally (a rate ratio of 1.2 or greater was used) – indicating worse health outcomes for Māori in BOPDHB than Māori in the rest of the country.

3. Ranking Health Issues

Rate ratios between Māori and non-Māori on BOPDHB were calculated. The list of health conditions and service utilisation options were then ranked based on the size of the rate ratio – this gave a measure of inequality within BOPDHB.

4. Scoring Health Issues

The issues with the highest rate ratios were scored against a list of indicator selection criteria developed by the National Centre for Health Outcomes Development (NCHOD).

5. Review and Finalisation

The highest scoring options were reviewed by a public health physician from the regional public health unit, before a set of three condition related indicators were finalised with the DHB's PoPAG and the General Manager Māori Health.

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