Te Pārekereke
Maori Health Innovation

POUWHENUA CLINICS
NURTURING WELL BEING

ACTUALISING WHANAU POTENTIAL THROUGH MAXIMUM HEALTH AND WELLBEING
Contents Page –

Poutiri Trust 4

The problem: Chronic conditions 5

The Innovation 6

The Pouwhenua Clinics 7

How do Pouwhenua Clinics Work? 10

Successful? 12

Feedback 16

Challenges to the Service 17

Plans for the Future 18
Poutiri Trust –

Poutiri Trust is a Maori Development Organisation established in 1997 to coordinate and promote a network of Maori healthcare providers throughout the Western, Eastern and Southern Bay of Plenty regions. The initial vision for the Trust came from Te Whanau Poutirirangiora ā Papa, a collective of kaumatua and kuia representing Iwi, who sought to communicate and connect the Treaty relationship in health to the equitable treatment of Maori, with an overarching goal of improving the health status of Maori across the region.

Above: Poutiri Trust Building

In 2009, Poutiri Trust was successful in their bid for funding from the Ministry of Health Te Ao Auahatanga Hauora Maori fund through the project “Actualising Whanau Potential through Achieving Maximum Health and Wellbeing”. Under this project the Pouwhenua Clinics – named by the late Tamati Clarke and Nan Huritu - were established in 2011 and are currently led by Theresa Ngamoki (previously led by Regina Berghan).
The problem: Chronic conditions –

Chronic and long term conditions are viewed by the Ministry of Health as the major health burden “now and into the foreseeable future” (Ministry of Health, 2012). This group of conditions primarily cardiovascular, diabetes and respiratory, are the leading causes of morbidity in New Zealand, and disproportionately affects the Māori population.

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<tr>
<th>Avoidable Mortality Maori</th>
<th>Avoidable Mortality Euro Other</th>
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<tbody>
<tr>
<td>1 CVD – IHD</td>
<td>1 CVD - IHD</td>
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<tr>
<td>2 Lung cancer</td>
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<td>3 Road traffic injuries</td>
<td>3 Colorectal cancer</td>
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<td>4 Diabetes</td>
<td>4 Suicide &amp; self harm</td>
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<td>5 COPD</td>
<td>5 Road traffic injuries</td>
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<tr>
<th>Avoidable Hospitalisation Maori</th>
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<tr>
<td>1 Respiratory infections</td>
<td>1 Respiratory infections</td>
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<td>2 Cellulitis</td>
<td>2 Angina</td>
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<td>3 Angina</td>
<td>3 Cellulitis</td>
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<tr>
<td>4 COPD</td>
<td>4 Road Traffic Injuries</td>
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<tr>
<td>5 Asthma</td>
<td>5 Gastroenteritis</td>
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*BOPDHB Maori Health Plan 2013/14*
The Innovation -

The overall aim of the project was to advance whanau ora by affirming Maori approaches that improve Maori health outcomes. The whanau centred approach is focused on whanau decision making and empowerment with the innovation coming from the ‘ground up’. Whanau were the ones who decided what it was that they required to ensure they were more able to participate fully in the daily rituals of life alongside the daily rituals of their communities. In doing so they were more able to achieve their own potential as well as support whanau members to achieve theirs.

This project contributes to existing programmes delivered by the Poutiri provider network utilising the following approaches:

- **To increase clinical access for whanau / hapu / iwi / communities members** affected by chronic disease conditions within our Kaumatua/Kuia and Whanau Ora and Mental Health services (although not restricted to these areas). This will reduce long-term costs through early access for whanau wellness.

- **To provide access to specialist health services in the communities** for chronic disease i.e. podiatry, retinal screening diabetes, asthma etc.

- **To provide workforce development for our non-clinical staff and opportunities** for community placements for nursing students.

- Actualising **whanau potential through the utilisation and normalisation of kaupapa Maori frameworks** (Matauranga Maori). Maori families are supported through culturally appropriate, wrap around services to achieve maximum health and wellbeing.
The Pouwhenua Clinics –

The key objectives of Pouwhenua Clinics are to:

• advance whanau ora and affirm positive Maori approaches that improve Maori health outcomes

• promote Maori service delivery systems that value health and social service integration as well as employing whanau centred interventions

• recognise service models that address the needs of whanau, hapu, iwi and Maori communities

• enhance physical, spiritual, mental and emotional health, giving whanau control over their own destinies

• support the ongoing contribution of rongoa Maori to Maori health and well-being through improved sustainability of rongoa resources and health practices

The Pouwhenua clinics were held at marae, clinic and other premises in the following rohe:

• Te Teko, Opotiki, Taneatua, Waimana, and Murupara (in the Eastern Bay of Plenty)

• Rotorua and Reporoa (in the South)

• Te Puke, Tauranga-moana and Matakana Island (in the Western Bay of Plenty)
Above: He Tohunga Ora mo Rangitaiki – Te Teko

Above: Te Ika Whenua Hauora - Murupara
Left: Te Kaha Marae – Te Kaha

Left: Opotiki Maori Women’s Welfare League - Opotiki

Left: Te Wairua o te Ora - Waimana
How do Pouwhenua clinics work? -

The Pouwhenua clinic began with the nurse specialist clinics, along with the podiatry and nutrition clinics.

The providers hold a specialist clinic on a set day each month, in various rural and semi-rural settlements, bringing health services, including chronic illness specialists, to the local Māori population. The specialist nurse ensures that each tangata whaiora/client receives a ‘Care Plan’ and actively participates in setting goals to improve their own health and wellbeing. The nurse specialist also becomes an intermediary between the whanau member and their General Practitioner, until such time where the individual is at a stage where they have re-engaged with their General Practitioner and/ or their nurse.

The podiatrist responsibility includes comprehensive foot assessments as well as subsequent treatment(s). Maintenance plans are implemented. The nutritionist takes a dual strategic approach where both nutrition intake and exercise regimes are addressed on a one-to-one basis. A pharmacist works through all of the clinics and whanau are encouraged to bring in their medications. They are then supported to gain more insight into their medication regimes as well as gather more knowledge of the rationale for the different medication uses.

All members of each whanau and hapu are welcome to attend the Pouwhenua clinic. Along with the clinical interventions by each of the clinicians the whanau members get the opportunity to partake in an informal forum, usually in the lunch room or kitchen, where korero covers all aspects of daily life. Often when the clinicians have down time they will congregate with whanau members to engage in this more relaxed conversation. At this time whanau members quite freely share information and knowledge about what is happening for them as individuals or as whanau. Often different strategies for addressing particular issues are discussed and storytelling becomes a part of this informal exchange.
The pictures below illustrate a glimpse of the work delivered:

Left: Consultation with Client at Opotiki Maori Women’s Welfare League – Opotiki

Right: One of a series of stretching activities produced and is given to patient to resume activity safely

Left: Podiatrist treatment of Client
Successful? -

Pouwhenua clinics have been extremely successful, both in the provision of health services to the target communities, and in the support of shared delivery opportunities by other healthcare professionals. Pouwhenua clinics are particularly effective at meeting the needs of Maori who suffered from the various forms of chronic conditions.

Pouwhenua clinics have provided workforce development for our non-clinical staff. They have also provided an opportunity for community placements for nursing students as well as supported whanau potential through the normalisation of Matauranga Maori. More importantly, Pouwhenua clinics support and encourage Maori whanau to be able to contribute significantly within their own communities.

The Pouwhenua clinic service delivery has also proved to be highly accessible for those who have required specialist clinical expertise. The community’s response and willingness to engage when often they had disengaged with clinical service is testimony to our service. The educative component of this Pouwhenua clinic has also added value. Medication regimes are now being followed along with recorded levels of weight loss. This improved access back to their primary health services is a clear target of the Pouwhenua clinic.

The following case study is a good example of how Maori individuals and their whanau are able to regain their own mana, and consequently take control of their own destinies, in respect to their health needs.
Consult with Mrs R. A 54 year old Maori Woman.

Patient referred by the local Maori Provider for diabetes management education. Mrs R is a 54 year old woman, employed and financially independent. She works fulltime at a kiwifruit orchard doing a variety of physically demanding work. She lives with her son and daughter and says they are very supportive. Whakawhanaungatanga is an important part of our initial consult. Mrs R and I established some iwi / hapu connections which built an immediate rapport. Mrs R told me she always felt dumb when she attended her nurse and Doctor’s appointments. She looked towards the floor as she told me she could not read properly and didn’t understand what the hand-out pamphlets were saying. I asked if she had family at home that could support her and we were able to locate her son to come and sit in on our appointment.

Topics covered:

1) What is diabetes and how can she manage it appropriately
2) Medication action and possible side effects
3) Why testing her BSL’s can assist with making changes to improve blood sugar level results
4) Importance of attending all medical appointments

Mrs R is given a video; “What is diabetes and how to manage it”. This brought a very big smile to Mrs R’s face, she grabbed my hand and thanked me several times.

Mrs R agreed to the following care plan:

1) Take all medications as prescribed
2) Start testing her blood sugar levels three times per week before breakfast, dinner and bed (logbook given to document results)

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1 This case study was written by Regina Berghan who was the clinical team leader for the Pouwhenua Clinic
3) Reduce rewana bread intake and add more vegetables
4) Attend diabetic photo screening (her son agreed to take her to her appointment)
5) Complete blood tests now and in 3 months

The Care plan was written out for her and given to her to take home, along with the DVD.

Referrals

Mrs R was seen by the Pouwhenua Clinic Podiatrist following this consultation. The Podiatrist removed/reduced calloused heals and trimmed toenails with a 3 month follow up appointment scheduled. She had an appointment confirmed for the Pouwhenua clinic Nutritionist for the following month.

Reflection

The Pouwhenua clinic works to reduce patient’s risk of developing complications with Type 2 diabetes. In this instance we were able to provide treatment with Mrs R from a nursing perspective e.g. educating the patient to use a glucometer to test her blood sugar levels, organising her prescription and passing key information onto her Nurse. Through her referral to our Podiatrist we also managed to educate the patient around the importance of maintaining good foot hygiene. It was great that she already had an existing appointment with our Nutritionist for the following month.

Whanau play an important role in assisting patient health improvements. If patients give permission whanau can be included in the consultation process and they can support their whanau member once they are home. Mrs R appears happier, more confident and is asking lots of questions. Her diabetes knowledge is improving and Mrs R states she has learnt a lot from the diabetes DVD.
Left: Ngati Tahu Ngati Whaoa Runanga Trust - Reporoa

Right: Te Toi Huarewa Trust – Ruatoki
Feedback -

The Pouwhenua clinical team have worked tirelessly to solidify the Pouwhenua clinics as a highly valued service which are starting to produce significant improved health outcomes for our people. Purely by simply being a part of this Pouwhenua clinic, whanau felt great about the experiences they had and gave feedback such as:

“It is really great to come to a clinic where I feel comfortable….my son brought me along”

“I really enjoy the korero we have here in the kitchen”

“Whakawhanaungatanga is a huge part of why I like coming here. It helps when you see the nurse”

“The kai lady and the foot man. He talks to me like I am a part of his whanau”

“Kua mohio ai me pehea te whaka haere i nga ahuatanga o te ngako o te ora tinana, wairua, hinengaro”

“Te noho tahi o te whanau ki te korerorero”
Challenges to the Service –

The biggest challenge identified was getting the provider network into a space where they were able to manage the clinics within each of their own rohe. The original intent was to group providers into groups, with each group made up of providers in close proximity to each other. However the level of acuity of the whanau members being seen meant that each of the separate providers was able to fill their appointment slots without having to introduce clients from neighbouring rohe. To meet the needs of each provider, it was decided to stagger each provider every two to three months, with the clinics held at their own premises. This also reduced the need for transport between rohe.

Protocols between the Pouwhenua Clinic and General Practitioner services took a while to get on track. This was not unexpected however and as a greater understanding of the intent of the Pouwhenua clinic became more accepted, the team leader was able to, through effective communication with the General Practitioner clinics and the Primary Health Organisation’s, align the Pouwhenua clinic with existing service delivery. Other provider organisations in primary health understood that the Pouwhenua clinic was not taking over their clinical responsibilities; rather the clinic was supporting whanau members to reengage with their General Practitioner services and where necessary the Pouwhenua clinic might intervene on a temporary basis, where they assisted whanau in the reengagement process.
Plans for the future –

- Nurse attains Nurse Practitioner standard.
- Student nurses attend Pouwhenua clinics and engage in service delivery.
- Pouwhenua clinics site hosts attend workforce opportunities.
- Pouwhenua clinic site hosts lead and coordinate health services on site.
- Pouwhenua will continue to develop relationships with existing primary, secondary and tertiary clinical services and key stakeholders within the Bay of Plenty region.
Above: Theresa Ngamoki RN, MHSci(hons), Nurse Practitioner Candidate

Left: Regina Berghan, RN, MN, DNS
The Pouwhenua Clinic exists in the context of:

1. The New Zealand Public Health and Disability Act 2000
2. The New Zealand Health Strategy
3. The New Zealand Disability Strategy
4. The Primary Health Care Strategy

Key Stakeholders:

1. Bay of Plenty District Health Board
2. Ministry of Health
3. Nga Iwi o Bay of Plenty