Whāia te ora: a hauora Māori initiative

Whāia te Ora (pursuit of health) is a collaborative framework for appropriately supporting Māori patients through their rehabilitation journey. This framework has been developed following Te Ara Mārama, a project that collated feedback from Māori patients in the Puāwai rehabilitation unit (PRU) about their experiences of rehabilitation.

The feedback identified that adjusting to their new roles and abilities immediately post-discharge was often the hardest and that, at times, relationships with the Accident Compensation Corporation (ACC) or Manatū Hauora | Ministry of Health rehabilitation teams broke down and supports were lost.

Through focusing on tikanga (protocols) and whakawhanaungatanga (relationship building) in our engagement with whānau and working closely with kaupapa Māori organisations who are very familiar with these, we can help to build a better network of support to improve recovery and reduce negative outcomes for whānau.

This document outlines the expectations for keyworkers at the PRU when engaging with Māori whānau, in line with the [equity responsibilities](https://pulse.southerndhb.govt.nz/_layouts/15/WopiFrame2.aspx?sourcedoc=/commsdocs/Whakamaua%20Maori%20Health%20Action%20Plan%202020-2025.pdf&action=default&DefaultItemOpen=1) of our organisation and health care system. While this framework is designed with Māori patients in mind, it can be successfully applied to engagement with any patients or whānau.

Further support can be accessed through the Māori health directorate (<https://southerndhb.sharepoint.com/sites/AHSTTrainingPlan/SitePages/Equity.aspx>) or contact Amy Rosenfeld (SLT).

This framework is still in development. Any feedback is greatly appreciated and can be sent to Amy Rosenfeld or any other member of the project team.

Keyworker tasks

1. Whanaungatanga (connection, reciprocal relationship)

Meet and establish connection with patient and whānau. Share some of your background, heritage and your role as a keyworker. This may take place over more than one session. During these conversations, try to gain an understanding of the whānau and/or patient’s cultural background (iwi/hapū, locations of importance) and their connection to this.

Be aware that everyone has a different level of knowledge and involvement with their Māori heritage. For many who are disconnected from it, this can be a source of shame or discomfort if they are made to feel as though they ‘should’ know things.

A key element to understand in this discussion is ***who is in their support network?*** This may be immediate or extended family, friends, iwi, health workers or government agencies. Let whānau guide you in who they want to be involved in supporting them in their recovery. This network may expand during their stay as an inpatient and as you get to know them. This network should include a whānau ora navigator whenever possible or appropriate (see below), and regular communication is essential.

Read an article in *The New Zealand Medical Journal* about the hui process: [The Hui Process: a framework to enhance the doctor–patient relationship with Māori (nzma.org.nz)](https://journal.nzma.org.nz/journal-articles/the-hui-process-a-framework-to-enhance-the-doctor-patient-relationship-with-maori)

Watch a short video explaining what whanaungatanga is and why it matters: [What is Whanaungatanga? - YouTube](https://www.youtube.com/watch?v=623_4wLxEJw)

2. Te Whare Tapa Whā (the four-sided house)

Once you have established a connection, explain to the patient and/or whānau that you would like to discuss what is important to them to help shape a plan for recovery and understand how we can support them.

This is unlikely to be in your first session with the patient – gauge when they are ready and feel comfortable with you. Ask who they would like to be present for this discussion – on their own or with whānau members.

The document for this ([TWTW visual](file:///C%3A/Users/kquick/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/LQ1V6J38/TWTW%20visual.docx)) will be saved in the patient’s folder and at U:\Disability & Community\Service Leader\Inpatients.

Many people will be familiar with Te Whare Tapa Whā and recognise a picture similar to Figure 1.

**Figure 1:** Te Whare Tapa Whā

If they are not familiar with Te Whare Tapa Whā, a brief explanation of the concept is all that is needed. The Health Navigator New Zealand website provides a useful summary: [Te whare tapa whā and wellbeing | Health Navigator NZ](https://www.healthnavigator.org.nz/healthy-living/t/te-whare-tapa-wh%C4%81-and-wellbeing/)

Explain that each of the four ‘walls’ of the whare represent mental/emotional, physical, family/social and spiritual aspects of their wellbeing and that we look at how they would have assessed each one before their admission (stroke/event that brought them to hospital), how they are now and where they would like them to be.

Start with the situation before admission. Discuss each wall separately:

*‘First, I want to talk about your physical wellbeing, taha tinana. What was that like before (your stroke/admission)?’*

Note down their comments for each taha or side on the back of the form.

Reflect back to the person what you have understood about how they are feeling about each.

Sometimes people have trouble understanding the idea of taha wairua. This is often translated as spiritual wellbeing. This can involve religion and/or spirituality but is often described as what makes you feel well, centred, and calm (eg, listening to music, being outside, being near the water, singing, being with my whānau).

Ask them to then rate each taha from 1 to 5, where 1 is very poor and 5 is very good. They can either circle it themselves or you can do it for them.

Repeat this process for where they are now (admission).

When you reach the rating point for each taha, ask what could help them get to the next level.

*‘You’ve said your taha wairua is “just okay” at the moment (3) – is there anything that would help make that taha “good” (4)?’*

Use these responses as a basis for goal-setting and identifying what is important for the patient to work on.

3. Referral to kaupapa Māori services

Now that you know a little about what is important to the patient and whānau, and who is in their support network, find out if they would like support from local kaupapa Māori services.

Information about what Whānau Ora navigators do can be found here:

[Navigation – Te Pūtahitanga o Te Waipounamu (teputahitanga.org)](https://www.teputahitanga.org/what-we-do/navigation/)

[Whānau Ora kaupapa (tpk.govt.nz)](https://www.tpk.govt.nz/en/nga-putea-me-nga-ratonga/whanau-ora/whanau-ora-kaupapa2)

[Whanau Ora services – Nga Kete Matauranga Pounamu Charitable Trust (nkmp.maori.nz)](https://nkmp.maori.nz/service/whanau-ora-services/)

Our main contact for Dunedin is [Araiteuru Whare Hauora](https://araiteuru.co.nz/), and for Southland is [Nga Kete Matauranga Pounamu](https://nkmp.maori.nz/).

Please note that these organisations may forward the referrals on to other Whānau Ora organisations if their navigators do not have capacity or another service is more appropriate. For discharge locations outside of Dunedin or Southland (eg, Central Otago), please send to Araiteuru and note that it may be forwarded to appropriate local organisations.

Both organisations offer wrap-around health and social services. More information about what is available are on the website links above.

The Te Ara Mārama pilot is trialling including whānau ora navigators as part of the rehabilitation team for inpatients and to support whānau after they leave the ward.

If whānau would like a referral to be made, referral forms are in the patient folder and U:\Disability & Community\Service Leader\Inpatients. Include in the referral:

* your contact details as the keyworker
* that this referral is part of the Whaia te Orapilot
* as much information as possible about the whānau and patient’s current/desired connection with their iwi/heritage
* estimated discharge date and location
* any identified risks for the patient/whānau or navigator on discharge
* ACC recovery partner contact details if applicable
* anything else that will help the navigator connect with the patient – detailed medical information is not generally necessary.

Email to:

Araiteuru - reception@araiteuru.co.nz

Nga Kete - Kerstin.Kummerer@kaitahu.maori.nz OR admin@kaitahu.maori.nz

4. ACC authority to act

If the patient has consented to navigator involvement and are under ACC, you will need to complete an Authority to Act (ACC5937) form to allow ACC to share information with the navigators.

This form is saved in the patient folder. Please complete this with the navigator’s details and ensure it is included in discharge information sent to ACC.

5. Follow-up with whānau ora

Whānau ora navigators should be updated on any significant changes in the patient’s discharge planning or rehabilitation.

Invite navigators to come to the ward to meet the team, patient and whānau and to attend team meetings and/or whānau hui as appropriate.

Ensure navigators are linked in with or have contacts for any community rehab teams/recovery partners before discharge.