

# Manawanui Whai Ora Kaitiaki:

Empowering self-management through a  
partnership approach

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HAURAKI  
PHO

HAURAKI  
PRIMARY  
HEALTH  
ORGANISATION  
NETWORK

Matua  
Rōpu  
Haurora

# Background

- Hauraki PHO is a Kaupapa Māori Primary Health Organisation within the Waikato DHB with 131,899 funded patients supported by 35 general practice clinics.
- There is a high proportion of high needs patients within this population with a high proportion of Māori (34%) and quintile five people (36%). The population is older than the national average.
- Data from the 2011-13 NZ Health Survey found 32.7% of the Waikato DHB population experienced unmet need for primary health care in the past 12 months (higher than the national average of 27%).





# The model

- Centred in general practice
- Built on the concept of nurse based outreach service to address LTC
- Provides intensive support for short term duration
- Incorporates the social determinants of health as part of the assessment

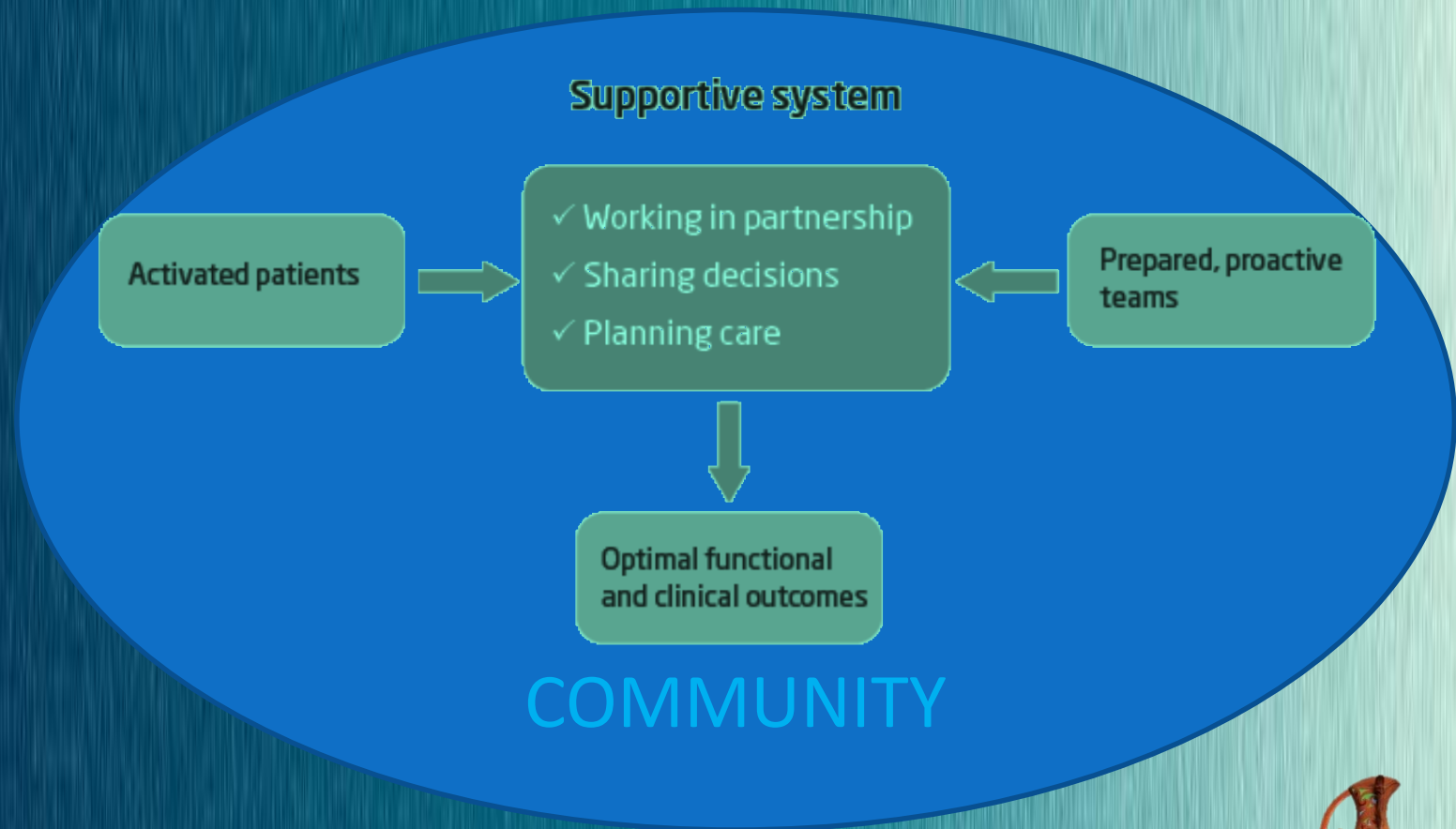


# The Differences

- Kaiawhina (navigator) role working in equal partnership with Case Manager (RN)
  - 7 FTE RN – 7FTE Kaiawhina
- Holistic approach to assessment and care planning
- Focus on patient activation/shared care planning
- Empowerment model – three way partnership



# Three way partnership





# Case Study

- 62 yr Female widowed 6 years
- Type 2 DM 5 yrs
- Poorly managed HbA1c ( 112-120 last 2 years)
- Hypercholesterol
- Weight loss ( 20 kgs over last 3 months)
- Frequent flyer to GP –weekly in last 4 weeks
- Anxiety
- “Non Compliant”
- Victim poor selfworth



# The problem “Not the problem”

- Severe left leg pain fell 1 month- No ACC
- Severe hypos overnight, fear of dying, Ambulance called
- Not eating or sleeping- Pacing 0200
- Anxiety and depression
- Financial strain- unemployed
- Fearful she has cancer
- Daytime catnaps and eating- very sweet tooth





# Actions

- Communication collaboration
- Pain management referral
- Hypo management- reviewing habits
- Partnership approach- interwoven
- Financial support/advice/assistance
- Intensive education/management using other  
3 Ps: Proactive  
Persistence  
Patience





# Successes

- T2 DM now T1 DM ( Relief)
- Change in mindset- thinker
- Insulin, carb counting, lifestyle changes
- Reflective self worth
- Volunteering and community work reengaged
- Successfully employed
- Self empowered
- Working through ACP with whanau



# Why MWOK works...

- Holistic approach with patient at the centre
- **Empowering to the people**
- **Highly skilled clinical staff with varied expertise**
- **Time rich staff unravelling complications**
- **Weavers amongst community, GP practice extension, allied health, whanau**
- **Colloborative partnership with RN and Kaiawhina**



# Data

