



MIDCENTRAL DISTRICT HEALTH BOARD

Te Pae Hauora o Ruahine o Tararua

MAORI HEALTH CARE SERVICE PLAN

23 August 2007

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1. INTRODUCTION

MidCentral District Health Board (MidCentral DHB) is responsible for coordination and development of health services to Maori living within its district. The Maori Health Care Service Plan supports current planning across the district. This document is an implementation plan that links and integrates the many Maori health actions which are identified in the health priority service plans for diabetes, cardiovascular, cancer, respiratory disease, oral health and depression. In its own way, the Maori Health Care Service Plan actions the directions in Oranga Pumau, District Maori Health Strategy (Oranga Pumau) and the Primary Health Care Strategy.

MidCentral DHB Primary Health Care Strategy also has six goals to achieve improved health outcomes through primary health care. These are:

Access	as in easy access for people to primary health care services
Community participation	with people actively contributing to shaping primary health care services that meet the priorities and needs of the community
Coordination of services	ensuring seamless follow through of services for all people
Infrastructure development	primary health care services supported by planned infrastructure development
Integration between primary and secondary care	meaning people receiving care that is not interrupted between primary and secondary care
Quality	having people expect the best possible quality when receiving primary health care services

1.1 Why do we need a Maori Health Care Service Plan?

The need to address health inequalities among Maori has been emphasised in strategic health policy documents including The New Zealand Health Strategy (2000), The New Zealand Public Health and Disability Act 2000 and He Korowai Oranga–Maori Health Strategy (2002). It has also been highlighted through MidCentral DHB’s many priority health plans including diabetes, cardiovascular disease, respiratory illness and cancer.

The proportion of Maori living in MidCentral District is 15%, which is slightly higher than in the total New Zealand population (14%). There is marked socioeconomic disadvantage, and greater health needs for Maori in New Zealand and MidCentral District overall.¹

MidCentral DHB’s Health Needs Assessment (2005) found that Maori:

¹ MidCentral DHB (2001) An Assessment of Health Needs in the MidCentral District Health Board Region pg 12

- show lower proportions in high income brackets, and higher proportions in low income brackets, than the total population.
- have high proportions of smokers (45.1%).
- are more likely to be obese than non-Maori.
- have the lowest overall consumption of fruit
- have disproportionately high numbers of meningococcal disease notifications (Maori meningococcal disease rates are 2.2 times higher than European rates)

The primary health care sector provides a sound base from which the most empowering model for achieving wholeness and cultural security has emerged and flourished – for Maori by Maori health service provision. This foundation is necessary to sustain in the most appropriate way in order to address the health inequalities, low socio-economic circumstances, dysfunctional systems, and poor health, Maori continue to experience.

1.2 Purpose of the Maori Health Care Service Plan

The overall purpose of the Maori Health Care Service Plan is to:

- Reduce the incidence and impact of illness for diabetes, cardiovascular, cancer, respiratory disease, respiratory, oral health and depression
- Improve the quality of life for Maori within these illnesses
- Reduce the levels of inequalities across the district through better access to services and improved service delivery.
- Improve the health of Maori living in the MidCentral district.

1.3 Vision for the future

The service plan seeks to ensure the best possible health and independence for its community. Te Pae Hauora o Ruahine o Tararua's vision for MidCentral district is:

Whanau Ora: Maori Families supported to achieve their maximum health and wellbeing

Kia ora ko te whanau: Me tautoko nga whanau Maori kia tino hauora ai, kia noho ara ai ratou

1.4 Objectives

The objectives of the Maori Health Care Service Plan are based around the continuum of care that is common to all the service plans for MidCentral. In the context of Maori health they are:

- Reduce the incidence of disease in the Maori population living in MidCentral district through promotion /prevention strategies.
- Ensure Maori participate in early detection and intervention programmes/services to reduce the impact of disease on their lives.
- Support and encourage Maori to improve their quality of life through proactive self management strategies and practices.

1.5 Principles

Achieving change will not be easy. A number of guiding principles have been developed to influence the way services are developed and delivered into the future:

- Ensure Maori are able to access services when they are needed.
- Ensure Maori models for wellness and care are provided as options for Maori seeking cultural safety and good health.
- Ensure that capacity building and service expansion of Iwi/Maori providers is a priority in reducing health disparities.
- Work towards improving intersectoral communication and relationships with key government departments and non government organizations.

1.6 Outcomes

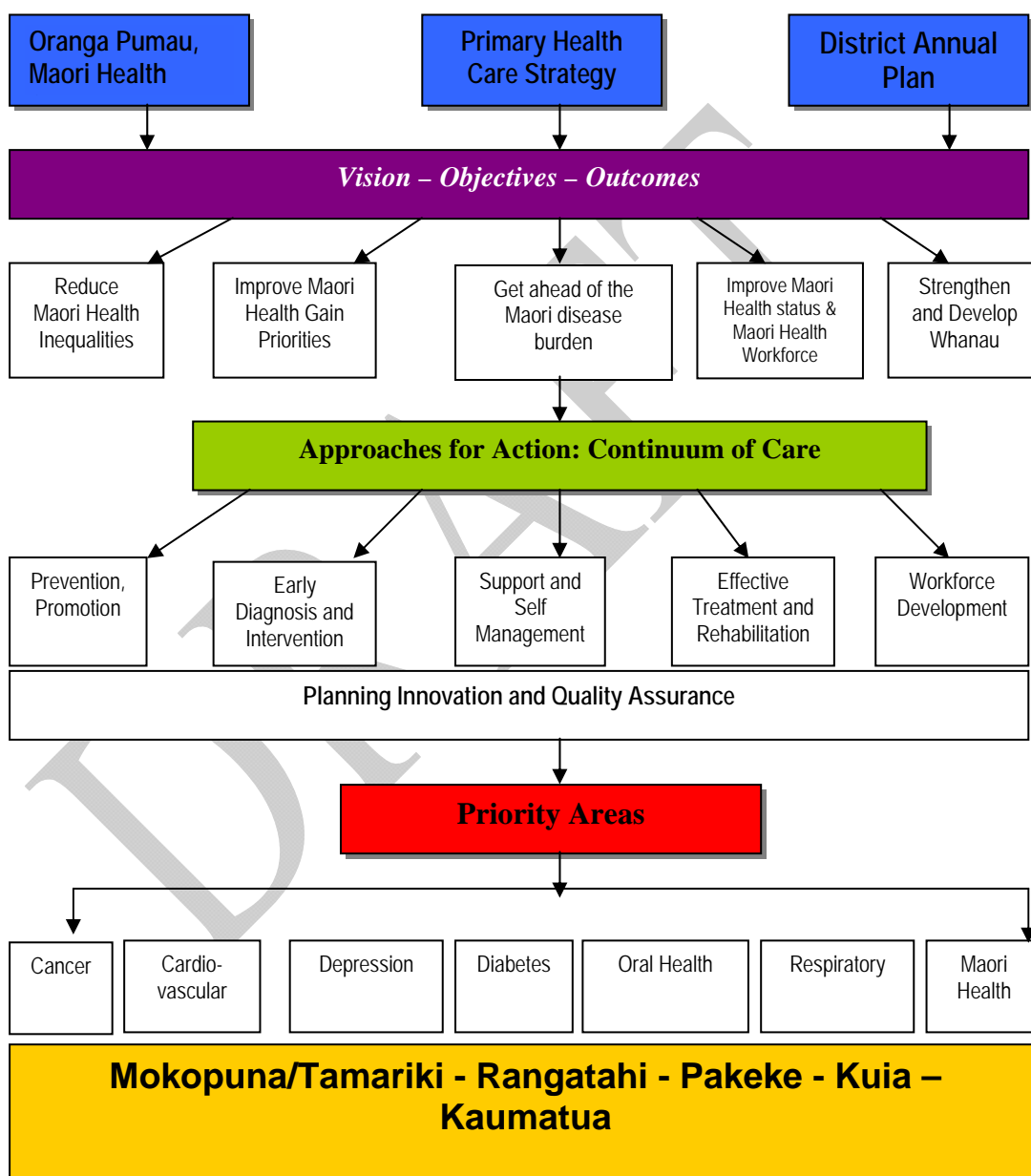
District planning in MidCentral DHB is now well advanced. Clinical and non-clinical indicators have been built into each of the service planning areas covering diabetes, cardiovascular, cancer, respiratory disease, respiratory, oral health and depression.

The Maori Health Care Service Plan will use these indicators to measure current performance against this document. More important, service outcomes will be linked backed to Oranga Pumau, District Maori Health Strategy to ensure that there is change against the high level outcomes for Maori health.

2. DISTRICT PLANNING FRAMEWORK

The planning framework has been developed by considering both national and local strategies for the district. The development of this service plan has included discussion with stakeholders in the community. Figure 1 shows the planning link for the Maori Health Care Service Plan.

Figure 1: Maori Health Care Service Plan



Targeted service development and health investment is underpinned by the DHB budgeted allocation for service planning and implementation which embraces the Diabetes, Respiratory, Cardiovascular, Cancer, Oral health and Maori health services plans for the district.

Ultimately the planning framework relies on key actions and directions from all the plans to reduce access barriers to services reduce wide ranging inequalities in health and improve on health gains for Maori communities.

2.1 Maori Health

Nowhere has the modern definition and concept of Maori health been better articulated than in the Whare Tapa Wha model. It supersedes the western medical concept and definition of health which focused narrowly on the absence of disease, and broadens the focus within those values Maori have always held – wairua, hinengaro, tinana and whanau. In describing the model, it likens the four sides of a house to the four dimensions that make up a whole picture of health for Maori. Although each 'aspect' of the house is different, all dimensions are required to give balance and wholeness.

All the dimensions belong within each individual and as such, are a natural integration and interactive dynamic, without which a person cannot experience good health.

This model/definition is widely accepted nationally and internationally, and is recognised by the World Health Organisation.

Table 1 below depicts the dimensions and themes:

	Taha Wairua	Taha Hinengaro	Taha Tinana	Taha Whanau
Focus	Spiritual	Mental	Physical	Extended
Key Aspects	The capacity for faith and wider communication	The capacity to communicate, to think, and to feel	The capacity for physical growth and development	The capacity to belong, to care, and to share
Themes	Health is related to unseen and unspoken energies	Mind and body are inseparable	Good physical health is necessary for optimal development	Individuals are part of wider social systems

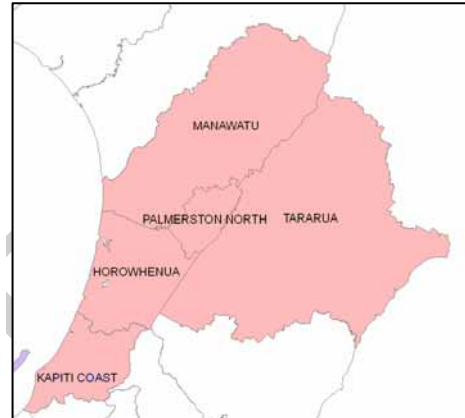
3. MIDCENTRAL POPULATION PROFILE

3.1 Demographic Profile

MidCentral District covers a wide range of geographical and demographical districts, through which the District Health Board aims to improve, promote and protect the health of the approximately 163,000 people.

Map.1 MidCentral DHB Region by TLA

Territorial Local Authorities (TLAs) are local council areas. In the MidCentral there are five TLAs: Manawatu, Palmerston North, Tararua, Horowhenua, and Kapiti Coast (Otaki Ward).



Not all Kapiti Coast TLA comes under MidCentral's designated District and within this TLA there are three Census Area Units (CAUs) including Otaki, Otaki Forks, and Te Horo.

Figure 1. MidCentral Population Distribution by TLA (2001) (taken from [24])

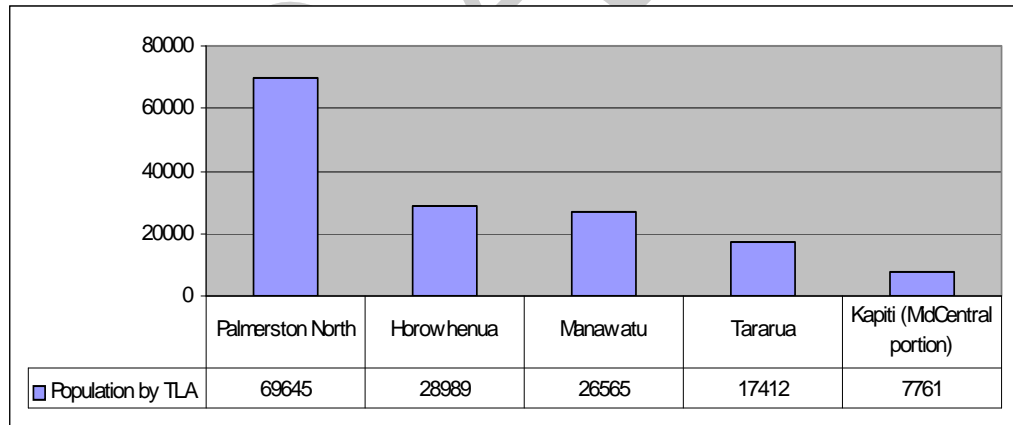


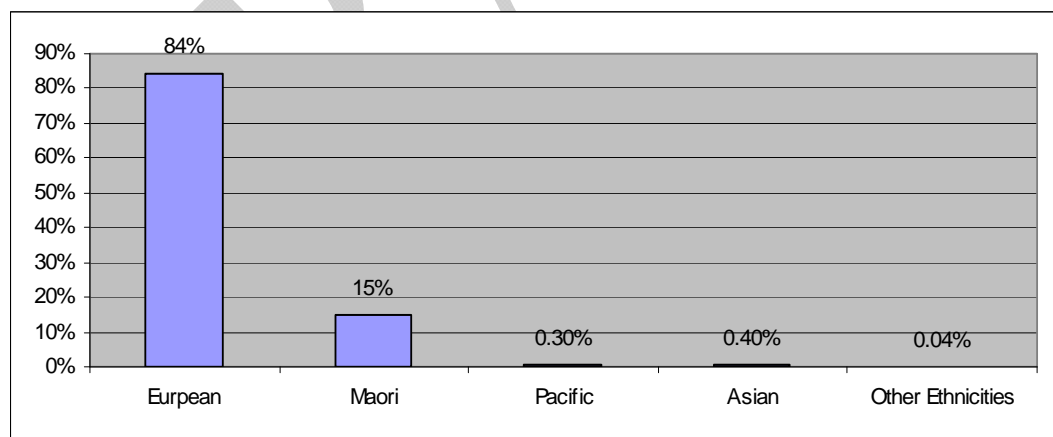
Table 2: MidCentral Proportional Maori Population Distribution by TLA (2001)

TLA	TLA Population	TLA Maori population	DEP. Status
Palmerston North	48% of the MidCentral District population	13%. This TLA has the highest number of Maori in any of the TLAs	43% of the economic activity is heavily service weighted
Horowhenua	20% of the MidCentral District population	Highest proportion of Maori (per TLA) at 20%.	Has low socio-economic deprivation
Manawatu	18% of the Districts population	Proportionally lower Maori population at 13%	Has a low socio-economic deprivation
Tararua	12% of the Districts population	Second highest proportion of Maori population at 18%	Tends towards moderate to low deprivation
Kapiti Coast	Kapiti Coast CAU, 5% of the Districts population	Of the 5% in this CAU, 24% are Maori, but the number of Maori is proportionally low (1,875)	Large aged population reflective of retirees settling on the coast

3.2 MidCentral population by ethnicity

There is a total population of 154,983 people living in the Mid-Central District with a median age of 34.6 years. 15% are Maori, 2% Pacific, 3% Asian, and 76% European and 4% other ethnicities (figure.2).

Figure 2. MidCentral District Population by Ethnicity (2001)



Population by Gender

MidCentral District's population is evenly distributed across gender with males comprising of 49% and females 51% of the population

Age and ethnic distribution

As a population group Maori are a comparatively young population with 79% below the age of 35 years. This pattern is in distinct contrast with MidCentral District's non-Maori population with 54% below the age of 35 years, and with the WHOWP at 59% below 35 years of age. After 40 years of age the Maori population rapidly declines, barely featuring at 65+, and

not at all at 85+ years. The following table shows the percentage distribution in age bands.

Table 3: Comparison of Maori to Non-Maori Population Distribution by Age Against WHOWP

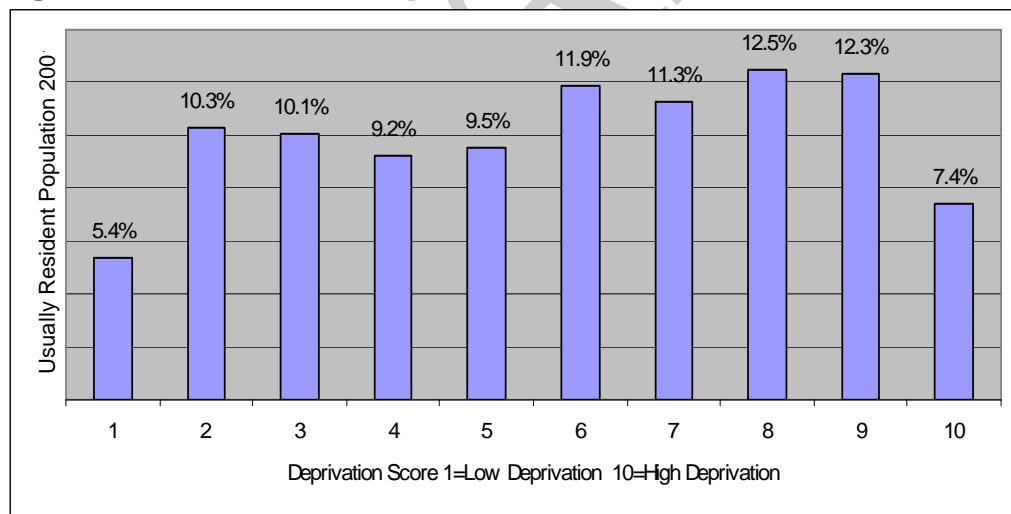
Age bands	WHO World Population	MDHB Population	Maori	Non-Maori
0-20	35%	30%	49%	27%
20-35	24%	20%	30%	27%
40-45	15%	14%	10%	14%
45+	28%	35%	15%	32%
65+	8%	13%	3%	15%
85+	1%	1%	0%	2%

Deprivation

Lower socio-economic status is associated with difficulties in accessing health (and many other) services. Increasingly, small area socio-economic deprivation is consistently associated with decreasing life expectancy, increasing mortality rates, increasing hospitalisation rates and higher smoking rates. High deprivation areas (deprivation 9 or 10) are an important indicator of likely areas of health need.

Overall, MidCentral District presents a slightly more deprived picture when compared to the national average².

Figure 3: MidCentral DHB Deprivation Profile



² Secondary Source: Oral Health Service Plan 2004 sourced from TAS DHB PG 11

Table 4: Maori and Total Population Socio-economic Indicators by TLA (2001)

	No telephone (%)		No vehicle (%)		Unemployment Rate (%)		No qualifications (%)	
	Maori	Total	Maori	Total	Maori	Total	Maori	Total
Manawatu	8.9	2.8	8.4	6.3	15.2	5.9	37.2	28.8
Palmerston North	7.8	2.9	12.0	10.2	16.0	8.4	29.7	20.7
Horowhenua	10.4	4.7	13.6	11.5	17.9	9.3	42.4	35.3
Tararua	12.9	4.6	13.7	9.0	13.7	5.3	42.8	34.2
Kapiti Coast (part)	10.4	4.7	13.0	10.2	NA	NA	33.3	29.8
MidCentral District	9.5	3.5	12.2	9.6	NA	NA	35.8	26.8
Qualifications: proportion of 15+ yrs population Unemployment rate: Proportion of persons unemployed divided by the total persons in the labour force Phone access & vehicle access: Proportion of households NA = Not available								

Maori continue to have a younger population structure than non-Maori, due to a higher birth rate and lower life expectancy. The difference in life expectancy between Maori and non-Maori is improving; however, it will take time for the population structure to show these changes.

4. HEALTH NEEDS ASSESSMENT

4.1 Summary report

MidCentral's Health Needs Assessment (2005) provides a snapshot on the Maori burden of disease which is sobering and provides us all with the resolve to move forward:

- As a population group, Maori have on average, the poorest health status of any group in New Zealand (MoH) and are far more likely (56%) to live in the most deprived areas of the country than their non Maori counterparts (24%)
- Maori have the highest rates of mortality for all categories of cardiovascular disease and are admitted to hospital for these at a much earlier age than other ethnicities
- The incidence rates for diabetes for Maori are more than three times higher than non Maori rates, and Maori are five times more likely to die from diabetes
- 30% of all Maori adults are overweight
- Maori children (12-13 years) have 60% more decayed and filled teeth than non Maori children the same age, and have worse caries-free percentages than any other ethnic group category
- The smoking rate for Maori women is 53% compared to 20% for non Maori women, (two and a half times greater)
- Hospitalisation rates for chronic obstructive pulmonary disease (COPD) occurs at much earlier ages for Maori than non Maori
- Asthma admissions are twice as common for Maori as non Maori, with the death rate for respiratory conditions in Maori children at 2.7 times that for non Maori children

The key priorities areas identified for action in the district and nationally include:

- Reduce smoking
- Improve nutrition and reducing obesity
- Increase physical activity
- Reduce the incidence and impact of cardiovascular disease
- Reduce the incidence and impact of cancer
- Reduce the incidence and impact of diabetes
- Minimize alcohol and drug use
- Reduce the rate of suicide

Oranga Pumau, Maori Health Strategy gives a summary on the health needs of Maori in the district and outlines this information by Population Group(s). They include:

Tamariki needs: hearing and oral health prevention/promotion.

There are high admission rates for asthma and childhood preventable diseases by immunization.

There are high dental caries rates in tamariki.

Rangatahi needs: suicide prevention, smoking cessation and a key message to Rangatahi, not to start.

There are high teenage pregnancy rates among Maori, and higher STD rates than non Maori.

Drug use amongst Maori is higher than non Maori, and more so in Maori males than females, although smoking remains high amongst Maori females.

There are disproportionately high numbers of Maori (under 20yrs) reported for meningococcal disease.

Pakeke needs: smoking cessation, prevention/promotion for diabetes, cancer, cardiovascular disease. Good nutrition and exercise is needed in this group.

Maori show a high death rate from these diseases and are more likely to be obese than non Maori, and less likely to engage in physical activity.

Maori have less consumption of fruit and vegetables than non Maori.

Maori men and women engage more in hazardous drinking than their non Maori counterparts.

Kuia/Koroua needs: prevention/promotion for diabetes, cancer, cardiovascular disease

Although the cancer statistics for Maori show that the population is not ageing, there is a trend that this pattern is changing to reveal a slow increase in older Maori across the population which will require future planning for Maori elderly within one decade.

Information

There is a need to investigate Maori utilisation of key services in primary and secondary health care, adequate accessibility to both primary and secondary care, and accurate ethnicity data collection at key points in these systems to track Maori service coverage.

There are ongoing needs for better measuring with more accuracy, the disparities between Maori and non Maori.

4.2 Priorities

Strategic priorities have been identified for Maori health and these listed as:

- Maori health workforce development

- Maori health provider development
- Whanau, Hapu Iwi and Maori community development
- Rongoa services, expansion of range and increased integration across the service continuum
- Service delivery in te reo and tikanga Maori

4.3 Primary Health Care

In the past decade, definitions for primary health care have been referenced as background and clarity on what it is in the New Zealand context. The National Health Committee has been the driving force behind defining primary health care. In the first instance, it is seen as - “local, first contact care for people that is accessed by self-referral, comprising a range of services, delivered by a range of health practitioners, designed to keep people well, from health promotion and screening to diagnosis and treatment of medical conditions.” (M. Durie (1999) Primary Health Care Work Programme.)

Coster and Gribben emphasise primary health care as being essential health care that is, amongst other factors, “- made universally acceptable and at a cost that the community and the country can afford to maintain at every stage of development in a spirit of self-reliance and self-determination -”. Their definition is wide reaching in that primary health care is viewed as the major focus for overall social and economic development of the community. It is confirmed as the first level of contact for individuals, family and the community with the health system, bringing health care as close as possible to where the people live and work, and that it begins the process of continuing care for them. In their study, Coster and Gribben discussed the blurring terminology between primary health care and primary medical care, stating that the main providers of primary care services are doctors and nurses, with other primary care providers offering supportive, cooperative, and linked services to these two main primary care providers.

They also presented the twelve characteristics of primary health care identified in the Charter for General Practice/Family Medicine in Europe. In summary:

General	not restricted to age groups, problem types or conditions
Accessible	in time, place, financing, and culture
Integrated	curative, rehabilitative, health promotion and disease prevention
Continuous	over substantial periods of time
Team	of health care providers operating as part of a multidisciplinary team
Holistic	physical, psychological, and social aspects of individuals, families and communities
Personal	person, rather than disease-focused care

Family orientated	problems understood in the context of family and social network
Community oriented	context of life in the local community. Awareness of health needs in the community; collaboration with other sectors for initiating positive change
Coordinated	coordination of all advice and support the person receives
Confidential	details of patient contacts are confidential
Advocacy	patient's advocate on health matters at all times and in relationship to all other health providers

4.4 Maori primary health care

In her study of Maori primary health care services, Dr Sue Crengle identifies key features of Maori primary care services as:

By Maori for Maori	Services that are in contrast to mainstream primary care services in philosophy, culture and accountability to the community
Philosophical approach	These approaches frame the services: positive Maori development and use of a Maori model of health and well being
Distinctive demography	The population served is unique with higher numbers of young people, fewer elderly, lower socio-economic status, low utilization of primary care with corresponding high use of secondary services
Variable sizes	The services/organizations providing primary health care vary in size
Broad health needs	Services provided are distinctively focused on the broader Maori health needs of that community
Delivery based on Maori values, practices, beliefs	Methods of delivery are based firmly in Maori values, practices and belief systems as well as localized methods of delivery that suit where Maori are located and how they prefer services to be delivered for their easy access and acceptability
Integrated care	Some Iwi/Maori providers support models of integrated care for the wider strategy of coordination, collaboration and integration
Multidisciplinary integration	Workforce characteristics of the services demonstrate easy integration of multidisciplinary groups of health practitioners

In the local context of MidCentral DHB, the intention of this service plan is to incorporate Maori health as part of the implementation programme for primary health care services in order to make the three main commitments of MidCentral's Primary Health Care Strategy real. This can be viewed as:

MidCentral primary health care commitments	Maori health implementation
Quality Main driver for change and measurement	Quality Enhanced Maori provider development so that more emphasis is on community values, practices and beliefs
Providers A treasured asset in the community	Providers Maori primary health care is developed in a spirit of self-reliance and self-determination with their services being the major focus for overall social and economic development of their community
Community Involved, with an effective voice for the community perspective	Community Maori community development continues with a strong say in philosophy, culture and accountability to the community for all primary health care services

4.5 Disease State Management

The Programme

The Nursing Council of New Zealand describes the term, disease state management (DSM), as the care of people living with the acute and long term effects of specific disease states such as: asthma, diabetes mellitus, cardiovascular disease. The aim of the DSM programme was to select suitably experienced registered Maori nurses, provide them with post graduate training to manage consumers with selected chronic disease states such as: diabetes mellitus, respiratory and cardio-vascular disease. In addition, an underlying strategic aim was to prepare the nurses for the emerging nurse practitioner role and status. The specific chronic disease states identified for the DSM programme have been highlighted in a Ministry of Health commissioned Burden of Disease study. It found that cardiovascular diseases, ischaemic heart disease, diabetes, and associated smoking, hypertension, low physical activity and high blood cholesterol, were the highest rating conditions and risk factors for disability adjusted life years (DALY's) amongst Maori males and females, (and ultimately causing death). The nurses were placed with selected Iwi/Maori providers in the country and were required to establish their client base within a case management model, both supplementing and complementing such services as whanau ora and other related services for the chronic disease states of their clients.

The Workforce

The review and evaluation of the DSM programme also highlighted assessments made of the workforce delivering the DSM programme – (registered nurses):

Opportunity to undertake specific education programme

The work and learning combined, was supported by a well-supervised and structured setting

Building capacity for Maori workforce and provider development

Providers viewed the programme as an investment for the future

Affirmation of a good baseline for clinical knowledge and practice

The Service

The service offered nurses the opportunity to gain extensive knowledge on the nursing management of chronic disease states. The service however, does require a high level of interaction and collaboration with other clinical colleagues in tertiary, secondary and primary care settings. The scope of practice covers the continuum of care set down by MidCentral, in that prevention/promotion, early diagnosis/intervention, support and self management, treatment and rehabilitation, planning, surveillance, research, workforce and quality assurance are all areas where the DSM plays an integral role, is often the 'glue' in the coordination of care, and is

certainly the expert professional for Iwi/Maori providers and other staff in the primary care setting.

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5. CURRENT SERVICES

5.1 Iwi/Maori Health Providers

Iwi/Maori Providers are a demonstration of how the concept of “for Maori by Maori” works. Establishment of these services has also allowed the evolution of acceptable Maori services that can work for others who are not Maori. This has meant the services have had the vital role, even if by default, of providing choice not only for Maori, but to non Maori as well.

There are opportunities for Maori providers to build on the delivery of new and innovative primary care services with skilled coordination and integration across other mainstream services. The volume, quality and range of existing Maori health services provides an ideal basis for primary health care expansion. Key strategies and directions of MidCentral already support this notion. Existing providers and services are:

Provider	Service type	Contract Type
Best Care (Whakapai Hauora) Charitable Trust	Maori health Mental health Primary health care	Whanau Ora Tamariki Ora – well child Reproductive and sexual health service – free contraception Alcohol and Drug services Maori disabilities liaison Inequalities – Mobile Nurse
Rangitane Tamaki Nui a Rua	Maori health Mental health	Whanau Ora Tamariki Ora – well child Mental health / Alcohol & Drug
Te Runanga O Raukawa Inc.	Maori health Mental health Primary health care Intersectoral community action for health	Whanau Ora Tamariki Ora – well child Mobile Maori Disease State Management Free Contraceptive service Community health Worker, Otaki Maori liaison Mental health / Alcohol & Drug
Te Wakahuia Manawatu Trust	Maori health	Whanau Ora Tamariki Ora – well child Mobile Maori Disease State Management’= Inequalities – Whanau Support Services
Te Whanau Manaaki o Manawatu	Mental health	Alcohol and Drug services
Whaioro Trust Board	Mental health	Rangatahi work rehabilitation / employment and education support service

6. THE WAY FORWARD – CHANGE MANAGEMENT

Maori health actions have been taken from each of the MidCentral service plans and been integrated into projects for implementation in this Maori Health Care Service Plan. Specific indicators and milestones have been provided for objectives and project areas along with measures for the District Health Board and outcome measures for Maori health.

There are six objectives that follow the continuum of care for MidCentral and projects are designed to meet the directions from the service plans with a focus for meeting Maori health needs and requirements as each service plan has identified.

Number	Objective
Objective One	Reduce the incidence of disease in the Maori population of MidCentral Health District through promotion /prevention strategies
Objective Two	Ensure Maori participate in early detection and intervention programmes/services to reduce the impact of disease on their lives
Objective Three	Support and encourage Maori to improve their quality of life through proactive self management strategies and practices
Objective Four	Encourage the development of mainstream services and the workforce to improve cultural awareness and practices in their services
Objective Five	Increase and Improve the Maori health workforce through integrated strategies across all service levels
Objective Six	Improve the quality of all services by ensuring planning activities and innovative programmes include Maori cultural perspectives and competence

7. IMPLEMENTING THE SERVICE PLAN

OBJECTIVE ONE: Reduce the incidence of disease in the Maori population of MidCentral Health District through promotion /prevention strategies

Promotion/Prevention – Projects And Initiatives

Cancer Prevention Key Actions

Develop workforce in Iwi/Maori providers to support cancer awareness and screening programmes

Promotion and education in nutrition, physical activity, alcohol use, national guidelines for screening, sex education, smoking cessation, information services, and general cancer awareness.

Target schools for health information and awareness.

INITIATIVE 1:

Iwi/Maori provider education for staff in cancer awareness and screening programmes Involve: Cancer screening specialists such as Radiologists, Radiographers, DSM's, GP's, Health Educators, Primary care teams, Maori Whanau Ora providers

Indicators of Change	Action	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Multidisciplinary approach to education of Maori staff evident • Maori workforce surveys identify increased provider capacity for cancer education and screening • Investments identified in Whanau Ora focused health plans to incorporate general cancer awareness and education activities 	<ul style="list-style-type: none"> • Iwi/Maori provider training plans developed for awareness and education in cancer screening in breast, colorectal, cervical, ovarian, lung, prostate, melanoma, head and neck cancers • Investments made to all Iwi/Maori providers delivering Whanau Ora services for focused health plans • Increases made 	<ul style="list-style-type: none"> • Maori community easily discusses personal cancer screening benefits amongst their whanau, hapu, Iwi • Increased Iwi/Maori provider workforce and service capabilities for cancer screening and education in breast, colorectal, cervical, ovarian, lung, prostate, 	<ul style="list-style-type: none"> • Two yearly Maori health workforce surveys to show clear tracking of workforce participation and development in Cancer prevention services, specialties, and activities • Maori capacity funding identified, reported, and utilized to increase staff capabilities in cancer

<ul style="list-style-type: none"> Evidence of increase in schools participating in nutrition education, physical activity, sex education, smoking cessation, and general cancer awareness information 	in identified primary, intermediate, secondary schools, Kohanga Reo and Kura Kaupapa Maori	melanoma, head and neck cancers.	screening, cancer services to Maori, and specialist abilities
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Maori Health Cancer Awareness Key Actions

Prevention and early detection strategies for Maori needed to cover cancer disease states:

Iwi/Maori providers, PHOs and DHB public health to be involved in cancer prevention and detection services for Maori

Health promotion and wellness programmes focused on increased uptake in early detection activities.

Social/ community based and consultative research programme targeted to Maori for cancer disease state experiences amongst whanau

INITIATIVE 2:

Cancer prevention and early detection strategies for Maori

Indicators	Milestones
<ul style="list-style-type: none"> Iwi/Maori providers, PHOs and DHB public health officers involved in a range of strategies covering cancers for: Breast, Prostate, Cervical, Ovarian, Colorectal, Lung, Melanoma, head and neck 	<ul style="list-style-type: none"> Health promotion and wellness programmes demonstrate increased uptake in early detection activities

INITIATIVE 3:

Social/community based and consultative research programme targeted to Maori

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none">• Whanau and hapu involved with Iwi/Maori provider support for investigating cancer disease state experiences amongst whanau• Projects initiated for at least three cancer disease states amongst Maori in the region	<ul style="list-style-type: none">• Social/community based and consultative research programme reports presented for three cancer disease states	<ul style="list-style-type: none">• Whanau and hapu are supported for investigating the early detection and management of cancer disease states amongst their members	<ul style="list-style-type: none">• Strategies to increase Maori participation in early detection for cancer programmes are funded• Identified whanau/hapu group/s resourced to conduct three cancer disease state social/community based and consultative research programmes

Cardiovascular Prevention Key Actions

Promote health promotion programmes and activities, marae based programmes, kohanga, kura, wanaanga and other locations where Maori meet or attend events

Use of Maori knowledge and cultural processes

Use of Maori health frameworks and models to action change

Coordination with Iwi/Maori providers, to access kaumatua, kuia, Whanau and iwi

Increase Smoke free advocacy and initiatives, general health education, lifestyle changing factors promoted, support regional/national initiatives such as Push Play, Five plus a day, Jump rope for heart, etc.

Work with specialist providers and disease state management nurses

INITIATIVE 4:

Maori health promotion programmes and activities promoted

Indicators	Milestones
<ul style="list-style-type: none"> • Lifestyle changing factors identified, promoted by whanau, marae, kohanga, kura, and wanaanga • Maori knowledge, cultural processes, and Maori health frameworks incorporate Te reo, Maori media, Arts, Crafts, local Whanau Ora models, all age groups, sports, kapa haka, waananga on rituals and their application, Treaty of Waitangi and decolonization, etc. 	<ul style="list-style-type: none"> • Innovative initiatives identified through whanau, marae, kohanga, kura, wanaanga • Mainstream and Maori services appropriately adopt Maori knowledge, cultural processes, and Maori health frameworks within their services for cardiovascular prevention/promotion • Adopt the Cultural Competency Framework as a guide to deliver good health promotion to Maori communities.

INITIATIVE 5:

Coordinated approach to reaching Maori communities

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Iwi/Maori providers, kaumatua, collaborate with multidisciplinary primary care teams on a wide range of initiatives for cardiovascular prevention/promotion • Prevention/promotion techniques shared between Maori, DSMs and other specialist providers that include Maori knowledge, frameworks and models, principles of tapu/noa aroha, whanaungatanga 	<ul style="list-style-type: none"> • Close coordination with Iwi/Maori providers, kaumatua, Iwi and multidisciplinary primary care teams achieved • Coordination of workshops and meetings held regularly between Iwi/Maori provider, specialist providers and disease state management nurses 	<ul style="list-style-type: none"> • Use of Maori knowledge and cultural processes is effective • Use of Maori health frameworks and models confirms acceptable primary health care provision to Maori 	<ul style="list-style-type: none"> • Cardiovascular prevention/promotion strategies reviewed two yearly for effectiveness in achieving Maori health status/health gain • Close work with Iwi/Maori providers, specialist providers and disease state management nurses monitored for easy integration of multidisciplinary primary care teams • Implement cultural competency framework with Iwi/Maori and mainstream providers

Depression Prevention Key Actions

PHOs to include depression in their plans

Work in schools to educate children and youth on depression, and support “Health Promoting Schools” programme

Public Health services to work with the community to raise awareness of signs and symptoms of depression, reduce the stigma of mental illness, develop mental health promotion and wellbeing, and advocate for policy that enhances mental wellbeing.

Develop mental health education and promotion programmes that include matauranga Maori, Maori health models and frameworks, Iwi/Maori providers and local kaumatua/Iwi members

Mental health services to Maori to be integrated and culturally competent

INITIATIVE 6:

Integrated and culturally competent Mental Health services

Indicators	Milestones
<p>Iwi/Maori providers work with:</p> <ul style="list-style-type: none"> • PHOs include cultural components in their depression plans • Schools provide cultural competence in their education to children and youth on depression including support of “Health Promoting Schools” programme • Public Health services work with the Maori community to raise awareness of signs and symptoms of depression, reduce the stigma of mental illness amongst Maori, develop Maori mental health promotion and wellbeing strategies, and advocate for policy that enhances Maori mental wellbeing 	<p>PHOs, Schools, Public Health services include:</p> <ul style="list-style-type: none"> • Kaumatua / kuia as an integral part of their service/programme • Emphasis on whanaungatanga • Support from local Maori community • Maori clinical and cultural consultation and liaison with whanau, other mental health services, Iwi/Maori and other primary care providers, and other health or social services agencies • Adopt Cultural Competency Framework as a guide

INITIATIVE 7:

Maori mental health education and promotion programmes

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Iwi/Maori providers and local 	<ul style="list-style-type: none"> • Framework for mental health education and 	<ul style="list-style-type: none"> • Maori wellbeing and identity strengthened 	<ul style="list-style-type: none"> • Integrated and culturally competent

<p>kaumatua/Iwi members develop and present a framework for use in mental health education and promotion programmes amongst Iwi/Maori and mainstream providers and that is based in matauranga Maori, and Maori health models</p>	<p>promotion programmes:</p> <ul style="list-style-type: none"> • Defines relevant Maori Tikanga, beliefs, values and practices • Promotes Te Whare Tapa Wha model • Provides tikanga Maori related to the kawa and kaupapa of specific services • and includes powhiri, mihimihi, hui, karakia, waiata or poroporoaki • Instruction on how to appropriately access kaumatua and kuia, rongoa Maori, tohunga, speakers in te reo Maori 	<p>through Maori values, beliefs and practices used in mental health and related services</p>	<p>Mental health services resourced and monitored for effectiveness to Maori</p> <ul style="list-style-type: none"> • Programme of cultural audits determined with Maori DHB Management level
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Diabetes Prevention Key Actions

Health promotion programmes and activities, marae based programmes, kohanga, kura, wanaanga and other venues or events that Maori attend

Use of Maori knowledge and cultural processes

Use of Maori health frameworks and models

Use of Iwi/Maori health providers to access kaumatua, Iwi and whanau

Promote healthy living, especially to Maori – smoking cessation, diet, physical activity

Work with territorial authorities, schools, marae, community organizations, providers, PHOs, to provide healthy environments and healthy public policy

INITIATIVE 8:

Maori health promotion programmes and activities

Indicators	Milestones
<ul style="list-style-type: none"> • Marae based programmes, kohanga, kura, wanaanga and other Maori community groups and organizations involved in diabetes awareness campaigns in the Maori community • Diabetes focused health promotion 	<ul style="list-style-type: none"> • Whanau, marae, kohanga, kura, wanaanga, Maori community groups and organizations participate in and promote diabetes checks • Diabetes 'at risk' factors communicated in te reo (written, graphic, verbal)

<p>programmes utilize Maori knowledge and cultural processes through Iwi/Maori providers, whanau members, kaumatua</p> <ul style="list-style-type: none"> • Promotion/prevention strategies have as their basis, Maori health frameworks and models 	<p>through marae based workshops</p> <ul style="list-style-type: none"> • Whanau ora promoted at local levels in the Maori community with whanau members leading discussion and education about diabetes
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INITIATIVE 9:

Promote healthy living to Maori

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Smoking cessation/Auahi Kore/Quitline programmes promoted by Maori role models • Diet/nutrition and physical activity programmes lead in the Maori community by Maori experts, specialists and motivators • Coordinated health promotion programmes supported by territorial authorities, schools, marae, community organizations, primary, secondary and public health providers, PHOs, to develop healthy environments and healthy public policy 	<ul style="list-style-type: none"> • Iwi/Maori providers target and coordinate a regional hui on diabetes prevention amongst whanau with healthy living as the focus • The regional hui on diabetes prevention establishes intersectoral collaboration, healthy environments and health public policy development 	<ul style="list-style-type: none"> • Maori participation in health promotion programmes for diabetes prevention is improved • Maori uptake in diabetes checks, and awareness of 'at risk' factors is increased 	<ul style="list-style-type: none"> • Support provided for Iwi/Maori providers to lead health promotion and prevention of diabetes programmes through funding and workforce capacity resourcing • Monitoring and review of mainstream and Iwi/Maori providers for effective healthy public policy developments and implementation in diabetes services/programmes

Oral Prevention/Promotion Key Action

PHOs to include oral health strategies in their plans

Work with communities to increase fluoride uptake, e.g in toothpaste

Establish the Well Child “Teeth For Keeps” programme in MidCentral region

Support school dental education, e.g: Hato Paora College programme, “Health Promoting Schools” programme

Encourage wearing mouth guards in sports, etc.

Work with the wide range of community and primary care providers, Iwi/Maori, Well Child providers, to promote education in oral health and having regular checks

Deliver culturally appropriate education and services in oral health and hygiene to Iwi/Maori communities

INITIATIVE 10:

Promote education in oral health

Indicators	Milestones
<ul style="list-style-type: none"> • Culturally appropriate education and services in oral health and hygiene planned with Iwi/Maori communities • The wide range of community and primary care providers, Iwi/Maori, Well Child providers involved in promotion and education in oral health, having regular checks, wearing mouth guards in sports promotion • Communities involved in increasing fluoride uptake, e.g in toothpaste • The Well Child “Teeth For Keeps” programme established with Iwi/Maori providers in MidCentral region • School dental education maintained for: Hato Paora College programme • Increase the presence of “Health Promoting Schools” programme 	<ul style="list-style-type: none"> • Oral/Dental health education programme has wide consultation in Iwi/Maori communities/marae • Oral/Dental health education programme provides practical advice/demonstrations to whanau on oral health checks, fluoride uptake, ideal nutrition, wearing mouth guards, etc. • Tamariki Ora services, Well Child services, Plunket, Dental health services and Public Health services workshop with Iwi/Maori providers on “Teeth For Keeps” promotion in Iwi/Maori communities • Evaluation process established for Hato Paora College, and “Health Promoting Schools” programmes

INITIATIVE 11:

PHOs include oral health strategies in their plans

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • PHOs work with Iwi/Maori providers to include oral 	<ul style="list-style-type: none"> • Maori oral health strategies identified from: 	<ul style="list-style-type: none"> • Iwi/Maori communities supported to engage with a wide range of 	<ul style="list-style-type: none"> • Maori participation in health promotion programmes for oral/dental health improves their oral

health strategies for Maori in their plans	<ul style="list-style-type: none"> Iwi/Maori consultation programme Oral/Dental health education programme “Teeth For Keeps” workshop “Health Promoting Schools” and Hato Paora College programme 	<p>oral/dental health promotion programmes</p> <ul style="list-style-type: none"> Evaluation programme established to track all oral/dental health promotion programmes and their effectiveness and efficiency in reaching Maori communities for improved oral health knowledge/practices 	health awareness/knowledge/ practices
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Respiratory Prevention/Promotion Key Actions

Investigate subsidized pneumovax immunization for targeted patients

Promote immunizations and vaccinations against respiratory disease

Support health-promoting schools programme

Promote healthy living, respiratory awareness, and risk factors to Maori and the general population

Support improved housing initiatives in ventilation, heating, and insulation

Support policies in reducing air pollution

Implement the Maori Tobacco Control Strategy and action plan

Increase a wider choice of smoking cessation programmes and include health professional training in identifying smoking status amongst clients and taking action, and preventing uptake in children and youth

INITIATIVE 12:

Promote immunisation programmes to Maori

Indicators	Milestones
Investigate the level of need amongst Maori for subsidized pneumovax immunization Immunizations and vaccinations against respiratory diseases promoted to high need areas of the Maori community	Iwi/Maori providers consulted for coordination of immunization promotion programmes in the Maori community with respiratory related services, GP's, PHO practices, and other primary care providers

INITIATIVE 13:

Promote healthy living to Maori

Indicators	Milestones
<ul style="list-style-type: none"> • Maori participation in health-promoting schools programme supported • Healthy living, respiratory awareness, and risk factors to Maori and the general population promoted • Improved housing initiatives in ventilation, heating, and insulation promoted in Maori communities of high need • Policies to reduce air pollution supported by Maori 	<ul style="list-style-type: none"> • Focused respiratory health promotion programmes delivered in high need areas of the Maori community, on marae, in kohanga, kura, specific health hui (e.g Asthma awareness, Influenza vaccination, Tuberculosis, etc.) • Intersectoral coordination and contracting with Iwi/Maori providers agreed for housing ventilation, heating and insulation in high need areas of the Maori community • Iwi/Maori providers informed on policy developments for reducing air pollution

INITIATIVE 14:

Ongoing proactive approach to smoking cessation amongst Maori

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Implement the Maori Tobacco Control Strategy and action plan • Increase a wider choice of smoking cessation programmes and include health professional training in identifying smoking status amongst clients and taking action, and preventing uptake in children and youth 	<ul style="list-style-type: none"> • Iwi/Maori providers and related primary care services (PHOs) agree on community development approaches with action plans and implementation processes for the Maori Tobacco Control Strategy that includes smoking cessation initiatives, training of health professionals, and prevention amongst Maori youth 	<ul style="list-style-type: none"> • Maori leadership in community development approaches to managing respiratory promotion and prevention strategies increases and improves their overall knowledge and awareness of healthy lifestyles that prevent respiratory diseases 	<ul style="list-style-type: none"> • Support and resources provided to the Maori community to adopt a community development approach to managing respiratory promotion and prevention strategies

OBJECTIVE TWO: Ensure Maori Participate In Early Detection And Intervention Programmes/Services To Reduce The Impact Of Disease On Their Lives

Early Detection And Intervention – Projects And Initiatives

Cancer Early Detection and Intervention Key Actions

Plan and develop a screening workforce of radiographers and radiologists.

Improve access to general cancer screening through multi-disciplinary cancer support groups across the range of eight common cancers: breast, cervical, ovarian, prostate, colorectal, lung, non-Hodgkins lymphoma, head and neck cancer.

Encourage healthy lifestyles: nutrition and physical activity/exercise

Increase access and capacity for: chemotherapy, radiotherapy, colposcopy.

Quit/Smoking cessation programmes, health promotion and well being programmes

INITIATIVE 15:

Cancer screening workforce development of radiographers and radiologists

Indicators	Milestones
<ul style="list-style-type: none"> • Maori communities are engaged in recruitment to the health workforce for radiography/radiology • Identify Maori high risk group/s and appropriate programmes/plans for managing their screening 	<ul style="list-style-type: none"> • Maori Radiography/Radiology group identified as part of recruitment drive for Maori health workforce • Management plans for cancer screening amongst Maori produced with Iwi/Maori providers and multidisciplinary primary/secondary service teams

INITIATIVE 16:

Multi-disciplinary cancer support groups across the range of the eight common cancers through increasing access and capacity for: chemotherapy, radiotherapy, colposcopy

Indicators	Milestones
<ul style="list-style-type: none"> • Multi-disciplinary cancer support groups made up of mobile primary and secondary service specialist education and screening staff • Relationship agreements with Iwi/Maori providers for regular contact and beneficial outcomes from screening programmes 	<ul style="list-style-type: none"> • Increased participation from Maori community, schools/kura, and consumers in cancer education and screening programmes • Review of relationships between Multi-disciplinary cancer support groups and Iwi/Maori providers shows user awareness of location and entry to screening service procedures

INITIATIVE 17:

Encourage healthy lifestyles: through nutrition and physical activity/exercise, smoking cessation programmes, health promotion and well being programmes

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • PHOs and Iwi/Maori providers implement relationship agreements that share resources, funds, staff, for advancing health and wellness plans • Increase investments, activities and services for: 	<ul style="list-style-type: none"> • Review of PHO health and wellness plans show high levels of Iwi/Maori provider and consumer satisfaction with shared resources, funds and staff • Review of specific marae 	<ul style="list-style-type: none"> • Prevention services for cancer screening amongst Maori achieve a smooth transition of multidisciplinary and specialist skills across primary and secondary services • Recruitment incentives for Maori explored/applied in clinical and non clinical areas of workforce need, 	<ul style="list-style-type: none"> • Prevention strategies assessed two-yearly for their effectiveness, and capability of meeting changing needs of high risk groups in the region

nutrition and physical activity/exercise, smoking cessation programmes, by extending these to specified marae and hapu groups willing to focus on reducing obesity and smoking in their whanau	and hapu based wellness lifestyle programmes to show increased independence and improved health status	such as for radiography/radiology	
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Cardiovascular Screening And Early Diagnosis Key Actions

Focus on Maori with CVD risk factors to improve physical activity, weight management and smoking cessation.

Develop a “Heart Health Warrant of Fitness Check” programme targeted to Maori

Enhance Green Prescription programme regionally.

Local physical activity programmes through PHOs, nutrition, health promotion, smoking cessation.

“Expert Patient” programme for better support in self management of CVD

INITIATIVE 18:

Focus on Maori with CVD risk factors to improve physical activity, weight management and smoking cessation

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> Targeted Maori programme for “Heart Health Warrant of Fitness Check” developed through Iwi/Maori providers and their CVD clients Regional Green Prescription programme coordinated with local Maori sports programmes PHOs work with 	<ul style="list-style-type: none"> DSM nurse-led initiative for Maori with CVD risk factors resourced and targeted in: Horowhenua, Palmerston North City and Tararua. A Maori dedicated position (FTE) identified for coordination of activities with: DSMs, Regional Green 	<ul style="list-style-type: none"> Maori community and Iwi/Maori providers have enhanced capacity to manage Maori with CVD risk factors 	<ul style="list-style-type: none"> Support the identified areas for increase of DSMs and recruit Recruit Maori Coordinator for regional CVD prevention/promotion/ early intervention activities Resource a “Maori Expert Patient” programme

<p>Iwi/Maori providers on targeted local physical activity programmes, nutrition, health promotion, smoking cessation.</p> <ul style="list-style-type: none"> • “Maori Expert Patient” programme resourced for better support in self management of Maori clients with CVD 	<p>Prescription programme, Maori sports programmes, PHOs, Iwi/Maori providers, “Maori Expert Patient” programme, and the Maori community</p>		
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Depression Early Detection And Early Intervention Key Actions

PHOs to ensure effective training in depression to general practices

Government agencies (CYFS, WINZ, MOE, etc) provide training to frontline staff to identify and recognize depression and reduce stigma of mental illness

Screening for depression promoted in primary care sector

Develop resources to be used in the community, such as tools for self assessment

Provide resources to be used between primary and secondary care services for people with depression

Supplementary resources to GP services for screening depression in Maori

INITIATIVE 19:

Coordinated mental health services for depression

Indicators	Milestones
<ul style="list-style-type: none"> • PHOs general practice training and development programme includes depression • GP services trained in Maori cultural assessment procedures for screening depression in Maori 	<ul style="list-style-type: none"> • GP training in Maori cultural assessments delivered • Maori mental health expertise has central focus at Intersectoral Forum of Government agencies’ destigmatisation training • Maori and mental health service providers contribute to workshop for Primary/secondary interface for people with depression

INITIATIVE 20:

Effective screening services for depression

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Iwi/Maori providers work with mental health services to promote screening for depression in Maori primary care sector • Maori involved in development of mental health self assessment tools 	<ul style="list-style-type: none"> • Workshops on screening for depression, early signs, prevention, and action strategies produced for Maori whanau/providers • Self assessment tools produced as checklist against existing Maori wellness model of: <ul style="list-style-type: none"> • Te Taha Wairua checklist reflects spiritual health, self practice of tikanga Maori; • Te Taha Tinana checklist reflects personal levels of physical health and self awareness of physical symptoms; • Te Taha Hinengaro checklist reflects personal level of emotional and mental wellbeing • Te Taha Whanau reflects individual values placed on the importance of whanau, its cohesiveness and collective unity within it 	<ul style="list-style-type: none"> • Iwi/Maori providers and whanau are assured of cultural quality and competence in Kaupapa Maori and mental wellbeing through their own participation in mainstream training and development in Maori mental health techniques/tools 	<ul style="list-style-type: none"> • Oversight and resource allocation identified for: <ul style="list-style-type: none"> • GP training in Maori cultural assessments • Intersectoral Forum of Government agencies' destigmatisation training • Workshop for Primary/secondary interface for people with depression • Workshops on screening for depression, a Maori mental health self assessment tool

Diabetes Screening And Early Diagnosis Key Actions

Provide general practice screening of Maori people

Promoting “opportunistic” screening in primary health settings for ‘high risk’ populations

INITIATIVE 21:

Promote comprehensive diabetes screening to Maori people

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none">• Health promotion programmes for Maori identify 'at risk' whanau and their members• Whanau members with diabetes are enrolled on a regular 'Get Checked' programme• Iwi/Maori providers with GP services and PHO practices have planned strategies in place to provide opportunistic screening• A diabetes multidisciplinary screening team identified for working with Maori in podiatry, retinopathy, renal and cardiovascular health	<ul style="list-style-type: none">• Iwi/Maori providers coordinate activities for 'at risk' whanau• A Maori diabetes education/prevention programme is coordinated with their provider/ GP services, PHO practices, and the diabetes multidisciplinary screening team across the region• Iwi/Maori providers deliver diabetes screening programmes in conjunction with the diabetes multidisciplinary screening team in the community, on marae, and in the home	<ul style="list-style-type: none">• Whanau with a high risk of diabetes incidence have increased awareness of screening opportunities• Whanau with a high risk of diabetes incidence have increased their use of diabetes screening services	<ul style="list-style-type: none">• Supplementary resources allocated to a regional Maori diabetes education/prevention programme administered and coordinated by Iwi/Maori providers with GP's• Two yearly review of GP services and PHO practices for their effectiveness in implementing planned strategies for opportunistic screening

Oral Screening And Early Detection Key Actions

All two and a half year olds to receive some form of oral health contact, and to be registered with the school dental service

Promote the availability of subsidized services through WINZ and other low income dental schemes

Promote adolescent free-dental service to school leavers under 18yrs

Promote regular dental checks to Maori

Mobile dental clinics promoted through coordination and outreach activities

INITIATIVE 22:

Promote regular dental checks to Maori across all age groups

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> Iwi/Maori providers, Child Health providers, School Health programmes, and School Dental Health services coordinate the register and track Maori oral health contacts for all two and a half year olds A promotion programme targeted to Maori communities on low income dental schemes is lead by: <ul style="list-style-type: none"> Iwi/Maori providers, Dentists, Ministry of Health and the DHB, and includes: Adolescent free-dental service for school leavers under 18yrs Availability of subsidized services through WINZ and other low income dental schemes Mobile dental clinics coordinated to reach high risk populations/communities 	<ul style="list-style-type: none"> Oral health contacts register established and tracks all Maori two and a half year olds Oral health programme established to target Maori community uptake / utilization of low income dental schemes such as: <ul style="list-style-type: none"> Adolescent free-dental service for school leavers under 18yrs Subsidized services through WINZ and other low income dental schemes Mobile dental clinics in high risk populations/communities 	<ul style="list-style-type: none"> All Maori two and a half year olds are regularly checked for oral/dental health Whanau with low incomes and high risk of oral/dental disease have increased oral/dental health awareness/knowledge and practices through effective dental health schemes and checks 	<ul style="list-style-type: none"> DHB receives progress and review reports on improved oral health contacts for all Maori two and a half year olds Oral health programme reports received on improved Maori community uptake / utilization and effectiveness of low income dental schemes established

Respiratory Screening And Early Diagnosis Key Actions

Integrate screening programmes with other marae and community-based programmes

Health professionals to identify client risk factors and provide timely interventions

INITIATIVE 23:

Integrated screening programmes for Maori

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> Screening programmes integrated with other 	<ul style="list-style-type: none"> Increased participation from Maori community, schools/kura, and 	<ul style="list-style-type: none"> Maori community and Iwi/Maori providers have enhanced capacity 	<ul style="list-style-type: none"> Resource allocation to marae and hapu based

<p>marae and community based programmes in the Maori community</p> <ul style="list-style-type: none"> • Health professionals identify Maori client risk factors and provide timely interventions • Free annual “get checked” programme is implemented for targeted Maori populations (high need/risk) with respiratory disease 	<p>consumers in respiratory education and prevention/promotion programmes</p> <ul style="list-style-type: none"> • Review of specific marae and hapu based wellness lifestyle programmes shows their increased awareness and improved health status • Health professionals lead workshops on screening for client risk factors and provide management plans for respiratory screening amongst Maori, produced with Iwi/Maori providers, and multidisciplinary primary/secondary service teams • A programme for respiratory illness prevention is integrated with the Diabetes programme and includes their provider GP services, PHO practices, and multidisciplinary screening teams across the region, e.g Dietician, physical activities, smoking cessation services. 	<p>to manage Maori with respiratory risk factors</p> <ul style="list-style-type: none"> • Whanau with a high risk of illness have increased awareness of screening prevention/promotion opportunities • Whanau with a high risk of respiratory incidence have increased their use of diabetes screening prevention/promotion programmes 	<p>wellness lifestyle programmes combined for other regional Maori ‘Get Checked’ programmes administered and coordinated by Iwi/Maori providers</p> <ul style="list-style-type: none"> • Two yearly review of respiratory screening programmes and management plans for their effectiveness in implementing planned strategies • Oversight and resource allocation identified for health professional training in respiratory screening for risk factors
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OBJECTIVE THREE: Support And Encourage Maori To Improve Their Quality Of Life Through Proactive Self Management Strategies And Practices

SUPPORT AND SELF MANAGEMENT – PROJECTS AND INITIATIVES

Cancer Support and Rehabilitation Key Actions

Programmes should support achieving quality of life physically, socially, psychologically, spiritually, nutritionally, and information wise.

Nursing workforce needed for clinical support, cancer specialist support, and palliative care

Support services in: prosthesis support, ostomy service support,

A psycho-oncology unit is needed for comprehensive psycho-oncology services

INITIATIVE 24:

Nursing workforce for clinical support, cancer specialist support, and palliative care

Indicators	Milestones
<ul style="list-style-type: none"> Iwi/Maori providers increase recruitment of DSMs in specified areas Whanau Ora nurses receive training and qualification in specialist cancer care Maori health practitioners coordinate care with Rongoa/Maori healing practitioners for training in rongoa practices 	<ul style="list-style-type: none"> Ongoing recruitment strategies are developed in the region to increase the available DSM nurses to increase Maori provider specialist care capability Rongoa/ Maori healing service explored to support care of Maori patients with cancer

INITIATIVE 25:

A psycho-oncology unit for comprehensive psycho-oncology services

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> Iwi/Maori providers participate in discussions about psycho-oncology support services where whanau can benefit from this service Improved 	<ul style="list-style-type: none"> Psycho-oncology support services continue to incorporate the Maori model of health and health care to increase Maori participation and access to these services 	<ul style="list-style-type: none"> Whanau are able to access well coordinated care for cancer support and rehabilitation through services that are close to them and that support their values, practices 	<ul style="list-style-type: none"> DHB clinical and non clinical working environments support Iwi/Maori provider recruitment and resourcing for disease state management of

collaboration between Whanau Ora services, Maori community mental health services, and counseling services to address support for Maori incorporating whanau, wairua, hinengaro, tinana support, rehabilitation and coordination with other carers	<ul style="list-style-type: none"> Iwi/Maori providers supported and resourced to coordinate whanau support and counseling appropriate to their needs, values and practices in managing whanau with cancer 	<p>and beliefs.</p> <ul style="list-style-type: none"> Psycho-oncology services are available to Maori cancer clients and their Whanau. 	<p>cancer amongst whanau</p> <ul style="list-style-type: none"> Access for Maori to cancer services monitored 2 yearly for improvements and includes Maori consumer satisfaction with DHB cancer services
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Depression Support and Self Management Key Actions

Community clinicians to support a greater range of support options in counseling, therapy, etc.

PHOs ensure all consumers with depression have a treatment plan in place

Consumer run WRAP workshops supported

Home support is coordinated and includes carer relief services

Develop support networks amongst community groups such as for Bipolar Support, Postnatal Depression Support

Service collaboration to focus on better management of problem solving and dealing with stress

Extended whanau support to be provided

Ensure more responsive and culturally appropriate suicide prevention services/programmes

INITIATIVE 26:

Coordinated support services for Maori across the range of mental health, secondary and primary care services

Indicators	Milestones
<ul style="list-style-type: none"> Community clinicians provide support to a range of options in counselling, therapy, etc. for Maori Access to clinical and financial support services is available to Maori Access for Maori to a multi-disciplinary 	<ul style="list-style-type: none"> Relationship agreements are established to ensure access, acceptability and availability to Maori, as in: <ul style="list-style-type: none"> Pharmacy services, psychiatry/psychology, counseling

<p>team is demonstrated in:</p> <ul style="list-style-type: none"> - Kaumatua - Cultural advisors - Maori mental health workers - Tangata Whai Ora - Specialist psychiatrists - Registered nurses - Psychologists - Occupational therapists - Social workers <ul style="list-style-type: none"> • Increased access to responsive and culturally appropriate suicide prevention services/programmes 	<p>therapy, nursing, social workers, suicide prevention services/programmes</p> <ul style="list-style-type: none"> - Care coordinated by a dedicated person (key worker/case manager) - Staff from varying backgrounds identified to contribute to care in accord with identified needs <ul style="list-style-type: none"> • Services to have: <ul style="list-style-type: none"> - an emphasis on whanaungatanga to build a sense of belonging to a family - A kaupapa that supports activities focused on tikanga Maori - Support for the strengths of the individual, their whanau and significant others - Kai awhina/mental health workers working together with whanau to reach desirable outcomes for all
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INITIATIVE 27:

PHOs ensure all consumers with depression have a treatment plan in place

Indicators	Milestones
<ul style="list-style-type: none"> • Community-based Kaupapa Maori mental health services contribute to ensure appropriate PHO treatment plans for Tangata Whaiora/whanau 	<ul style="list-style-type: none"> • Referral protocols with community-based Kaupapa Maori services in place to support treatment plans

INITIATIVE 28:

Consumer-run WRAP (Wellness Recovery Action Plan) workshops supported and Support Networks Developed

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Maori/whanau involved in WRAP workshops • Develop support networks such as : <ul style="list-style-type: none"> - Bipolar Support - Postnatal Depression Support - Discussions result in service collaboration that focuses on better management of problem 	<ul style="list-style-type: none"> • Maori community activities used to promote normalisation and community involvement for whanau with members suffering depression • Self responsibility for Maori determines the content of their support and self management programme • A safe 	<ul style="list-style-type: none"> • Whanau have improved participation in community life for their mental wellbeing: <ul style="list-style-type: none"> - a strengthened identity - improved knowledge of tikanga Maori - pre-vocational skills maintained, developed - greater stability of lifestyle 	<ul style="list-style-type: none"> • Monitoring for well managed and coordinated care is through: <ul style="list-style-type: none"> - Community and clinical service relationship agreements with Iwi/Maori providers/ Kaupapa Maori services - Services demonstrating referral protocols in place with community-

solving and dealing with stress – Home support with carer relief is coordinated	environment for mutual support, information exchange and socialisation available to whanau		based Kaupapa Maori services – Services having a dedicated position in a key worker/case manager – services having identified staff available to contribute to care to meet identified needs – Iwi/Maori/whanau involved in WRAP workshops
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Diabetes Support And Self Management Key Actions

Offer marae, community based programmes to improve physical activity, weight management and smoking cessation

Ensure Maori participate in the diabetes programme and club

Primary health settings for education, self management, healthy lifestyles, blood monitoring machines, and appointment of a youth coordinator for promoting healthy family relationships, and access to psychological support

INITIATIVE 29:

Whanau Ora self management programme for Diabetes

Indicators	Milestones
<ul style="list-style-type: none"> • DSM lead Whanau Ora self management programme is linked with the Maori diabetes programme and whanau ora services • Maori on the 'at risk' register targeted for improved physical activity, weight management and smoking cessation • Whanau education programmes provided for self management techniques and processes for achieving healthy lifestyles and supported by regular self education sessions 	<ul style="list-style-type: none"> • Maori Whanau Ora providers coordinate self management workshops with whanau at their regional hui on diabetes prevention • Maori with diabetes and their whanau participate in Diabetes Youth Camps • Maori participate in the appointment of a youth coordinator for promoting healthy family relationships, and access to psychological support

INITIATIVE 30:

Whanau ora diabetes programme

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> Whanau Ora diabetes programme and Maori diabetes programme coordinated with the diabetes club 	<ul style="list-style-type: none"> Whanau ora concepts promoted within the Diabetes health programme and club with whanau members leading discussion and education about diabetes Whanau Ora diabetes programme has established working relationships with other primary/PHO, and secondary providers of diabetes related services 	<ul style="list-style-type: none"> Maori with diabetes and their whanau have appropriate choices for the management and support of their condition Maori with diabetes have increased ability to manage it and share in diabetes education support sessions 	<ul style="list-style-type: none"> Analysis provided on diabetes clinical targets for Maori for case detection, management, eye screening, % on Ace Inhibitor/A2 agents to show %s tracking toward 2006/07 targets Cost analysis for resource allocation to Maori diabetes initiatives and programmes demonstrates matching increases in Maori participation, awareness, and self management of diabetes Reviews planned for effectiveness of new diabetes services/ programmes to Maori

Respiratory Support And Self Management Key Actions

Review DSM service agreements to reflect assessment of health status and treatment regime effectiveness

A dedicated, integrated respiratory psychological service

Explore application of Palliative Care model

Explore establishment of a community specialist pharmacist service

Support consumer education about treatment

Develop specialist respiratory nurse-led clinics with primary care and Iwi/Maori providers

INITIATIVE 31:

Integrated Respiratory Initiatives with Maori primary care services

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • DSM service agreements reviewed for effectiveness of respiratory assessment and treatment regime • Planning and review workshops held to establish support services for: <ul style="list-style-type: none"> • Psychological respiratory integration • Specialist community pharmacist • Specialist integrated respiratory nurse-led clinics • Implementation of Palliative Care model • Consumer support for respiratory education about treatment 	<ul style="list-style-type: none"> • DSM reviews recommend improvements in integrated primary/secondary assessment and treatment processes • Iwi/Maori providers / health professionals / related respiratory services contribute to service planning and review with relevant Maori components for specialist, integrated services and models for respiratory support and self management for Maori, including Maori consumer support for respiratory education about treatment 	<ul style="list-style-type: none"> • Iwi/Maori providers/community/consumers have enhanced respiratory support and self management through effective initiatives for their conditions/services 	<ul style="list-style-type: none"> • DSM review resourced and recommendations monitored for implementation • Specific implementation plans commissioned for establishing specialist integrated respiratory services with each planned pathway identifying Maori content in each new service/model for respiratory care • Evaluations planned/resourced for new respiratory support/self management initiatives

OBJECTIVE FOUR: Encourage The Development Of Mainstream Services And The Workforce To Improve Cultural Awareness And Practices In Their Services

Treatment And Rehabilitation – Projects And Initiatives

Cancer Diagnosis And Treatment Key Actions

Iwi/Maori to have a role in cancer support process linked to palliative care

Multi-disciplinary care for cancer patients

Nursing workforce to have a specialist care role for cancer treatment

Introduce and monitor any new cancer treatments, medications, and radiations

Psychosocial support, rehabilitation, and close coordination with palliative care

INITIATIVE 32:

Iwi/Maori provide cancer support for palliative care incorporating whanau, wairua, hinengaro, tinana, support, rehabilitation and coordination with other carers

Indicators	Milestones
<ul style="list-style-type: none"> • Rongoa/Maori healing providers amongst whanau and hapu communities identified to work in cancer support for palliative care • Existing Whanau Ora services explore cancer support for palliative care to whanau with cancer 	<ul style="list-style-type: none"> • DHB budget allocation identified for rongoa providers in palliative services • Whanau Ora services report on current and potential support services to whanau with cancer

INITIATIVE 33:

Multi-disciplinary care includes new cancer treatments, medications, and radiations

Indicators	Milestones
<ul style="list-style-type: none"> Relationships between Iwi/Maori providers and multidisciplinary teams for education and information sharing, training Maori health practitioners 	<ul style="list-style-type: none"> Iwi/Maori providers report on education and training received about new cancer treatments, medications, and radiations

INITIATIVE 34:

Nursing workforce provides specialist care for cancer treatment

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> Relationships between Specialist Cancer Care Nurses and Disease State Management Nurses in Iwi/Maori provider organizations evident Key areas for access for Maori with cancer, to specialist nursing care identified 	<ul style="list-style-type: none"> Increase in DSM capability for provision of specialist care for cancer treatment to whanau reported Iwi/Maori providers report increased quality of life for whanau with cancer due to access of specialist nursing care and information 	<ul style="list-style-type: none"> Services for Maori by Maori increased with inclusion of Rongoa/ Maori healing services in palliative care Whanau cancer disease states have improved through management of care and easy access to treatment 	<ul style="list-style-type: none"> Rongoa/Maori healing services and Iwi/Maori provider capacity funding identified, reported, and utilized to increase cancer support for palliative care for whanau Multidisciplinary care strategies reviewed for effectiveness of new cancer treatments, medications, and radiations to Maori with cancer Specialist nursing care strategies and DSM services reviewed for effectiveness of coordinated care to Maori with cancer

Cancer Palliative Care Key Actions

Programmes and services for comprehensive, patient-centered care across all conditions and in all settings

Fund enhancement of specialist palliative care services

Develop systems of family support, welfare and rehabilitation

Establish a Palliative Care Nurse Practitioner role

Strengthen child and adolescent palliative care support services

INITIATIVE 35:

Programmes and services for comprehensive, patient-centered care and specialist palliative care

Indicators	Milestones
<ul style="list-style-type: none"> • Iwi/Maori providers ensure linkages for comprehensive, patient-centered care and specialist palliative care are clear and whanau are informed/aware of these • Providers and their clients/consumers provide input and feedback on the most effective strategies for Maori for access, referral, and care from cancer programmes and services 	<ul style="list-style-type: none"> • Whanau service utilization increased, and reported • Maori consumer satisfaction reported on access, referral, and care from cancer programmes and services

INITIATIVE 36:

Systems of family support, welfare and rehabilitation including child and adolescent palliative care and support

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Coordinated care is managed by Iwi/Maori providers for their clients across the sectors, and multidisciplinary specialists to ensure whanau wellbeing, support and rehabilitation throughout the continuum of cancer care • Special attention given to Maori children and adolescents with cancer through whanau hui and workshops that focus on their 	<ul style="list-style-type: none"> • Maori consumer satisfaction reported on access, referral, and coordinated care from cancer programmes and services • Iwi/Maori providers report strategies for strengthening whanau and community support systems for Maori children and adolescents with cancer 	<ul style="list-style-type: none"> • Whanau members with cancer demonstrate increased quality of life through effective strategies for their care and support 	<ul style="list-style-type: none"> • Providers (Iwi/Maori and mainstream) are resourced to deliver effective programmes and services that are patient-centred and emphasise specialist palliative care • Hui and workshops are funded to develop effective strategies for Maori needing better access, referrals, and coordinated care for cancer

special and general needs.			
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Cardiovascular Effective Treatment And Rehabilitation Key Actions

Collaboratively run programmes in the community.

Involve Iwi/Maori providers in the care of Maori patients with CVD.

Increase disease state management nursing to Dannevirke and surrounding areas.

Phase 11 and Phase 111 rehabilitation programmes accessible to Maori.

Appropriate referrals and support provided for hospital appointments.

Develop an organized stroke service.

Improve access to nutrition and psychological support services in the hospital environment as well as the community.

Develop specialist cardiac services in the primary health care sector.

Develop specialist cardiac nurse led interdisciplinary clinics in community settings with primary care and Maori health providers.

INITIATIVE 37:

Collaboratively run programmes in the community

Indicators	Milestones
<ul style="list-style-type: none"> • Specialist cardiac services developed with Maori in the primary health care sector and coordinated with secondary services • Iwi/Maori providers and DSMs lead developments for specialist cardiac nurse led interdisciplinary clinics in the Maori community • Iwi/Maori providers and DSMs lead a coordinated and interdisciplinary specialist programme for Maori communities for Phase 11 and Phase 111 rehabilitation programmes 	<ul style="list-style-type: none"> • Multidisciplinary specialists and Iwi/Maori providers' forum established • Specialist cardiac interdisciplinary clinics established with Cardiac Specialist Nurse, DSMs, and Iwi/Maori providers • A programme of consultation in the Maori community commenced with Maori who have CVD to raise awareness of cardiac rehabilitation programmes

INITIATIVE 38:

Involve Iwi/Maori providers in the care of Maori patients with CVD

Indicators	Milestones
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<ul style="list-style-type: none"> • Iwi/Maori providers and DSMs coordinate an organized stroke service throughout Maori communities in the region • Community based heart failure service for Maori is coordinated through DSMs based in Maori primary care providers 	<ul style="list-style-type: none"> • DSM appointed to Maori primary care provider in Dannevirke • Maori community involved with established stroke service, and heart failure service through DSMs and Iwi/Maori providers
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INITIATIVE 39:

Improve access for Maori in the hospital environment

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • A Maori Clinical Coordinator recruited to improve access to internal/external hospital and specialist support services for Maori • Nutrition and psychological support services in the hospital and the community are coordinated for Maori with CVD and their whanau • Appropriate referrals and support provided for hospital appointments for Maori with CVD • Maori Clinical Coordinator ensures opportunities for Maori clients to have Iwi/Maori providers as their carers 	<ul style="list-style-type: none"> • A coordinated programme for internal/external hospital and specialist support services for Maori is produced • Referral protocols and CVD guidelines for care for Maori produced with psychological support services, CVD specialists, Maori Clinical Coordinator and Iwi/Maori providers • Hospital admission forms identify all Iwi/Maori providers in the region and Maori patients are aware of their choices for care 	<ul style="list-style-type: none"> • CVD contributory risk factors reduced in Maori • Maori individuals and whanau have strengthened capability to self manage CVD 	<ul style="list-style-type: none"> • Maori individuals with CVD are managed with care plans that are coordinated with them and their appropriate Maori and mainstream providers • A Maori CVD programme is enhanced with Maori specialist workforce capability • Iwi/Maori provider profiles are identified through hospital admissions process

Depression Treatment Care And Recovery Key Actions

Health professionals deliver on best practice guidelines and consistent pathways

Number of specialist clinicians available to PHOs to provide clinical oversight is increased

Recovery approach/model implemented in primary and secondary care environments

People with co-morbidities supported

Involve whanau in depression treatment

Enhance youth support groups through sports, therapy programmes, and cultural interventions

Access for Maori through Iwi/Maori providers

Resources targeted to culturally appropriate responses such as for suicide prevention services

INITIATIVE 40:

Best practice guidelines for health professionals

Indicators	Milestones
<ul style="list-style-type: none"> • Health professionals deliver on best practice guidelines and consistent pathways for Maori in mental health services • More specialist clinicians are available to support PHOs • Recovery approach/model implemented in primary and secondary care environments 	<ul style="list-style-type: none"> • Cultural training workshops held with health professionals include: <ul style="list-style-type: none"> – Maori Cultural Practices – Maori Cultural Policies – Treaty of Waitangi Implementation – Cultural competencies produced to cover: <ul style="list-style-type: none"> – concepts of safety and competence – cultural quality and competence – identifying/eliminating cultural risk • Multi-disciplinary teams provide services in accordance with the needs of Tangata Whai Ora, people with co-morbidities, etc. • Specialist clinicians recruited to PHOs through specified resource allocations

INITIATIVE 41:

Access for Maori through Iwi/Maori providers

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Involve whanau in depression treatment • Resources targeted to culturally appropriate responses such as for suicide prevention 	<ul style="list-style-type: none"> • Iwi/Maori providers support youth groups through whanau development initiatives that include: <ul style="list-style-type: none"> – Marae based youth sports programmes 	<ul style="list-style-type: none"> • Whanau/Maori youth have improved quality of life through strengthened efforts for whanau development and wanaanga 	<ul style="list-style-type: none"> • DHB maintains a two-pronged approach to supporting and resourcing Maori and mainstream services to deliver culturally

services <ul style="list-style-type: none"> • Youth groups supported through sports, therapy programmes, and cultural interventions/activities 	<ul style="list-style-type: none"> – Marae based studies – Marae based youth leadership workshops – Whanau wananga – Whakapapa workshops – Te Reo Rumaki/Ataurangi wananga – Tiriti o Waitangi workshops – Decolonisation workshops – Maori youth suicide prevention/awareness workshops 	that meet their needs	competent services <ul style="list-style-type: none"> • Cultural quality reviews of both Maori and mainstream services maintained two yearly
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Diabetes Treatment Key Actions

Improve access to specialists using agreed referral protocols, a range of coordinated primary/secondary health services including with Iwi/Maori providers and PHOs

Provide specialist resource teams, existing treatment guidelines, a foot care programme, and coordination across the secondary/primary care continuum

INITIATIVE 42:

Improved access to diabetes services for Maori

Indicators	Milestones
<ul style="list-style-type: none"> • Iwi/Maori providers, DSMs, GPs, and specialists agree referral protocols for Maori diagnosed with diabetes • Coordinated primary / secondary health services including with Iwi/Maori providers and PHOs review existing treatment guidelines for access and effectiveness in reaching Maori clients with diabetes 	<ul style="list-style-type: none"> • Maori with diabetes obtain full access to diabetes services' multi-disciplinary team • Maori with diabetes and their whanau increase utilization of primary care services for diabetes including prescription uptake for ACE inhibitors, GP and DSM appointments kept

INITIATIVE 43:

Coordination with specialist diabetes resource teams

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Timely provision is reviewed and monitored across specialist 	<ul style="list-style-type: none"> • Aggregated Maori diabetes data provided from Iwi/Maori 	<ul style="list-style-type: none"> • Increased and improved access to treatment for diabetes is 	<ul style="list-style-type: none"> • Monitoring and review of information and data from Local

<p>resource teams such as:</p> <ul style="list-style-type: none"> - Iwi/Maori provider linkages - Foot care/podiatry programme - Secondary/primary care coordination - Eye screening/retinopathy localized clinics - Renal failure reduction efforts through early effective medication (ACE Inhibitors, etc.) - Regular reviews of recommended guidelines/pharmacy schedules 	<p>providers and DSM reports against the:</p> <ul style="list-style-type: none"> - Maori on 'Get Checked' programme - and Whanau ora diabetes programme - Records show improved access and uptake for Maori with diabetes in all specialist services to Maori 	<p>achieved for Maori whanau through appropriate diabetes services</p>	<p>Diabetes Team, Iwi/Maori providers, PHOs, Specialist secondary diabetes services to track Maori diabetes targets and report for District Annual Plan</p> <ul style="list-style-type: none"> • Referral protocols and treatment guidelines reviewed annually for achieving Maori diabetes targets and appropriate primary/secondary responses
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Oral Health Effective Treatment Key Actions

Iwi/Maori providers supported to provide better access to dental health services for Maori people

Improve availability of essential dental services in MidCentral region through addressing contract issues with private dentists

Offer school holiday dental services

Establish an urgent dental referral pathway for children needing prompt treatment

Establish contracts with private dentists to ensure back up support for school and essential dental services

INITIATIVE 44:

Better access to dental health services for Maori people

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • A regional dental service with a Iwi/Maori provider 	<ul style="list-style-type: none"> • Maori regional dental service appropriately located to reach 	<ul style="list-style-type: none"> • Maori children and adults with high risk of chronic dental 	<ul style="list-style-type: none"> • Targets for Maori children and adults are monitored with

<p>established</p> <ul style="list-style-type: none"> • Low income dental services with other Iwi/Maori providers as satellite services to the regional dental service for high risk Maori populations established • Specific mobile dental service contracts with identified/willing Dentists developed • Dental access plans developed that include strategies for: <ul style="list-style-type: none"> – school holiday dental services – urgent dental referral pathways for high risk Maori children/whanau – contracts with private dentists to ensure back up support for school and essential dental services 	<p>high risk Maori populations</p> <ul style="list-style-type: none"> • Dentist/s and staff employed by Iwi/Maori provider to implement their dental access plans • Specific targets developed and coordinated with MidCentral Oral Health performance measures for improving oral/dental health care for Maori 	<p>disease have improved access to affordable dental services</p>	<p>overall DHB performance measures established for oral health, annually</p> <ul style="list-style-type: none"> • Dental/Dentist contracts are aligned with accessible dental services for Maori in the region
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Respiratory Treatment Care And Rehabilitation Key Actions

Review the DSM nursing services to spread equitably across the region

Use of the “Liverpool Care of the Dying Pathway” for terminally ill patients with respiratory illness

An integrated service for management of sleep apnoea

Dedicated respiratory physiotherapist

Extend current services according to tuberculosis guidelines

Resource support of Infectious Disease services for longer staff contacts

Extend Pulmonary Rehabilitation services into Horowhenua and Tararua

Extend capacity of hospital in the home services

Establish a paediatric integrated respiratory service across secondary and primary services

INITIATIVE 45:

Review of DSM nursing services

Indicators	Milestones
<ul style="list-style-type: none">• DSM services reviewed for overall effectiveness of equitable spread across the region	<ul style="list-style-type: none">• DSM reviews and recommendations are aligned with CVD and Respiratory support and self management requirements

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INITIATIVE 46:

Maori perspectives on death, grief, and dying shared alongside the “Liverpool Care of the Dying Pathway” for terminally ill patients

Indicators	Milestones
<ul style="list-style-type: none"> Iwi/Maori providers consulted on the Maori response to the model for the “Liverpool Care of the Dying Pathway” for terminally ill Maori patients with respiratory illness 	<ul style="list-style-type: none"> Maori perspectives on death, grief, and dying are shared as part of the culturally appropriate pathway of care for terminally ill Maori patients with respiratory illness

INITIATIVE 47:

Consultation with Maori on an integrated service for management of sleep apnoea

Indicators	Milestones
Iwi/Maori provider-led consultation held for education and awareness of treatment management for sleep apnoea amongst Maori/whanau	Maori consumers/whanau with sleep apnoea identified and supported by whanau/providers for treatment of the condition

INITIATIVE 48:

Support of new, and extended current respiratory treatment related services

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> Iwi/Maori providers/ community/whanau involved in processes to establish: <ul style="list-style-type: none"> Dedicated respiratory physiotherapist position A paediatric integrated respiratory service across secondary and primary services Extension of current services according to tuberculosis guidelines Extension of pulmonary 	<ul style="list-style-type: none"> Maori contribution demonstrated in: Recruitment and appointment processes to ensure Maori have opportunities Service integration requirements aligned with Iwi/Maori providers and relevant services Appropriate protocols for Maori with TB integrated with tuberculosis guidelines Maori high risk/need areas identified for 	<ul style="list-style-type: none"> DSM overall review resourced and recommendations monitored for implementation Support for Maori demonstrated through appropriate initiatives/models/services for them in respiratory treatment and rehabilitation Evaluation programme implemented for new respiratory initiatives/models/services accounts for cultural 	<ul style="list-style-type: none"> Whanau respiratory illnesses improved through quality treatment and easy access to respiratory care that is culturally relevant to their needs Iwi/Maori providers and whanau have increased opportunities to influence delivery and innovation of respiratory services to them

<p>rehabilitation services into Horowhenua and Tararua</p> <ul style="list-style-type: none"> • Extension of hospital capacity into home services • Resource support of Infectious Disease services for longer staff contacts 	<p>emphasis in pulmonary rehabilitation</p> <ul style="list-style-type: none"> • Primary/secondary interface practices improve access for Maori being cared for at home • Whanau supported during care of infectious disease conditions 	<p>relevance and effectiveness to Maori</p>	
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OBJECTIVE FIVE: Increase And Improve The Maori Health Workforce Through Integrated Strategies Across All Service Levels

Responsive Workforce – Projects And Initiatives

Cardiovascular Professional Development Key Actions

Work with local Iwi/Maori providers in planning, purchasing, delivering and monitoring culturally appropriate services for whanau and members who have CVD.

A more culturally aware and skilled workforce.

Develop a cardiovascular education programme for primary health care.

Support nursing professional development through primary health care WFD framework.

Increase the workforce to facilitate integration between primary and secondary care professionals.

INITIATIVE 49:

Iwi/Maori providers involved in planning, purchasing, delivering and monitoring culturally appropriate CVD services

Indicators	Milestones
<ul style="list-style-type: none"> • Develop a cardiovascular education programme for Maori and their whanau with CVD • Maori cardiovascular education programme is delivered in the primary health care sector • A more culturally aware and skilled workforce is evident in CVD services 	<ul style="list-style-type: none"> • Monitoring framework for cultural competency developed for CVD education programme • Iwi/Maori and mainstream providers identified for resourcing and delivering the CVD education programme • Cultural competency training and development implemented with CVD specialists, Iwi/Maori providers and multidisciplinary primary care teams

INITIATIVE 50:

Supportive and integrated professional workforce for CVD

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Support evident for nursing professional development through primary health care WFD framework • Increase in the workforce to facilitate integration between primary and secondary care professionals 	<ul style="list-style-type: none"> • Career opportunities, pathways, and peer support group established in conjunction with the Primary Nursing Care Project • Multidisciplinary specialists and Iwi/Maori providers' forum include non clinical Maori health practitioners to develop protocols, guidelines, care plans for primary/secondary integration of CVD services/activities for Maori with CVD 	<ul style="list-style-type: none"> • Maori with CVD and their whanau have improved self awareness and education about their condition • Maori health workforce has increased capacity through recruitment and training in CVD management 	<ul style="list-style-type: none"> • Maori capacity funding allocation to Maori health workforce strategies • for: Maori clinical specialists, DSM professional development, and cultural competency workforce training

Depression Responsive Workforce Key Actions

Tertiary training professionals to include depression and recovery approach/model in training courses

Recovery approach/model training provided to all mental health professionals

Stigma and discrimination training to health professionals working in mental health

Training in recognition of depression provided to the wider health workforce

Health professionals especially in primary care encouraged to identify depression and provide appropriate interventions for it

Training on kaupapa Maori models of practice to ensure appropriate delivery to Maori

Build workforce capacity to understand the mental health needs of Maori

INITIATIVE 51:

Develop effective training packages to support Maori mental health workforce development and build relationships with Te Rau Matatini

Indicators	Milestones
<ul style="list-style-type: none"> • Maori mental health professionals/whanau/providers contribute Maori components to training in: <ul style="list-style-type: none"> – depression and recovery approach/model – stigma and discrimination – identifying depression and providing appropriate interventions for it – Maori mental health experts contribute to training for: <ul style="list-style-type: none"> – Tertiary training courses – All Mental health professionals – Health professionals working in mental health – Maori mental health professionals – Health professionals in primary care 	<ul style="list-style-type: none"> • Training links established with local Tertiary Institutes and Maori mental health experts/trainers and providers • Relationship agreements between Maori and mainstream providers specify shared training resource people, skills, course content • Programme of training implemented by Maori for relevant input for: <ul style="list-style-type: none"> – depression and recovery approach / model – stigma and discrimination – Identifying depression and providing appropriate interventions for it

INITIATIVE 52:

Kaupapa Maori based training programmes are explored and developed to support service development

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Training delivered on kaupapa Maori models of practice to ensure appropriate delivery to “for Maori by Maori” 	<ul style="list-style-type: none"> • Programme of training implemented by Maori includes: <ul style="list-style-type: none"> – Kaupapa Maori models of practice – Meeting mental health needs of Maori – Up-skilling of current/future mental health practices/procedures 	<ul style="list-style-type: none"> • Maori health workforce capacity strengthened through mental health strategies for training mainstream and Maori workforce 	<ul style="list-style-type: none"> • Monitoring and evaluation of training programmes for Maori and mainstream identifies priority areas for Maori health workforce development and other training options inter/intra sectorally

Oral Health Responsive Workforce Key Actions

Actively recruit dental professionals including new graduates for studentships to work in MDHB

Appoint an oral health coordinator to work in the community to educate in oral health

Continue to engage an Adolescent Oral Health Coordinator for MDHB

Formalise dental professional and other providers training programmes through local forums and involvement of the NZ Dental Association and Dental Council

Include dental training in other training courses such as for teacher and nanny training

Promote dentistry as a career option and establish an oral health information website

INITIATIVE 53:

Recruitment of a dental health workforce

Indicators	Milestones
<ul style="list-style-type: none"> • Iwi/Maori providers engaged in strategies and processes to actively recruit dental professionals including new graduates for studentships to work in MDHB • Maori community and Maori dental professionals involved in the appointment process for recruiting an oral health coordinator to work in the community to educate in oral health 	<ul style="list-style-type: none"> • Dental professionals, /graduates/students engaged with Iwi/Maori providers for dental health service delivery • Oral Health Coordinator has an agreed work programme for oral health education in high risk Maori population areas developed in consultation with Iwi/Maori providers and community

INITIATIVE 54:

Formalise training programmes

Indicators	Milestones
<ul style="list-style-type: none"> • Iwi/Maori providers, health educators/trainers and dental professionals involved in forums to develop dental professional and other providers' training programmes • Iwi/Maori providers, health educators/trainers and dental professionals involved in providing dental training in courses for teacher and nanny training 	<ul style="list-style-type: none"> • Iwi/Maori providers, health educators/trainers and dental professionals' workshops deliver Maori components of dental professional and other providers' training programmes including those for teacher and nanny training

INITIATIVE 55:

Dentistry as a career option is promoted

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Iwi/Maori providers, health educators/trainers and dental professionals participate in Maori workforce development strategies for capacity, capability and competence to include dentistry as a career option • Iwi/Maori providers, health educators/trainers and dental professionals participate in consultation processes to establish an oral health information website 	<ul style="list-style-type: none"> • Iwi/Maori providers, health educators/trainers and dental professionals implement recruitment strategies for dental career options via: <ul style="list-style-type: none"> – Workshops/hui – local Maori media – Maori training institutes (wananga, kura, PTE's, etc.) – other provider organizations – mainstream training institutes (polytechnics, University, COE, etc.) – Maori components for oral health included on website 	<ul style="list-style-type: none"> • Maori health workforce capacity strengthened through oral/dental health strategies for training mainstream and Maori workforce 	<ul style="list-style-type: none"> • Strategies to increase Maori participation in dental health service delivery, oral health education in high risk Maori population areas, are funded • Maori capacity funding allocation to Maori health workforce strategies • Maori components (including cultural competencies) of dental professional and other providers' training programmes • Monitoring and evaluation of training programmes for Maori and mainstream identifies priority areas for

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
			Dental health workforce development and other training options

Respiratory Responsive Workforce Key Actions

Support nursing professional development through MidCentral's Nursing Framework

Develop a respiratory education programme for primary health care providers and include interactive sessions on user determined topics

INITIATIVE 56:

Support nursing professional development

Indicators	Milestones
<ul style="list-style-type: none"> Nursing professional development through MidCentral's Nursing Framework is supported by Maori health professionals in primary health care 	<ul style="list-style-type: none"> DSMs and other Maori health professionals in primary health care agree the broad areas for nursing professional development: <ul style="list-style-type: none"> – high quality care – safety of patients/clients – roles and scopes of practice DSMs and other Maori health professionals in primary health care agree underlying principles for their workforce practices: <ul style="list-style-type: none"> – assessing families in the context of their communities, their participation/contribution, their whanau, homes, marae, and

	– monitoring for safety, quality and competence
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INITIATIVE 57:

Participation in a respiratory education programme for primary health care providers

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Iwi/Maori providers/whanau involved in development of a respiratory education programme for primary health care providers 	<ul style="list-style-type: none"> • Iwi/Maori providers/whanau include components of the respiratory education programme for primary health care providers as determined by their (high risk) needs: <ul style="list-style-type: none"> – Plain language – Services where/when needed – The illnesses and how to cope – The medicines and what they are for, etc. – Cultural appropriateness 	<ul style="list-style-type: none"> • Maori Whanau receive high quality care and education about respiratory conditions from an informed Maori health professional workforce • Maori health professional workforce have enhanced ability to support their Maori clients with respiratory conditions, through well planned professional development pathways 	<ul style="list-style-type: none"> • Support and resources for Iwi/Maori provider workforce contributions to integrated primary care initiatives in respiratory education and training provided • Support and resourcing for DSM nursing professional development practices/principles as applied in their workplace environment

OBJECTIVE SIX: Improve The Quality Of All Services By Ensuring Planning Activities And Innovative Programmes Include Maori Cultural Perspectives And Competence

Planning Innovation And Quality Assurance – Projects And Initiatives

Cancer Research And Surveillance Key Actions

Establish a comprehensive cancer plan inclusive of a monitoring and surveillance framework at either local or regional level for accessing timely, coherent data on cancer disease states

INITIATIVE 58:

A comprehensive cancer plan inclusive of a monitoring and surveillance framework

Indicators	Milestones
<ul style="list-style-type: none"> • Iwi/Maori providers and whanau are involved in planning for Maori cancer data collection and collation. • Maori cancer data is timely, coherent, and easily accessible by Maori 	<ul style="list-style-type: none"> • A comprehensive cancer plan presented with distinctive Maori cancer data

INITIATIVE 59:

A research advisory group

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Maori are involved in cancer research processes and methodologies to ensure benefits to them from research findings 	<ul style="list-style-type: none"> • Maori representation evident in an established research advisory group 	<ul style="list-style-type: none"> • Maori cancer research and information contributes to Whanau Ora developments and whanau health gains 	<ul style="list-style-type: none"> • Maori cancer research opportunities identified and initiated • Detailed Maori cancer information informs service developments for Maori

Cardiovascular Quality Services, Innovation, Quality Assurance Key Actions

Involve Iwi/Maori in the Collaborative Cardiovascular Health and Wellbeing Group for improved coordination, continuity, and access to appropriate services.

PHOs include a CVD strategy in their plans.

Coordinate primary and secondary resources across the continuum of care – in policy, communication, and clinical collaboration.

Establish a Collaborative Cardiovascular Health and Wellbeing Group for –

Performance indicators, annual surveys of service delivery, research projects, innovations for health improvements, advice to DHB, best practice guidelines, quality framework.

Develop a broad health promotion strategy to focus actions across health areas and gain best use of resources.

Information innovations in web-based applications.

Financial assistance for travel from rural and isolated areas to services.

Improve outpatient booking system to be more patient-friendly.

INITIATIVE 60:

Iwi/Maori involved in the Cardiovascular District Management Group (DMG)

Indicators	Milestones
<p>The Cardiovascular DMG develops and incorporates: Maori health performance indicators for CVD; Annual surveys for cultural competency of CVD service delivery Cultural quality in CVD research projects; Innovations for Maori health improvements; Advice to DHB on Maori CVD requirements/improvements, coordination, and access to appropriate services; Development of cultural best practice guidelines; Maori cultural quality and competency framework. The Cardiovascular DMG provides policies for financial assistance for travel from rural and isolated areas to services, and guidelines for an improved outpatient booking system that is more patient-friendly.</p>	<p>A Maori CVD caucus to the Cardiovascular DMG convened A Maori health framework for CVD service delivery across Maori and mainstream providers developed by the Maori CVD caucus Financial assistance for travel allocated to Maori in rural areas to meet Maori needs in CVD service access Guidelines for an improved outpatient booking system for Maori with CVD presented to the Cardiovascular DMG Primary and secondary resources coordinated through the Cardiovascular DMG</p>

Depression Quality Improvement And Assurance Key Actions

High needs groups and pilot projects to be encouraged for innovation in dealing with depression

Broader health promotion strategy to focus across health services for better use of resources for depression and mental wellbeing

Depression issues included in other service plans such as for: Child, Youth, and Disability Support services

Develop a 'web health directory'

Work with Iwi/Maori providers and community in planning, purchasing, delivering and monitoring appropriate services to Maori whanau

INITIATIVE 61:

Planning with Iwi/Maori providers

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> Iwi/Maori providers and community involved in MidCentral programmes/meetings/hui for planning, purchasing, delivering and monitoring appropriate services for depression to Maori 	<ul style="list-style-type: none"> Service planning groups, provider groups, monitoring and review workshops fully engaged with Maori across the region, for planning appropriate services to Maori Iwi/Maori providers, Tangata Whai Ora, Whanau involved in developing Maori components of a 'web health directory' 	<ul style="list-style-type: none"> Maori mental health and well being is enhanced by inclusive service planning, monitoring and quality focused programmes across the DHB 	<ul style="list-style-type: none"> Monitoring maintained of DHB service plans for appropriate input of Maori depression issues Maori depression issues included in other key planning areas such as: Child Health Service Plan, and Disability Support Services Plan

Diabetes Planning, Innovation, Workforce Development, Quality Monitoring Key Actions

Ensure Maori participate in the Diabetes programmes established.

Continue working with local Iwi/Maori providers for cultural input into all programmes for improving health and reducing diabetes amongst Maori

Establish Diabetes District Management Group

Establish local diabetes management groups under PHOs

Establish a diabetes awards programme as part of the Health Innovations Programme

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INITIATIVE 62:

Maori participation in Diabetes programmes

Indicators	Milestones
<ul style="list-style-type: none"> • A Whanau Ora Diabetes Programme is explored • A Maori primary health self management programme is established within the Whanau Ora Diabetes programme and participates with PHOs and other local diabetes management groups in the region • Iwi/Maori providers participate to establish a diabetes awards programme as part of the Health Innovations Programme 	<ul style="list-style-type: none"> • Terms of Reference agreed for the Whanau Ora Diabetes Programme • Protocols agreed between the Whanau Ora Diabetes Programme and the Diabetes DMG • Protocols agreed between the Whanau Ora Diabetes Programme and the PHOs in the region • A Maori component of the Health Innovations Programme is agreed between Iwi/Maori providers and other organizers of the Health Innovations Programme

Review and monitor for effectiveness of programmes to improve Maori health and reduce diabetes amongst Maori

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • A monitoring role is established as part of the terms of reference of the Whanau Ora Diabetes programme • Whanau and Maori with diabetes in the primary health self management group provide cultural input to all services and programmes established to improve health and reduce diabetes amongst Maori • Recruitment and retention strategies produced for supporting a Maori diabetes specialist workforce 	<ul style="list-style-type: none"> • A Maori diabetes monitoring framework is agreed for implementation by the Whanau Ora Diabetes programme • Cultural competencies presented for Iwi/Maori and mainstream services / programmes established to improve health and reduce diabetes amongst Maori • Working relationships developed with diabetes specialist workforce • Support gained for recruitment / retention of a Maori diabetes specialist 	<ul style="list-style-type: none"> • High level of participation from Maori with diabetes and their whanau in the development, monitoring and review of culturally enhanced diabetes services to them. 	<ul style="list-style-type: none"> • Maori capacity funding identified for establishing the Whanau Ora Diabetes programme • Relationship agreements/protocols supported between Whanau Ora Diabetes programme and Diabetes Health Improvement Group, PHOs in the region, MidCentral's diabetes specialist workforce • Resources allocated to the Maori component of the Health Innovations programme

	workforce		
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Oral Health Quality Improvement And Assurance Key Actions

Improve the utilization of the mobile dental clinic at Iwi/Maori provider sites

Innovation in oral health around high needs groups

Indicators for adult oral health status and monitor service performance

Six monthly planning meetings with stakeholders

INITIATIVE 63:

Improve Maori utilisation of existing dental health services

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> • Consultation programme to improve Maori utilization of the mobile dental clinic at Maori provider sites, commenced • Consultation hui held with Maori whanau – youth, adults, providers, to explore innovative ideas in oral health for high needs groups • Iwi/Maori providers engaged with oral/dental health services to further develop indicators for adult oral health status and monitor service performance • Six monthly oral health planning meetings with • Maori health 	<ul style="list-style-type: none"> • Mobile dental clinic and Iwi/Maori providers agree on protocols to include mobile dental clinic services in their dental access plans • Mobile dental clinics implement Iwi/Maori providers' dental access plans in high needs areas identified by providers and the Maori community • Iwi/Maori providers and oral/dental health services providers agree on initiatives and new indicators for the adult population • Ongoing six monthly oral health planning meetings attended by Iwi/Maori providers/whana u/ community 	<ul style="list-style-type: none"> • Maori Whanau (children, adolescents, and adults) have improved oral/dental health status through access to and utilization of all available dental health services • Maori oral health is enhanced by inclusive service planning, monitoring and quality focused oral/dental health programmes/initiatives across the DHB 	<ul style="list-style-type: none"> • Maori capacity funding allocation to Iwi/Maori providers for development of their Dental Access Plans • Support for the implementation of the Iwi/Maori providers' Dental Access Plans through Iwi/Maori providers, Mobile dental clinic service, oral/dental health services including Dentists, Child Health services, other oral/dental health initiatives and programmes

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
service stakeholders conducted			

Respiratory Quality Improvement And Assurance Key Actions

Identify a coordination organization for a district-wide approach to health promotion

PHOs to include respiratory services in their plans

Innovations supported especially around high needs areas/populations

Strengthen clinical alliances to improve clinical alliances and early referral to appropriate services

INITIATIVE 64:

Maori input into planning for improvements to clinical alliances and early referral services

Indicators	Milestones	Maori Health Outcome Measures	District Health Board Measures
<ul style="list-style-type: none"> Strengthen clinical alliances to improve clinical alliances and early referral to appropriate services 	<ul style="list-style-type: none"> Service planning groups, provider/clinical groups, consult and fully engage with Maori across the region, for planning appropriate working relationships and alliances, and referral protocols and service networks to strengthen respiratory services/programmes delivered to the Maori community 	<ul style="list-style-type: none"> Maori health and well being is enhanced by inclusive service planning, monitoring and quality focused programmes across the DHB 	<ul style="list-style-type: none"> Monitoring maintained of DHB planning workshops and initiatives for appropriate input of Maori health promotion strategies/techniques Evaluation process in place to track effective implementation and establishment of a coordination organization with a broader health promotion approach

8. INVESTMENT IN MAORI HEALTH

8.1 Maori Health Investment Opportunities

Reducing health disparities in health is the key to improving service coverage to Maori. Some specific areas will need to be targeted for both investment and health gain and these areas affect resources for future investment in Maori health.

With the implementation of the service plans MidCentral DHB has allocated existing funds against each of these priorities. Maori health is a key component of these service plans. Some of the key themes to be highlighted for action include:

To reduce health inequalities for poor Maori oral/dental care in children, adolescents and adults, a regional dental service for low income families is required.

Disease state management in adult/elderly Maori and further investment in the health professional workforce for managing diabetes, cardiovascular disease and respiratory illnesses needs investment

Collaborative and well coordinated programmes need to be resourced between Maori and mainstream providers, many of which will need to be Maori provider or Maori health workforce led

Low Maori utilisation of both primary and secondary services is a concern and many collaborative programmes are geared for improved access for Maori, along with an initiative to profile and print Iwi/Maori providers on the hospital admission forms so that records are made of Maori accessing providers of their choice more appropriately

Specific Maori health workforce positions are required especially in coordinating roles where Maori data for utilisation requires accuracy and improvement, and services across the sectors need better linkages

Resourcing and funding of Iwi/Maori providers needs a planned and well reviewed approach for likely expansions in the community such as for Rongoa Maori services

9. OUTCOMES FOR MAORI HEALTH

9.1 Strategic Outcomes

The Maori Health Care Service Plan is designed to achieve the following improvements:

Improve health outcomes in a way that respects Maori cultural values and practices

Ensure convenient, easy access to a range of quality-driven providers, facilities, and programmes

Reduce fragmentation, service gaps and achieve greater accountability

Greater coordination across the levels of care available

Demonstrated creativity and innovation in a service delivery approach that incorporates collaboration, integration, and timely responsiveness to clients needs

Application of technology and infrastructure development to support service delivery

The intent of the outcomes is to ensure that quality principles are the basis of appropriate and timely care, and that it is delivered to the optimum level that meets individuals and communities stated needs. We now present a series of tables that can be used to measure and monitor progress against the MidCentral Health Needs Assessment and across the district.

Principle	Access
Objective	<ul style="list-style-type: none"> • Services are readily available, timely, and affordable to Maori • Information is readily available and understandable to Maori consumers
Indicators	<ul style="list-style-type: none"> • Proactive, innovative services • Complaints resolution processes • People treated with dignity and respect • Best practice guidelines are actioned • Cultural identity, values, benefits are recognised • Providers can give transport when needed • Services accommodate socio-economic circumstances of whanau

Principle	Acceptability
Objective	<ul style="list-style-type: none"> • Services ensure clients feel comfortable and their opinions are sought • Their needs are understood and they are satisfied
Indicators	<ul style="list-style-type: none"> • Maori clients increasingly report service acceptability • Complaints are resolved speedily • Iwi/Maori providers have a high profile in services delivered in mainstream

Principle	Efficiency
Objective	<ul style="list-style-type: none"> • Services analyse costs and budget for clients' needs
Indicators	<ul style="list-style-type: none"> • Planning in services shows that Maori needs are addressed • Comparison of relative costs and benefits to Maori are made across services • Maori utilisation in services is accounted for e.g. number of attendance's, visits Show increases / decreases and ensure specific targets are met • Services show accurate records for tracking Maori health status • Expeditious delivery compliments efficient operational systems

Principle	Effectiveness
Objective	<ul style="list-style-type: none"> • Services contribute to better outcomes for Maori clients • Coordination across a range of services is matched with competent and skilled workforce • Operating costs demonstrate efficiencies
Indicators	<ul style="list-style-type: none"> • Services operate seamlessly in: coordination, support, delivery and information collection • Services show progress of Maori clients through their systems and record Satisfaction and organised follow-up/discharge • Provider support offered to Maori clients and whanau • Information given that was relevant, understandable • Coordination of delivery was speedy, easy, safe • Mainstream facilities (hospitals) profile and promote Iwi/Maori providers to Maori clients • Services demonstrate strong links with all related agencies impacting on the health and care of Maori clients

Principle	Safety
Objective	Services protect Maori clients from avoidable physical, non-physical harm
Indicators	<ul style="list-style-type: none"> • Systems are in place to identify key risk areas of avoidable harm physically, non physically • Services show measures are in place to eliminate, reduce and isolate identified risks to Maori clients • Cultural quality and competency programmes are proactive features in services and cover: <ul style="list-style-type: none"> – environment / facilities – (te wa/te ao turoa – workforce – responsive/qualified (whanaungatanga) – information/confidentiality – (kawa tapu/noa) – policies/procedures - meet regulatory requirements (korero tika/pono)

Oranga Pumau, district Maori Health Strategy has presented some overarching outcomes for whanau derived from He Korowai Oranga, but also based on MidCentral's District Strategic Plan and developments from MidCentral Health's Maori Health Unit.

Whanau Ora directions from He Korowai Oranga have been to ensure that whanau are facilitated to achieve well health (whanau ora) through their own actions, in order to improve their health.

Facilitation is an essential skill for workers in the Whanau Ora services and for all other health practitioners across mainstream and Iwi/Maori services. The outcomes are therefore a guide for recognising the desired result from skilled facilitation for whanau achieving their own health and wellbeing.

Whanau are nurturing	and have a secure identity, high self-esteem, confidence and pride
Whanau have skills	and knowledge and opportunities to achieve their own goals
Whanau experience wellbeing	physically, spiritually and emotionally and have control over their destinies
Whanau exercise their rights	and are free from harm and actively involved in and valued in their community of choice
Whanau are able to participate	in Te Ao Maori as well as the wider New Zealand society
Whanau have the necessities	to physically, socially and economically participate fully and to provide for their own needs

8.2 Measures to monitor Maori health care investment

Prevention/Promotion

Priorities	Maori Primary Health Care Outcomes	DHB Measures
Cancer	<p><i>Whanau</i> Maori community investigate and discuss personal cancer screening benefits, early detection and management of cancer</p> <p><i>Workforce</i> Increased Maori provider workforce and service capabilities for cancer screening and education in cancer</p>	<p><i>Whanau</i> Number of funded strategies to increase Maori in early cancer detection programmes Three cancer disease state consultative research programmes with whanau</p> <p><i>Workforce</i> Two yearly Maori health workforce surveys for participation in Cancer prevention activities Amount of Maori capacity funding for staff capabilities in cancer screening</p>
Cardiovascular	<p><i>Maori health models</i> Use of Maori knowledge and cultural processes is effective Use of Maori health frameworks and models confirms acceptable primary health care provision to Maori</p>	<p><i>Maori health gains</i> Review report on two yearly achievements for Maori CVD health gains Effectiveness of integration monitored in multidisciplinary primary care teams</p>

		<p><i>Cultural competency framework</i></p> <p>Number of Maori and mainstream providers implementing the cultural competency framework</p>
Depression	<p><i>Kaupapa Maori services</i></p> <p>Maori wellbeing and identity strengthened through Maori values, beliefs and practices used in mental health and related services</p>	<p><i>Effective integration</i></p> <p>Report on effectiveness to Maori for integrated and culturally competent Mental health services</p> <p>Cultural audits programme of cultural audits determined with Maori DHB Management level</p>
Diabetes	<p><i>Increased participation</i></p> <ul style="list-style-type: none"> • Improved Maori participation in health promotion programmes for diabetes prevention • Maori uptake in diabetes checks, and awareness of 'at risk' factors is increased 	<p><i>Workforce</i></p> <p>Amount of funding to Iwi/Maori providers for workforce capacity to lead health promotion and prevention of diabetes</p> <p><i>Reviews</i></p> <p>Monitoring and review of mainstream and Iwi/Maori providers for effective healthy public policy developments and implementation in diabetes services/programmes</p>
Oral	<p><i>Increased awareness</i></p> <p>Maori participation in health promotion programmes for oral/dental health improves their oral health awareness/knowledge/practices</p>	<p><i>Support & evaluation</i></p> <p>No. & location of Iwi/Maori communities supported to engage with a wide range of oral/dental health promotion programmes</p> <p>Evaluation programme report on all oral health promotion programmes and their effectiveness and efficiency in improving Iwi/Maori communities' oral health knowledge/practices</p>

Priorities	Maori Primary Health Care Outcomes	DHB Measures
Respiratory	<p>Increased knowledge</p> <p>Maori leadership in community development approaches to managing respiratory promotion and prevention strategies increases and improves their overall knowledge and awareness of healthy lifestyles that prevent</p>	<p><i>Community development approach</i></p> <p>Amount of support and resources to Maori community to adopt community development in managing respiratory promotion and prevention strategies</p>

	respiratory diseases	
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Early Diagnosis/Intervention

Priorities	Maori Primary Health Outcomes	DHB Measures
Cancer	<p><i>Coordination</i> Maori experience smooth transition of prevention services for cancer screening across primary and secondary services</p> <p><i>Workforce</i> Maori benefit from recruitment incentives in clinical and non clinical areas of workforce need, e.g radiography/radiology</p>	<p><i>Effectiveness assessments</i> Number of prevention strategies assessed for their effectiveness, and capability of meeting changing needs of high risk groups in the region</p>
Cardiovascular	<p><i>Enhanced capacity</i> Maori community and Iwi/Maori providers have enhanced capacity to manage Maori with CVD risk factors</p>	<p><i>Workforce resourcing</i> Number of DSMs recruited Recruitment of Maori CVD Coordinator Amount of resource to “Maori Expert Patient” programme</p>
Depression	<p><i>Maori quality assurance</i> Iwi/Maori providers and whanau are assured of cultural quality and competence in Kaupapa</p> <p>Maori and mental wellbeing through their own participation in mainstream training and development in Maori mental health techniques/tools</p>	<p><i>Workforce development</i> Amount of resource allocation to: GP training in Maori cultural assessments Intersectoral Forum of Government agencies’ destigmatisation training Workshop for Primary/secondary interface for people with depression Workshops on screening for depression, a Maori mental health self assessment tool</p>
Diabetes	<p><i>Awareness & utilisation</i> Whanau with a high risk of diabetes incidence have increased awareness of screening opportunities</p> <p>Whanau with a high risk of diabetes incidence have increased their use of diabetes screening services</p>	<p><i>Screening resourced</i> Supplementary resources allocated to a regional Maori diabetes programme administered and coordinated by Iwi/Maori providers Review report on GP services and PHO practices for their effectiveness in implementing strategies for opportunistic screening</p>
Oral	<p><i>Access for high risk</i> All Maori two and a half year olds are regularly checked for oral/dental health</p> <p>Whanau with low incomes and high risk of oral/dental</p>	<p><i>Low Income Regional Dental Service</i> Progress and review reports on improved oral health contacts for all Maori two and a half year olds</p>

	disease have increased oral/dental health awareness/knowledge and practices through effective dental health schemes and checks	Evaluation programme reports on improved Maori community uptake / utilization and effectiveness of low income dental schemes established Report on establishment of regional dental service for low income families
Respiratory	<i>Enhanced capacity</i> Maori community and Iwi/Maori providers have enhanced capacity to manage Maori with respiratory risk factors Whanau with a high risk of illness have increased awareness of screening prevention/promotion opportunities Whanau with a high risk of respiratory incidence have increased their use of diabetes screening prevention/promotion programmes	<i>Screening effectiveness</i> Amount of resource allocated to marae and hapu based wellness lifestyle programmes combined for other regional Maori 'Get Checked' programmes Number of Iwi/Maori providers supported to administer/coordinate programmes Two yearly review of respiratory screening programmes and management plans for their effectiveness in implementing planned strategies Amount of resource allocation to health professional training in respiratory screening for risk factors and integrated 'Get Checked' programme

Support And Self Management

Priorities	Maori Primary Health Outcomes	DHB Measures
Cancer	<i>Access</i> Whanau are able to access well coordinated care for cancer support and rehabilitation through services that are close to them and that support their values, practices and beliefs.	<i>Monitoring</i> Report on clinical/non clinical working environments supportive of disease state management of cancer amongst whanau Monitoring report on access for Maori to cancer services and improvements in Maori consumer satisfaction with cancer services
Depression	<i>Increased participation / knowledge</i> Whanau have improved participation in community life for their mental wellbeing: a strengthened identity improved knowledge of tikanga Maori pre-vocational skills maintained, developed	<i>Monitoring</i> Monitoring report on coordinated care in: Number of community and clinical service relationship agreements with Maori/Iwi/Maori providers/ Kaupapa Maori services Number of services with

Priorities	Maori Primary Health Outcomes	DHB Measures
	greater stability of lifestyle	referral protocols in place with community-based Kaupapa Maori services Number of services with a dedicated position of key worker/case manager Number of services with identified staff to meet identified needs Identified Iwi/Maori/whanau involved in WRAP workshops
Diabetes	<i>Support & appropriate choices</i> Maori with diabetes and their whanau have appropriate choices for the management and support of their condition Maori with diabetes have increased ability to manage it and share in diabetes education support sessions	<i>Analysis</i> Analysis provided on % diabetes clinical targets for Maori for case detection, management % eye screening covered % on Ace Inhibitor/A2 agents % tracking toward 2006/07 targets Cost analysis for resource allocation to Maori diabetes initiatives and programmes % increases in Maori participation, awareness, and self management of diabetes Review report for effectiveness & no. of new diabetes services/programmes to Maori
Respiratory	<i>Effective initiatives</i> Iwi/Maori providers/community/consumers have enhanced respiratory support and self management through effective initiatives for their conditions/services	<i>Monitoring</i> DSM review report with recommendations monitored for implementation Number of specific implementation plans commissioned for establishing specialist integrated respiratory services No of planned pathways identifying Maori content in each new service/model for respiratory care Evaluation reports of planned/resourced new respiratory support/self management initiatives

Treatment And Rehabilitation

Priorities	Maori Primary Health Outcomes	DHB Measures
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Priorities	Maori Primary Health Outcomes	DHB Measures
Cancer	<p><i>Quality of life</i> Whanau members with cancer demonstrate increased quality of life through effective strategies for their care and support</p> <p>Services for Maori by Maori increased with inclusion of Rongoa practitioners in palliative care</p> <p>Whanau cancer disease states have improved through management of care and continuing easy access to treatment / psycho-oncology</p>	<p><i>Effective service delivery</i> Rongoa Maori provider capacity funding to increase whanau support for palliative care</p> <p>Review report of multidisciplinary care strategies for effectiveness of new cancer treatments to Maori with cancer</p> <p>Review report of Specialist nursing and DSM services for effectiveness of coordinated care to Maori with cancer</p> <p>Number of Providers (Maori and mainstream) resourced patient-centred care in specialist palliative services</p> <p>Number of hui and workshops funded to develop effective strategies for Maori needing better access, referrals, and coordinated care for cancer</p> <p>% Maori continually accessing psycho-oncology services</p>
Cardiovascular	<p><i>Strengthened capability</i> CVD contributory risk factors reduced in Maori Maori individuals and whanau have strengthened capability to self manage CVD</p>	<p><i>Maori CVD programme</i> % of Maori with CVD with coordinated care plans</p> <p>Report on a Maori CVD programme is enhanced with Maori specialist workforce capability</p> <p>Number of Maori provider profiles identified through hospital admissions process</p>
Depression	<p><i>Whanau development</i> Whanau/Maori youth have improved quality of life through strengthened efforts for whanau development and waananga that meet their needs</p>	<p><i>Reviews</i> Review of two-pronged approach to supporting and resourcing Maori and mainstream services to deliver culturally competent services</p> <p>Number of cultural quality reviews of Maori and mainstream services maintained</p>
Diabetes	<p><i>Improved access</i> Increased and improved access to treatment for diabetes is achieved for Maori whanau through appropriate diabetes services</p>	<p><i>Monitoring performance</i> Monitoring and review report of information and data from LDT, Iwi/Maori providers, PHOs, Specialist secondary diabetes services</p> <p>% Maori diabetes targets achieved for District Annual Plan</p> <p>Number of referral protocols and treatment guidelines reviewed annually</p> <p>Report on appropriate primary/secondary responses</p>

Priorities	Maori Primary Health Outcomes	DHB Measures
		to Maori diabetes targets
Oral	<i>Improved access</i> Maori children and adults with high risk of chronic dental disease have improved access to affordable dental services	<i>Monitoring performance</i> Monitoring report on targets for Maori children and adults % performance measures established for oral health, annually Number of Dental/Dentist contracts aligned with accessible dental services for Maori
Respiratory	<i>Quality treatment/increased opportunities</i> Whanau respiratory illnesses improved through quality treatment and easy access to respiratory care that is culturally relevant to their needs Iwi/Maori providers and whanau have increased opportunities to influence delivery and innovation of respiratory services to them	<i>Effective performance</i> DSM recommendations monitored for implementation Number of appropriate initiatives / models/ services effective in respiratory treatment and rehabilitation for Maori Evaluation report on implementation of new respiratory initiatives/models/services that are culturally relevant and effective to Maori

Responsive Workforce

Priorities	Maori Primary Health Outcomes	DHB Measures
Cardiovascular	<i>Quality treatment</i> Whanau respiratory illnesses improved through quality treatment and easy access to respiratory care that is culturally relevant to their needs Iwi/Maori providers and whanau have increased opportunities to influence delivery and innovation of respiratory services to them	<i>Review & Evaluation</i> DSM review of recommendations for implementation Number of initiatives/models/services for Maori in CVD treatment and rehabilitation Evaluation report on cultural relevance and effectiveness to Maori for CVD initiatives/models/services
Depression	<i>Workforce strengthened capacity</i> Maori health workforce capacity strengthened through mental health strategies for training mainstream and Maori workforce	<i>Monitoring & evaluation</i> Monitoring and evaluation report of training programmes for Maori and mainstream Identified priority areas for Maori health workforce development and other training options inter/intra sectorally
Oral	<i>Workforce strengthened capacity</i> Maori health workforce capacity strengthened	<i>Funding/resourcing increased</i> Number of strategies to increase Maori participation in

Priorities	Maori Primary Health Outcomes	DHB Measures
	through oral/dental health strategies for training mainstream and Maori workforce	dental health service delivery Amount of funding to oral health education in high risk Maori population areas Amount of funding to Maori health workforce strategies for Maori components (including cultural competencies) of dental professional and other providers' training programmes Monitoring and evaluation report of training programmes for Maori and mainstream Identified priority areas for Dental health workforce development and other training options
Respiratory	<i>Informed/enhanced Maori health workforce</i> Maori whanau receive high quality care and education about respiratory conditions from an informed Maori health professional workforce Maori health professional workforce have enhanced ability to support their Maori clients with respiratory conditions, through well planned professional development pathways	<i>Support and resources</i> Amount of support and resources to Maori provider workforce for integrated primary care initiatives in respiratory education and training Amount of support and resourcing for DSM nursing professional development practices/principles as applied in their workplace environment

Planning Quality Research

Priorities	Maori Primary Health Outcomes	DHB Measures
Cancer	<i>Enhanced whanau ora developments</i> Whanau Ora developments and whanau health gains enhanced by Maori cancer research and information	<i>Research opportunities for Maori</i> Number of Maori cancer research opportunities identified and initiated Report on Maori cancer information for Maori service developments
Cardiovascular	<i>Improved access</i> Maori with CVD and their whanau have improved access to CVD services across the continuum of care for CVD	<i>CVD Maori Health Framework</i> % Maori capacity funding a Maori CVD caucus Report on development of Maori health framework for CVD service delivery across Maori and mainstream providers Report on implementation of the Maori health framework for CVD service delivery

Priorities	Maori Primary Health Outcomes	DHB Measures
		through Iwi/Maori providers and PHOs
Depression	<i>Inclusive service planning</i> Maori mental health and well being is enhanced by inclusive service planning, monitoring and quality focused programmes across the DHB	<i>Maori Depression Issues Service Plans</i> Monitoring report on service plans for Maori depression issues % Maori depression issues included in other key planning areas such as: Child Health Service Plan, and Disability Support Services Plan
Diabetes	<i>Culturally Enhanced Diabetes Services</i> High level of participation from Maori with diabetes and their whanau in the development, monitoring and review of culturally enhanced diabetes services to them.	<i>Capacity Relationships Resources</i> % Maori capacity funding for Whanau Ora Diabetes programme % Relationship agreements / protocols signed between Whanau Ora Diabetes programme and Diabetes Health Improvement Group, PHOs in the region, MidCentral's diabetes specialist workforce % Resources allocated to Maori component of Health Innovations programme
Oral	<i>Increased participation/Inclusive planning</i> Maori whanau (children, adolescents, and adults) have improved oral/dental health status through access to and utilization of all available dental health services Maori oral health is enhanced by inclusive service planning, monitoring and quality focused oral/dental health programmes/initiatives across the DHB	<i>Dental Access Plans</i> % Maori capacity funding to Iwi/Maori providers for development of Dental Access Plans Report for DHB District Annual Plan on support for the implementation of the Iwi/Maori providers' Dental Access Plans through Iwi/Maori providers, Mobile dental clinic service, oral/dental health services including Dentists, Child Health services, other oral/dental health initiatives and programmes
Respiratory	<i>Quality focused programmes</i> Maori health and well being is enhanced by inclusive service planning, monitoring and quality focused programmes across the DHB	<i>Coordination organization</i> Monitoring report of DHB planning workshops and initiatives for Maori health promotion strategies/techniques Evaluation report on implementation of a coordination organization with a broader health promotion approach

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