Auckland and Waitemata DHBs

Kaumātua Action Plan

2015 – 2018

Planning and Funding Team
Auckland & Waitemata District Health Boards

And

E ngā iwi, e ngā reo, e ngā karangatanga maha

Tēna koutou, tēna koutou, tēna koutou katoa

Kā rere hoki ngā mihi, ngā tangi, ngā poroporoaki kia ratou kua takahia kētia te ara namunamu, ā tane, ā kua piki atu koutou i te ahurutanga tuturu ki ngā ngā rangi tuhaha, okioki atu.

Na reira moe mai, moe mai, moe mai

Hoki mai kia tatou, tēna tatou katoa

Nei hoki te purongo pa ana ki te rōpu Kaumātua o Ngāti Whātua

Tēna ra koutou katoa

We hope to replicate within this document the proud legacy that our kaumātua have laid before us.

We acknowledge those kaumātua whose tireless endeavours in pursuit of health and wellbeing, recognition of tikanga Māori and tino rangatiratanga (self-determination) for their whānau, iwi and people benefit all of us who call Tāmaki Makaurau home.

In particular, Te Rūnanga o Ngāti Whātua, and Auckland and Waitemata DHBs, thank kaumātua rōpu from Te Whānau o Waipareira, Te Puna Hauora o te Raki Paewhenua, Te Hononga o Tāmaki me Hoturoa, Te Hā Oranga, Ōrākei Health Services and Ngāti Whātua who supported the development of this document.

The contents of the *Auckland and Waitemata DHBs Kaumātua Action Plan 2015-2018* were informed by the invaluable information you provided. This will impact on present and future kaumātua services right across the health sector in Tāmaki Makaurau.

Photo left to right: George Taipari and Ripeka Taipari with their mokopuna Te Kauri Taipari, Ron Baker, Patrick Taylor and his mokopuna Cody Waerena Faithfull

Foreword

Māori are living longer today than ever before. The availability of information about living healthy lifestyles, within environments that are more encouraging of this lifestyle, as well as greater access to advanced medical treatments and care, explain, in part, why.

Although an increasing kaumātua population is a cause for celebration, our enthusiasm should be tempered with the reality of, and inequities within, socio-economic and health data as they relate to kaumātua. For example, socio-economic data show that kaumātua are less financially stable than their non-Māori counterparts with fewer owning a mortgage free home or having access to savings. Within the Waitemata DHB catchment area, kaumātua do not have the same level of social support structures in place, or access to family members, in comparison to other populations.

An increase in kaumātua will also see an increase in age related illnesses amongst Māori. This will mean an increased demand on health and disability services across the board. However, the strain will be felt more so by those services designed to cater to older adults yet ill equipped, in many cases, to respond to the specific social and cultural needs of kaumātua.

The way in which services are designed and provided to older adults will also be affected as Māori live to and well beyond 65 years of age. This is the age by which the government deems a person to be an older adult. This is reflected in access criteria for many older adult services where one must be aged at least 65 years of age to qualify for that service. It should be noted, however, that the age for older Māori to qualify for certain services may be lowered to 55 years of age. This is testament to the fact that Māori experience age related illnesses at an earlier age as a result of health and socio-economic factors. Therefore, the standard 'older adult' age of 64 years may be too late for many Māori suffering from these illnesses before they can qualify for the necessary services and support.

All of these factors are a reality for many kaumātua, and will continue to be unless dramatic changes are made across the entire sector now. The *Auckland and Waitemata DHBs Kaumātua Action Plan 2015-2018* presents an opportunity for both Auckland and Waitemata DHBs, and their partners, to ensure Māori who reach their later years of life are living healthy and fulfilling lives in their communities, surrounded by their whānau and, when need be, have access to appropriate health services that meet their needs.

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1. Executive summary

The Māori population within New Zealand is aging. This is due to a combination of increasing life expectancy and decreasing birth rates among Māori (Waldon, 2004). As a consequence, the kaumātua population across Auckland is expected to double by 2026.

Tāmaki Makaurau is home to an ethnically diverse population (Auckland Council, 2014). The discourse on the need for culturally safe health services and a culturally competent health workforce is quite clear. A health service and workforce that recognises, and , more importantly, is able to respond to individual cultural needs of patients, through the integration of accepted and appropriate cultural protocols with high quality clinical practice, will have a demonstrable impact on the patient's health and wellbeing in the long run (Durie, 1998). Such a positive experience will have ongoing implications for the patient and their whānau. Patients that have had positive experiences when accessing health care will be more willing to engage with health services, have increased confidence to engage with health professionals and, therefore have a greater understanding of their health condition and what is expected of them to manage it, or prevent it, in the future. For Māori, who view health holistically and therefore see health as all encompassing of social, cultural and spiritual aspects (Durie, 1997), this point is extremely important for planners and providers of health services to understand.

Over the next ten years, we will see increasing numbers of Māori experiencing and presenting with age related illnesses to services currently unprepared, according to our engagement with kaumātua, to meet their social and cultural needs. A failure by services, and planners of these servicers, to meet these needs will impact negatively on the overall health and wellbeing of an increasing proportion of the Māori population, already unjustly overburdened with ill health (Robson & Harris, 2007).

The *Auckland and Waitemata DHBs Kaumātua Action Plan 2015-2018* (the Action Plan) is Auckland and Waitemata DHBs first step in recognising what implications this significant change to the Māori population, moreover the population of Tāmaki Makaurau, will have on the way in which services are planned, funded and provided to older Māori.

In three year increments, activities will be undertaken that contribute to the achievement of the overall vision for this Action Plan:

Kaumātua age well within our *rohe*

The activity within the Action Plan is based on:

- areas of need informed by kaumātua during consultation undertaken across Auckland and Waitemata in 2014,
- areas of inequity identified through analyses of health and social data collected by both Auckland and Waitemata DHBs and their partners, and;
- alignment with the national health targets, and local and national health strategies.

2. Health needs assessment summary

2.1 Demographics

In 2013 there were estimated to be nearly 1,400 Māori aged 65 years and older in Auckland DHB and over 1,600 aged 65 years and over in Waitemata DHB, and nearly 60 per cent were female (see Table 1). In terms of the total Māori population, this equates to only a very small proportion (3.7% in Auckland DHB & 3.0% in Waitemata DHB) of the Māori aged over 65 years. However, by 2026 this is expected to dramatically increase by more than double to 9.4% and 6.7% within each respective DHB area.

Table 1: Numbers of older Māori by DHB in 2013

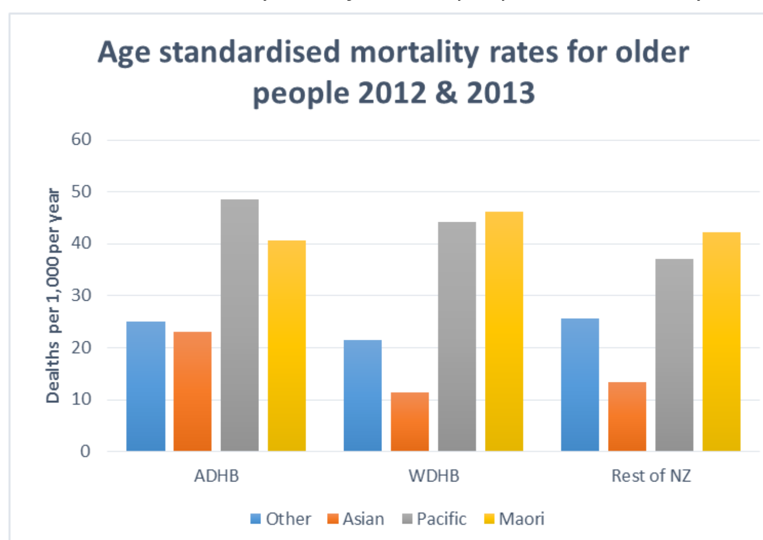
	Auckland			*Waitemata*		
	Men	Women	Total	Men	Women	Total
55-59 years	745	855	1600	900	1110	2010
60-64 years	540	615	1155	655	775	1430
65-69 years	315	370	685	365	500	865
70-74 years	190	235	425	180	280	460
75-79 years	95	115	210	80	150	230
80-84 years	15	50	65	10	60	70
85 years and over	0	10	10	5	5	10

2.2 Overall health status

2.2.1 Age standardised mortality rates

The Age standardised mortality rates for kaumātua (older Māori aged 65 years and over in this case) in 2012 and 2013 across both DHB catchment areas are considerably higher than 'Other'[1] ethnic groups. Graph 2 below shows that kaumātua in Auckland DHB are 60% more likely to die than their counterparts from the same illnesses, while for Waitemata DHB kaumātua are twice as likely to die from the same illnesses.

Graph 1: Age standardised mortality rates for older people 2012/2013 by DHB[2]



[1] Other means all ethnicities excluding Māori, Pacific and Asian

2.2.2 Acute Hospitalisation

Across Auckland and Waitemata DHBs, kaumātua are twice as likely to be hospitalised as members of the same aged cohort of Other ethnic groups. This includes hospitalisations for acute episodes for long term conditions they are managing as well as serious incidents including falls.

2.2.3 Influenza Vaccination

Approximately 60% of kaumātua enrolled Māori with a Primary Healthcare Organisation within Auckland and Waitemata DHBs received an influenza vaccination in 2013/14. Despite these vaccinations being free for kaumātua, the uptake amongst Māori is still significantly lower than non-Māori.

2.3 Access to support services

2.3.1 Aged residential care (ARC)

Māori make up only a very small proportion of the ARC population across both DHBs. Only 2.5% of the Waitemata DHB kaumātua population lives in ARC facilities. In January 2013 for example there was a total of 50 Māori funded or subsidised to live in an ARC facility. Similarly for Auckland DHB the numbers are extremely low. In April 2013 there were 58 Māori from living within Auckland DHB in funded ARC facilities which is 3.3% of the total older person population.

Table 2: Number and Proportion of WDHB Māori and Non-Māori in Aged Residential Care

Waitemata DHB	*65-74*	*75-84*	*85+*	*Total*
Number of Māori	14	30	6	50
Proportion of ARC population	5.4%	3.8%	0.5%	2.1%
Proportion of population in ARC				
Māori	1.0%	6.4%	10.0%	2.5%
Non-Māori	0.6%	3.5%	14.3%	3.3%

Note that if people pay the entire cost of ARC privately they will not be captured in ARC statistics. This means that the true difference in ARC use between Māori and non-Māori is likely to be greater as the non-Māori population is more likely to be able to afford private ARC.

2.3.2 Home Based Support Services (HBSS)

Only a small number of Māori receive HBSS (just over a 100 in each DHB), and make up a small proportion of total users (see Table 3). While kaumātua seem to have a marginally higher utilisation within each age group they also have a significantly higher hospitalisation rate. This suggests that Māori may be accessing HBSS support proportionate to population size but not equitably in proportion to need.

Table 3: Number and Proportion of ADHB and WDHB Māori and Non-Māori receiving Home Based Support Services

Proportion receiving HBSS	***Auckland DHB***				***Waitemata DHB***			
	65-74	75-84	85+	Total	65-74	75-84	85+	Total
Māori	3.0%	14.5%	21.4%	6.5%	1.9%	12.3%	26.7%	5.2%
Non-Māori	2.6%	12.5%	22.0%	8.0%	1.5%	10.5%	25.7%	7.3%

2.3.3 Dementia

There is a scarcity of reliable information about the prevalence of dementia amongst kaumātua. Table 4 shows the estimated number of Māori in Auckland and Waitemata with dementia in 2013 to 2026. These estimates are based upon British prevalence studies applied to our populations. Following the application of British rates, the information below suggests the proportion of people with a diagnosis of dementia on admission to hospital in New Zealand is 50% higher for kaumātua than for European older people.

Table 4: Estimated number of Māori in Auckland and Waitemata with dementia in 2013 to 2026

Age Group	***Prevalence estimate (%)***	***WDHB estimates***			***Auckland estimates***		
		2013	**2021**	**2026**	**2013**	**2021**	**2026**
65-69	1.3	11	16	23	9	14	18
70-74	3	15	25	31	14	22	27
75-79	5.9	20	28	44	16	25	39
80-84	12.2	16	30	41	18	33	39
85-89	20.3	10	16	27	11	22	34
90+	28.6	3	12	17	6	12	20
Total		**75**	**128**	**183**	**74**	**127**	**178**

2.3.4 Palliative care

It is difficult to assess access to palliative services because we do not have needs estimates and actual utilisation from the same years. Best estimates suggest utilisation of community hospices in both DHBs by Māori seems to be in accordance with need (see Table 5).

The table below includes all cancer deaths and deaths from non-cancer palliative conditions (heart, liver and renal failure, COPD, AIDS/HIV, and a range of neurological conditions). The numbers for Māori are about equally spread between people younger and older than 65 years of age. This is in stark contrast to non-Māori where over three quarters of palliative care deaths are aged over 65 years.

Table 5: Estimated number of deaths each year amongst Māori that may have resulted in palliative care

	Waitemata			*Auckland*		
	<65	65+	Total	<65	65+	Total
Non-Cancer Palliative	2	7	10	5	5	10
Cancer	24	20	44	26	20	46
All Palliative	**26**	**27**	**53**	**31**	**25**	**57**
Not palliative	54	38	92	45	37	82
Total	80	66	146	76	63	139

2.4 Socio-economic status

Socio-economic status is a determinant of health and wellbeing (Marmot et al, 1987). That is, your health is determined by a number of complex factors not traditionally associated with health including, for example, level of education, access to essential services, and employment. For Māori, who associate health and wellbeing with factors beyond their physical health, this should be expanded to include community and cultural factors as well (Robson & Harris, 2007). These latter two factors are compounded when living in highly deprived areas. Moreover, social connectedness can contribute positively to community and cultural factors by providing increased access to cultural facilities and experts, and eliminating the effects of loneliness.

Graph 2 shows that older Māori tend to live in middle to higher deprivation areas, particularly in the Auckland DHB region. Table 6 shows that a significant proportion of kaumātua live alone, particularly women.

Graph 2: Proportion of older Māori population living in NZDep quintile areas by DHB

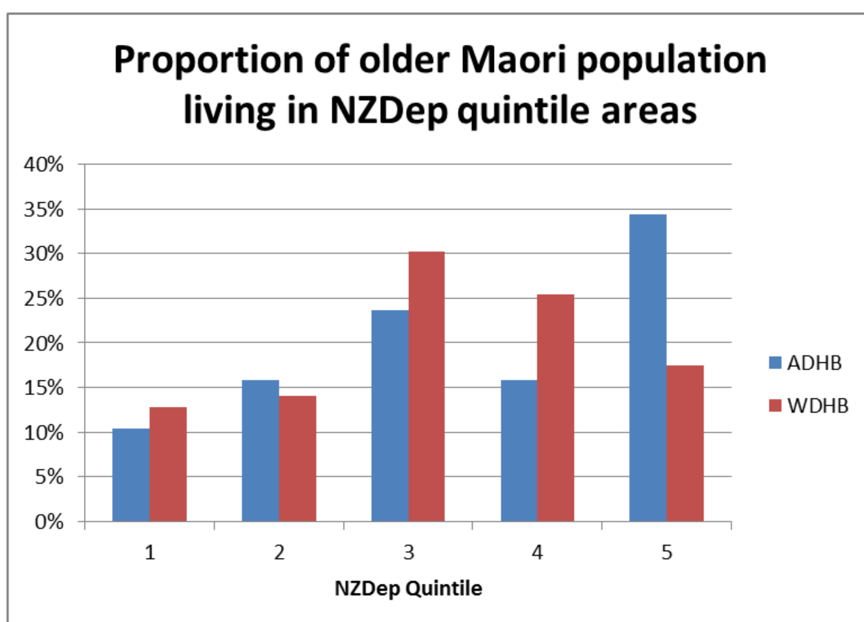


Table 6: Percentage of Māori living alone by gender and DHB

	Male	*Female*
Auckland DHB	25%	35%
Waitemata DHB	16%	26%

3. Prioritisation process

The prioritisation process for this Action Plan was made up of three key aspects. The first involved consultation with a number of kaumātua rōpu (existing older Māori groups and networks) across Auckland and Waitemata DHB regions.

The consultation process involved a total of 57 kaumātua, many of whom had at some point received, or were currently involved in receiving, health care. In total, six consultation meetings were run over a 3 month period (September 2014 - November 2014). In order to access the appropriate cohort for the consultation process, partnerships with a number of Māori providers were entered into where they were charged with bringing together kaumātua. This was an extremely effective method as many already had existing kaumātua rōpu.

A general inductive approach (Thomas, 2003) was used to analyse the qualitative data and develop main themes. From these themes a number of priority areas for activity were identified.

The areas identified by kaumātua during consultation included:

- **Access:** Access to timely, financially viable supports within the hospital, community and their own home
- **Kaupapa Māori:** Māori led health and disability services based in the community
- **Clinical and Tikanga quality:** A workforce that understood their health and cultural needs
- **Māori workforce:** Preferably a Māori workforce supporting them
- **Health literacy/information:** Being informed of what is available and having an understanding of their health and disability needs

The second component involved a detailed analysis of available health data. This process produced information about what services were being accessed by kaumātua, resource allocation, and an overall picture of kaumātua health. It should be noted, however, that this analysis found that reliable data for this cohort of the Māori population was difficult to ascertain due to poor data capturing protocols across the sector. The small total numbers of kaumātua accessing health services or experiencing ill health also made comparisons to the wider population extremely difficult. This aspect of the process also involved comparing feedback from the kaumātua rōpu to health data. This gave us a picture of need within the community that showed major gaps between what is needed and what is currently offered. This process also provided qualitative information about the quality of the services both DHBs' provide and purchase.

This analysis showed that:

- The kaumātua population across both DHBs is growing rapidly,
- Kaumātua are living in more deprived areas especially within the Auckland district,
- Mortality amongst kaumātua is considerably higher than that of the older Other ethnic group,
- Kaumātua are twice as likely to be hospitalised than older Other ethnic group in both DHBs
- Māori may not be accessing Home Based Support Services equitably in proportion to their need.

The third and final step of the prioritisation process was strategic alignment. In order to align the activity within this Action Plan to current national, regional and local strategic policy, the following documents were reviewed. The *Guide to He Korowai Oranga: Māori Health Strategy 2014*, *The Health of Older People's Strategy 2002*, *Auckland DHB Healthy Ageing 2020 Plan 2006*, *Waitemata DHB Health of Older People Strategy 2006*, *Auckland & Waitemata DHB 14/15 Māori Health Plans*, *Auckland & Waitemata DHB 14/15 Annual Plans, and Waitemata – Auckland DHB Māori Health Workforce Development Strategy 2014-2017.*

The important themes identified within these documents included:

- Pae ora (healthy futures) provides a platform where Māori can live with good health and wellbeing in an environment that supports a good quality of life,
- Whanau Ora is a whānau-centred approach that involves providing support that strengthens whānau capacities to undertake functions that are necessary for healthy living and contributing to the wellbeing of whānau members and the whānau collective,
- Ngā kaupapa tuku iho requires acknowledgment and respect for Māori values, beliefs, responsibilities, protocols, and knowledge that are relevant to and may guide health service planning and service delivery for Māori,
- Achieving best health outcomes for whānau and health equity for Māori is a whole-of-system responsibility,
- Support and enable older people to participate to their fullest ability in decisions about their health and well-being,
- Support them to stay at home when it is safe and cost effective to do so,
- Work with local iwi and Māori communities in planning, purchasing, delivering and monitoring culturally appropriate services for older Māori and their whānau
- To increase the number and improve the skills of the Māori health and disability workforce

At the conclusion of the prioritisation process, the following areas were identified for action:

1. Supporting development of Māori led community based support programmes for kaumātua,
2. Ensuring Māori values, beliefs, responsibilities, protocols, and knowledge are used to guide health service planning and service delivery for Māori,
3. Strengthening the Māori workforce involved in older people's health,
4. Ensuring Health of Older people models of care and services are highly responsive to and incorporate Māori needs,
5. Ensuring Home Based Support Services meet the needs of kaumātua while also assisting them to live in the community when they choose to,
6. Preventing ill health where possible, especially via flu vaccinations,
7. Ensuring kaumātua who need residential care have options that meet their needs, and
8. Ensuring kaumātua who have a Dementia diagnosis have options that meet their needs.

Action outline, monitoring and reporting for Year 2015/2016

No#	Activity	Key Actions	Monitoring Measurement	Responsibility	Funding requirements	Reporting Frequency
1	Collaborate with Te Rūnanga o Ngāti Whātua to develop Tikanga Best Practice Guidelines for Aged Residential Care (ARC) that align with the District Health Boards ARC Quality Framework	• Develop guidelines and audit framework • Align with ARC Quality Framework • Dissemination of Guidelines amongst ARC facilities • Training package developed and piloted • Implementation of guidelines and training package	• Development of guidelines completed by December 2015 • Guidelines disseminated by June 2016 • Training completed by June 2016	Planning and Funding Team (HoP)	Existing	Yearly
2	Work in partnership with Alzheimers Auckland to develop and pilot standardised performance indicators for mainstream services that can measure improvement in outcomes in Maori Health Gain	• Development of indicators • Development of data dictionary • Implement training • Implementation of indicators • Disseminate individual and collective performance	• Develop indicators by Ocober2015 • Development of data dictionary by Ocober2015 • Training completed by December 2015 • Implementation of indicators by February 2016 • Disseminate	Planning and Funding Team (Māori Health Gain), Planning and Funding Team (HoP) Alzheimers Auckland	New	Yearly

No#	Activity	Key Actions	Monitoring Measurement	Responsibility	Funding requirements	Reporting Frequency
		results	individual and collective performance results by June 2016			
3	Work with joint HBSS working group to ensure that the newly developed service delivery model and funding model, which will go out to procurement in 2015/2016, is responsive to Māori needs and enables Māori providers to participate in the delivery of HBSS to kaumātua	• Participate in the development of the new model through joint HBSS working group	• The procurement of a HBSS model that is responsive to Māori home-based needs • The procurement of a HBSS model that is financially viable for Māori providers to participate in	Planning and Funding Team (HoP Team), Planning and Funding Team (Māori Health Gain)	Existing	Yearly
4	Work in partnership with ADHB Rapid Response Team to link Māori clients with Māori services within the community	• Work with Rapid Response team to understand their target group • Ensure target group criteria considers higher Māori need • Identify what services in the community	• Māori clients linked with Māori providers by June 2016	Planning and Funding Team (Māori Health Gain), Māori Providers, ADHB Rapid Response Team	Existing	Yearly

No#	Activity	Key Actions	Monitoring Measurement	Responsibility	Funding requirements	Reporting Frequency
		delivered by Māori providers meet these needs • Develop directory of services including Māori provider services • Develop mechanisms for making linkages between Rapid response team and Māori providers				
5	Investigate the feasibility of developing and implementing an equity focussed incentivised flu vaccination programme for Māori 65+ based in primary care	• Develop an equity-focussed, incentivised flu vaccination programme for Māori aged 65+ years and based in primary care • Implement programme • Equity-focussed, incentivised flu vaccination programme	• Develop programme by December 2015 • Implement programme by March 2016 • Programme completed by June 2016	Planning and Funding Team (Māori Health Gain), PHOs, Planning and Funding Team (Primary Care)	Existing	Yearly

No#	Activity	Key Actions	Monitoring Measurement	Responsibility	Funding requirements	Reporting Frequency
		completed				
6	Complete a comprehensive analysis of the Māori workforce within Health of Older people provider arm services	• Obtain data • Analyse data • Report findings	• Obtain data by August 2015 • Analyse data by December 2015 • Report findings by March 2016	Planning and Funding Team (Māori Health Gain)	Existing	Yearly
7	Investigate the need and feasibility of developing a Māori specific group based community support programme that address the issues of social isolation and loneliness for older Māori	• Review literature – re current models dealing with social isolation and loneliness and kaupapa Māori models • Stocktake of current services that address social isolation and loneliness across both DHBs • Develop a demographic profile of the Māori clients receiving these services and where they live • Report	• Review literature by August 2015 • Stocktake of current services that address social isolation and loneliness across both DHBs by August 2015 • Develop a demographic profile of the Māori clients receiving these services and where they live August 2015 • Report recommendations by October 2015	Planning and Funding Team (Māori Health Gain)	Existing Note: New funding will be needed if new approach is deemed feasible	Yearly

No#	Activity	Key Actions	Monitoring Measurement	Responsibility	Funding requirements	Reporting Frequency
	recommendations					

Action outline, monitoring and reporting for Year 2016/2017

No#	Activity	Key Actions	Monitoring Measurement	Responsibility	Funding requirements	Reporting Frequency
8	Investigate with ARC providers the feasibility of developing and implementing a Maori model of care	• Evaluate current indigenous models by reviewing literature • Key informant interviews • Complete stocktake of what Aged Related Residential Care services currently existing • Evaluate effectiveness of current services • Develop demographic breakdown of this group • A report with recommendations submitted to Manawa Ora	• Evaluate current models by October 2016 • Complete stocktake of services by December 2016 • Evaluate effectiveness of current services by March 2017 • Develop demographic breakdown of this group by March 2017 • A report with recommendations submitted to Manawa Ora by June 2017	Planning and Funding Team (Māori Health Gain), Planning and Funding Team (HoP Team)	Existing Note: New funding will be needed if new model is deemed feasible	Yearly

No#	Activity	Key Actions	Monitoring Measurement	Responsibility	Funding requirements	Reporting Frequency
9	Evaluate whether CARE model processes, care planning, and treatment protocols are achieving health equity for Māori	• Qualitative research completed • Evaluation report recommending improvements completed	• Qualitative research with Māori CARE participants completed June 2017 Evaluation report completed by June 2017	Planning and Funding Team (Health Outcome Team), Planning and Funding Team (Māori Health Gain)	Existing	Yearly
10	Introduce and socialise standardised Maori performance indicators with the range of Mainstream providers	• Implement Communication Strategy • Maori Health Gain Performance Indicator training • All new and renewed mainstream service provision contracts contain the Mainstream Maori Health Gain Performance Indicators	• Implement Communication Strategy across mainstream providers advising about the new performance targets and the rollout timeframe – Mass communication strategy completed by 30 September 2016 • Maori Health Gain Performance Indicator training for Mainstream Providers available	Planning and Funding Team (Māori Health Gain), Planning and Funding Team (HoP)	New	Yearly

No#	Activity	Key Actions	Monitoring Measurement	Responsibility	Funding requirements	Reporting Frequency
			at regular intervals across 2016/2017 • All new and renewed mainstream service provision contracts from 1 July 2017 will contain the Mainstream Maori Health Gain Performance Indicators			
11	Investigate level of stress for Maori/ Whanau carers and identify options to address this (eg respite care, education, flexible packages of care)	• Consultation with Maori clients and whanau • Work in collaboration with HoP stakeholders to identify the possible support mechanisms to address this issue • Report recommending improvements completed	• Complete consultation with Maori clients and whanau by Dec 2016 • Identify the possible support mechanisms by Mar 2017 • Report recommending improvements by June 2017	Planning and Funding Team (Māori Health Gain), Planning and Funding Team (HoP)	Existing	Yearly

Action outline, monitoring and reporting for Year 2017/2018

No#	Activity	Key Actions	Monitoring Measurement	Responsibility	Funding requirements	Reporting Frequency
12	Develop Health Needs Analysis (HNA) for older Maori	• Determine scope and content • Obtain and analyse available data • Identify information from published literature e.g. Lilac study • Develop report • Identify gaps and priority areas • Disseminate findings	• Collect by Ocober2017 • Priority Areas determined by December 2017 • Report completed by March 2018 Report released by June 2018	Planning and Funding Team (Health Outcome Team), Planning and Funding Team (HoP Team) Planning and Funding Team (Māori Health Gain)	Existing	Yearly

4. Glossary

4.1 Glossary of Māori words and terms

Iwi	Tribe/grouping
Kaumātua	Older Māori (both male and female), within this document used to describe 'older Māori' or Māori aged 65 years and older
Kaumātua rōpu	A group of older Māori
Kaupapa Māori	Used to describe 'by Māori, for Māori' methodology
Mokopuna	Grandchild
Ngā kaupapa tuku iho	Māori values, beliefs, responsibilities, protocols, and knowledge
Rohe	A defined geographic area
Tāmaki Makaurau	The Māori name for Auckland City
Whānau	Family or, more broadly, support structures
Whānau ora	Māori model of care, literally means family health

4.2 Glossary of abbreviations

ADHB	Auckland District health Board
AIDS	Acquired Immune Deficiency Syndrome
ARC	Aged Residential Care
DHB	District health Board
CARE	Co-ordinated care, Assessment, Rehabilitation, Education Project
COPD	Chronic Obstructive Pulmonary Disease
GNS	Gerontology Nurse Specialist
HBSS	Home Based Support Services
HIV	Human Immunodeficiency Virus
HNA	Health Needs Analysis
HoP	Health of Older People
InterRAI	Aged Care assessment
WDHB	Waitemata District Health Board

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