Manawanui Whai Ora Kaitiaki (Supporting a Pathway to Wellness)

Long Term Conditions Whanau Ora Programme

Interview with Lindsey Webber, Deputy CEO, Hauraki PHO

Background

Manawanui Whai Ora Kaitiaki (MWOK) started as a pilot programme supported with innovation funding through the Ministry of Health's Self-Management and Shared Care contract. The programme is funded through the Hauraki Hauora Alliance Flexible Funding Pool. The MWOK model of care is intended to respond to patients with Long Term Conditions (LTCs) through empowering people with LTCs to successfully self-manage their condition in partnership with a range of practitioners. Patients who are more actively engaged in their self-care are more likely to experience better health outcomes. The focus on a partnership approach activates and empowers patients and is designed to mitigate dependency.

The focus of MWOK is on those patients with complex health issues who have the highest hospital admission rates (top 5%). To be eligible for the programme people must have:

- two of eight identified LTCs including Diabetes, ischaemic disease, asthma, COPD, Ischaemic Heart Failure, Renal impairment, depression and anxiety
- more than 3 hospital admissions in past year
- frequent presentation to ED
- frequent or nonattendance at primary care.

GPs refer patients who the GPs think might benefit from more intensive assessment and intervention which GPs don't have the time to do. MWOK started enrolling patients in September 2014. Hauraki PHO has an enrolled population of 132,000 and approximately 300 people and /or whanau are in the programme at any one time. Patients generally remain in the programme for a period of about 6 months and during this time receive intensive social and health support.

The programme

- Nurse (employed by PHO) outreach service to address LTCs
- The MWOK team consists of seven registered nurses partnered with seven health care kaiawhina.
- The team works as part of an integrated model with Hauraki PHO practice team partners, community support teams, and community and hospital-based health service provider colleagues. The team proactively provides wrap around support to high-needs individuals and their family/whānau. Existing whānau ora/mobile nursing and kaiawhina services are incorporated into a continuity of care model to avoid duplication of care.

The model of care supporting the programme transcends traditional health and social sector boundaries and incorporates clinical, social and environmental interventions and navigation support.

The model of care is patient/whānau centred and:

- provides care that is respectful, responsive and meaningful to the individual patient preferences, needs and values and that ensures the patient and whānau goals inform clinical decisions.

- encourages high quality and sustainable long-term condition management within the community that empowers individuals and their whānau to take control of their wellness.
- is accessible, equitable and culturally appropriate.

Centred in primary care with referral from primary care

First the patient has a home-based assessment, often including their family. The assessment and care plan are developed using the Flinders tools. The team usually starts working on social issues. The kaiawhina connect with agencies around social needs, improve health literacy and focus on activating patients and families so they are less reliant on health services.

Example: A patient's poor housing is having an impact on his respiratory health. Team contact housing provider, set up key worker relationship with housing provider and work with the patient until they are confident enough to manage the relationship themselves.

There is a small discretionary fund which the programme can use. For example, if a patient has stopped going to see their GP because they owe money to the GP, the programme will pay the debt and set up a regular payment system so that the patient doesn't accumulate debt in the future.

Current situation

Kaiawhina (navigator) role working in partnership with Case Manager (RN).

Holistic approach to assessment and care planning.

Focus on patient activation/shared care planning.

Evaluation framework at project initiation means data has been collected throughout the project.

Key findings from evaluation after one year

- Improvements in health literacy and patient activation.
- Increased patient involvement in managing their LTCs.
- Improvements in adherence to treatment and health advice.
- Improvements to patient health and wellbeing.
- Support with social care needs assisted patients to focus more specifically on their health needs.
- Reduced avoidable hospitalisations.
- More appropriate use of health care.
- Changed model of care at one practice.

Challenges

1. **Getting buy -in from practices at the beginning**

The original vision for the programme was to have it based and 'owned' by primary care. In the past 'silo' services have been put in and haven't worked because of lack of integration with primary care teams. The kaiawhina and nurses are employed by the PHO but are seen as part of the practice team resources. The kaiawhina and nurses document care in the patient PMS, attend multidisciplinary team reviews and practice team meetings.

2. **Need to get the right people into the role**

The nurses are highly skilled primary care nurses with broad primary care experience and people who can work independently. The kaiawhina come from a range of backgrounds, including social work, care assistants, and mental health. Key factors for kaiawhina are having good networks, understanding community, and knowledge of NGOs.

3. **Care planning function**

Have an electronic care plan in Medtech. Developed to be patient friendly so can be viewed through patient portal but most patients have a paper copy stuck to the fridge. Technology is a challenge. Ken Leech from Procon developed the care plan. Next step is to develop a cloud-based care plan that can be accessed and updated by patients and all members of the multidisciplinary team. Waikato DHB HealthTap project will also be a key enabler to improving patient access to their health information.

4. **Flexible funding pool from DHB was a challenge**

Traditionally many service contracts have been based on volumes and outputs. The PHO are working with the DHB to create better understanding and funding formula based on the quality of health improvements rather than quantity of patients going through the programme and outcome sustainability rather than any immediate improvement seen at the end of the programme.

5. **Measurement Tools**

Had to rewrite PACIC so patients could understand it.

Used CollaboRATE to measure GP/patient collaboration.

Key learnings

- Importance of understanding the relationship and expectations with practices. Set up an agreed way of working in partnership with patients. Kaiawhina have to be absolutely integrated into the team. Often in health teams, there is a hierarchy with the doctor at the top then the nurse and on down the chain. This needs to change.
- All members of the team are Flinders trained. This supports team work as everyone on the team has a common understanding about what they are doing and trying to achieve.
- Flexible funding pool.
- Electronic care plan.
- Measurement tools.

- Practices need to have these components:
    - Electronic Support Tools
    - Monthly practice payment from flexible funding pool for protected nurse and admin time for care plan development and implementation
    - Electronic Care Plan tool
    - Clinical Champions based in general practice and the PHO
    - Self-management support and resources.

References

Manawanui-Whai-Ora-Kaitiaki programme: Implementation and initial outcomes. Presentation by Synergia, Nov 2015

Manawanui Whai Ora Kaitiaki: Empowering self-management through a partnership approach. Presentation by Debi Whitham & Elizabeth Johnson Long-Term Conditions Workshop, Ministry of Health April 2017

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