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 they think might benefit from more intensive assessment and intervention which GPS don't have the time to do with patients..MWOK started enrolling patients in September 2014. Hauraki PHO has an enrolled population of 132,000 and there are approximately 300 people and /or whanau in the programme at any one time.

The programme

Nurse (employed by PHO) outreach service to address LTC

Patients generally remain in the programme for a period of about 6 months and during this time receives intensive social and health support. The Manawanui Whai Ora Kaitiaki team consists of registered nurses partnered with health care kaiawhina. The team works as part of an integrated model with HPHO practice team partners, communiity support teams and community and hospital-based health service provider colleagues, to proactively provide wrap around support to high-needs individuals and their family/whanau Existing whanau 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 across traditional health and social sector boundaries and incorporates clinical, social and environmental interventions and navigation support.

It is a model of care that is patient/whanau centred and:

- Provides care that is respectful, responsive and **meaningful** to the **individual** patient preferences, needs and values and that ensures the patient and **whanau goals** inform clinical decisions.
- Encourages high quality and **sustainable** long term condition management within the community that **empowers** individuals and their whanau 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 includes their family. The assessment and care plan are developed using the Flinders tool. Usually start working on social issues first. 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 and work with the patient until they are confident enough to manage the relationship themselves.

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 from the beginning

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 because in the past 'silo' services have been put in and haven't worked because of lack of

integration with primary care teams. The Kaiawhina (7) and nurses (7) are employed by the PHO but are seen as part of the practice team resources Tthey document care in the patient PMS, attend MDT reviews and practice team meetingsetc.

2. Need to get the right people into the role.
   The nurses are highly skilled primary care nurses with broad primary care experienceand people who can work independently. The Kaiawhina come from a range of backgrounds, including social work, care assistants, mental health etc. 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 Leach from Procon developed the care plan. Next steps to develop a cloud based care plan that can be accessed and updated by patients and all members of the MDTWaikato DHB Healthtap project will also be a key enabler toimproving 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. 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. Tools used to measure
   Had to rewrite PACIC so patients could understand it.
   Needed a tool to measure GP patient collaboration. . Used CollaboRATE

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 programmes in health there is a hierarchy with the doctor at the top then the nurse etc.
- 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 FFP 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