Manawanui Whai Ora Kaitiaki:

Empowering communities to improve health outcomes through a partnership approach

Phase 2 Evaluation
July 2018
Background

- Hauraki PHO- a Kaupapa Māori Primary Health Organisation operating within the Waikato DHB district
- 150,000 patients supported by 36 general practice clinics
- Māori 34%, Pacific 5%, Quintile 5 36%.
- Total population is older than the national average.
Our Vision

E whakakaha ana i te oranga me te mana o te whānau me ngā hapori
Empowering wellness and mana in whānau (family) and communities
Our Values

- Ko ngā pou (Foundations)
- Whanaungatanga (Whānau/patient-centric relationships)
- Tika (Doing what is right with Integrity)
- Aroha (Love and Respect)
- Whakamana (Empowerment)
- Pono (Working in an ethical way)
The MWOK model

- Commenced Jul 2014 and rolled out to all HPHO practices during 2014-15 year
- Centred in general practice
- Built on the concept of nurse and kaiawhina outreach service to address LTC
- Provides intensive wrap around support for short term duration (up to 6 months)
- Applied Te Whiringa Ora experience to incorporate social determinants of health
- Embeds principles of Te Whare Tapa Wha
**Programme Logic for MWOK Model of Care**

**MWOK aim:** To provide a model of care that empowers people with long-term conditions (LTCs) to successfully self-manage or share-care of their condition with the goal of experiencing better health outcomes.

<table>
<thead>
<tr>
<th>MWOK Inputs and Activities</th>
<th>Increased capacity</th>
<th>Behaviour change</th>
<th>Health outcomes</th>
<th>System outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>The MWOK model of care is provided by a team of registered nurses partnered with kalawhina.</td>
<td>Increased patient activation:</td>
<td>Improvement in patients’ lifestyle and riskfactors:</td>
<td>Improvement in patients’ health and wellbeing:</td>
<td>Improvements in health equity</td>
</tr>
<tr>
<td>Initial patient engagement, rapport building and development of a trusting relationship.</td>
<td>• Skills</td>
<td>• Smoking status</td>
<td>• Improvement in clinical indicators e.g. HbA1c</td>
<td>Reduction in preventable ED presentation and hospitalisations from MWOK patients</td>
</tr>
<tr>
<td>An assessment of need that goes broader than the presenting medical issues, based on the Te Whare Tapa Whā model of health.</td>
<td>• Knowledge</td>
<td>• Use of drugs and alcohol</td>
<td>• Improved management of symptoms associated with LTC</td>
<td>Cost savings associated with reduced ED utilisation</td>
</tr>
<tr>
<td>A series of home visits where they can see clients in their home environment and have more time and opportunity to identify and support patients’ health, social, and cultural needs.</td>
<td>• Confidence</td>
<td>• Physical activity</td>
<td>• Reduction in complications related to the LTC</td>
<td></td>
</tr>
<tr>
<td>Development and implementation of a shared care plan.</td>
<td></td>
<td>• Diet and nutrition</td>
<td>• Reduction in acute health events</td>
<td></td>
</tr>
<tr>
<td>Referring patients to other social, community and health services in their comprehensive networks.</td>
<td></td>
<td>• Engagement with general practice</td>
<td>• Reduction in utilisation of ED</td>
<td></td>
</tr>
<tr>
<td>Advocacy on behalf of patients to improve social determinants.</td>
<td></td>
<td>• Adherence to medical treatment</td>
<td>• Improved quality of life</td>
<td></td>
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<tr>
<td>Self-management support and education.</td>
<td></td>
<td></td>
<td>Sustained changes in patient wellness.</td>
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</tr>
</tbody>
</table>

- Improved shared-care:
  - Empowerment
  - Health Literacy
  - Self-management
The MWOK model

What’s different?

• Kaiawhina (navigator) role working in equal partnership with Case Manager (RN)
  • 8 FTE RN – 8FTE Kaiawhina
• Holistic approach to assessment and care planning
• Focus on patient activation/shared care planning
• Empowerment model – three way partnership
Three way partnership

Activated patients

Supportive system

- Working in partnership
- Sharing decisions
- Planning care

Optimal functional and clinical outcomes

Prepared, proactive teams

COMMUNITY
All ready to go
To identify

- changes in patient wellbeing.
- sustainability of changes in patient wellness.
- contribution to changes in system level outcomes.
- key considerations for the transferability of the model of care to other contexts.
- areas for modifications and improvements.
- recommendations for ongoing evaluation and monitoring
Methodology:

- Quantitative analysis of MWOK service data, clinical outcome data, and hospital utilisation data (Hauraki PHO)
- Thematic analysis of a sample of qualitative case notes recorded by MWOK staff (Synergia)
- Interviews with practice staff, and key stakeholders working across child and youth health (Synergia)
Referrals to MWOK - Ethnicity

Proportion of enrolled/referred population

- Asian
- European
- Māori
- Other
- Pacific Island
- Unknown

Hauraki PHO  MWOK
Referrals to MWOK - Age
Referrals to MWOK - Quintile
Utilisation Rates before and after MWOK

- High users (n=16)
- Medium users (n=72)
- Low users (n=50)

Number of appointments with GP in 12 months

Before | After
--- | ---
Before | After
Before | After
Before | After
Evaluation Phase 2 Findings

- Improvements in patient activation as demonstrated by more appropriate GP utilisation rates and health literacy.
- Action to support patients’ emotional wellbeing and experiences of the social determinants of health.
- Actions to support self-management and improvements in adherence to treatment and health advice.
- Increasing numbers of smokers attempting to quit.
- Improvements in diabetes management.
- Likely to be reducing blood pressure and reducing BMI.
Average ED presentations before and after MWOK (n=138)

Before MWOK: 1.13
After MWOK: 0.86
### Kaiawhina activity – types of support provided

<table>
<thead>
<tr>
<th>Type of Support</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical observations</td>
<td>45</td>
</tr>
<tr>
<td>Referral</td>
<td>42</td>
</tr>
<tr>
<td>Education</td>
<td>22</td>
</tr>
<tr>
<td>Advocacy</td>
<td>14</td>
</tr>
<tr>
<td>Support for home help</td>
<td>12</td>
</tr>
<tr>
<td>Support clients to appointments</td>
<td>9</td>
</tr>
<tr>
<td>Social support</td>
<td>9</td>
</tr>
<tr>
<td>Housing support</td>
<td>7</td>
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</table>
Impact of MWOK on Smoking Cessation

Before (n=681):
- Smokers: 38%
- Accepted referral to cessation: 28%

MWOK (n=637):
- Smokers: 56%
- Accepted referral to cessation: 28%

After (n=257):
- Smokers: 57%
- Accepted referral to cessation: 25%
Summary of improvements

- Measured improvements in individual health outcomes
  - 108 Patients reduced their HbA1c
  - Average reduction in BMI of 0.3kg/m²
  - 144 Patients reduced their systolic blood pressure

- Significant improvement in patients’ ability to self-manage their LTCs
  - Engagement rates up for low utilisers
  - Utilisation rates down for patients with complex LTCs
Impact of MWOK on reduction of HBA1C levels for diabetic patients

Before (n=383): 22%
MWOK (n=360): 38%
After (n=153): 39%
The learnings

- Practice partnerships key to success
- GP as MDT lead
- Community facing approach works. Patients lead the way – goals need to be their goals not our goals
- Value of the RN and Kaiawhina roles as equal partners
- Need for ongoing evaluation to measure long term sustainability of improvements