The Rise and Fall of Te Whiringa Ora
An Integrated Care model for Long Term Conditions

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Community Health

Presentation to Edad & Vida
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Agenda

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- Health in New Zealand
- Who is Healthcare NZ?
- Te Whiringa Ora – the model
- Results of the Evaluation (the ups)
- Success Factors
- What happened next (the downs)
- Lessons to Share

New Zealand

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- Population = 4.78 million
- Maori are our indigenous people = 15.6% of the New Zealand population

Life expectancy at birth (2013)			
Maori Male	Non-Maori male	Maori Female	Non-Maori female
73.0 yr	80.3 yr	77.1 yr	83.9yr

- Cardiovascular disease mortality rate> 2x higher in Maori than Non-Maori
- Cancer mortality 1.5x higher in Maori than non-Maori

Eastern Bay of Plenty

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- Declining population
- 48% Maori
- 50% low socio-economic
- 26% of Maori are unemployed

Who is Healthcare NZ?

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- Largest Home Based and Disability provider in NZ – covers whole of NZ
- Specialises in providing home and community-based health, rehabilitation and disability support services
- 7,000 people support 18,000 clients
- All services delivered in the home

Te Whiringa Ora –Background (TWO)

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- Was a response to the Minister of Health's request for new models of care to address health inequalities
- Te Whiringa Ora (Maori word) means to weave a web of care around the client (TWO)
- Was in Partnership with the local Primary Health Organisation (PHO)

Our Drivers

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Make better use of ***existing resources*** (provider ecosystem)

Greater use of supervised but ***unregulated staff*** (non-clinical)

Greater use of patients own personal resources

- The concept of 5000 hours
- Improve clients self-management and self-efficacy

Objectives

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Focus on clients with complex and chronic conditions and high users of hospital services (top 5% of all hospital admissions)

Wrap a web of care around client and their family

Utilise the existing ecosystem – GP still ‘Medical Home’

Help clients navigate health and social systems

Reduce hospital admissions and burden of demand

AIM IS TO IMPROVE CLIENT’S SELF MANAGEMENT

How it works

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- Case managers (*registered nurses*) work with the client and family to complete an *assessment* (Flinders)
- Patient-driven care plan ensures co-ordinated access to services *"what matters to you"*
- One-on-one support *(with family)*, education and guidance provided by specially trained *health coach/navigator*
- Takes a *holistic view* and focuses on client's entire wellbeing
- Non-dependency model - support period of 3-6 months
- *Telehealth* technology allows remote monitoring of client's wellbeing, and *reinforces self-management*

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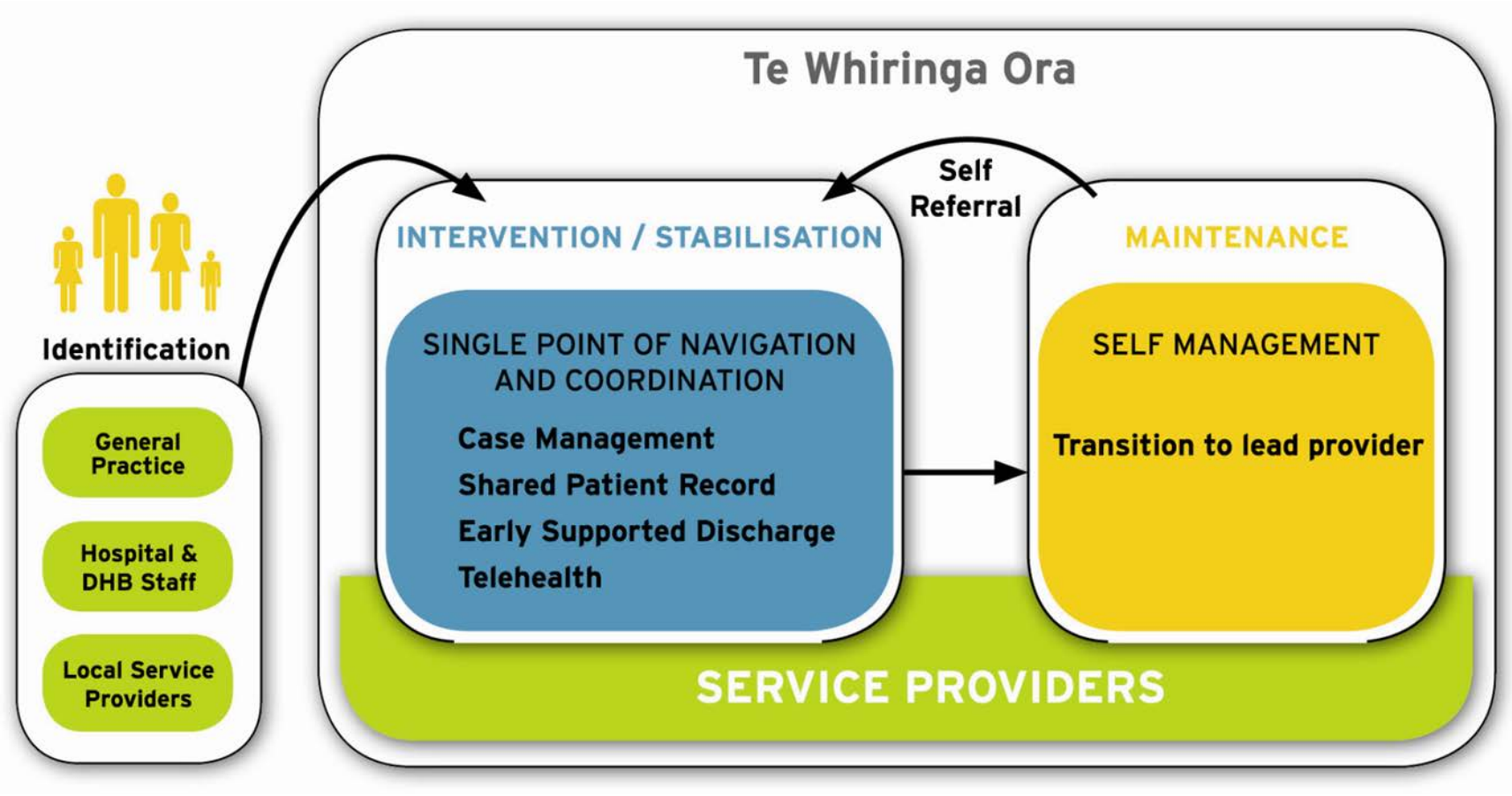

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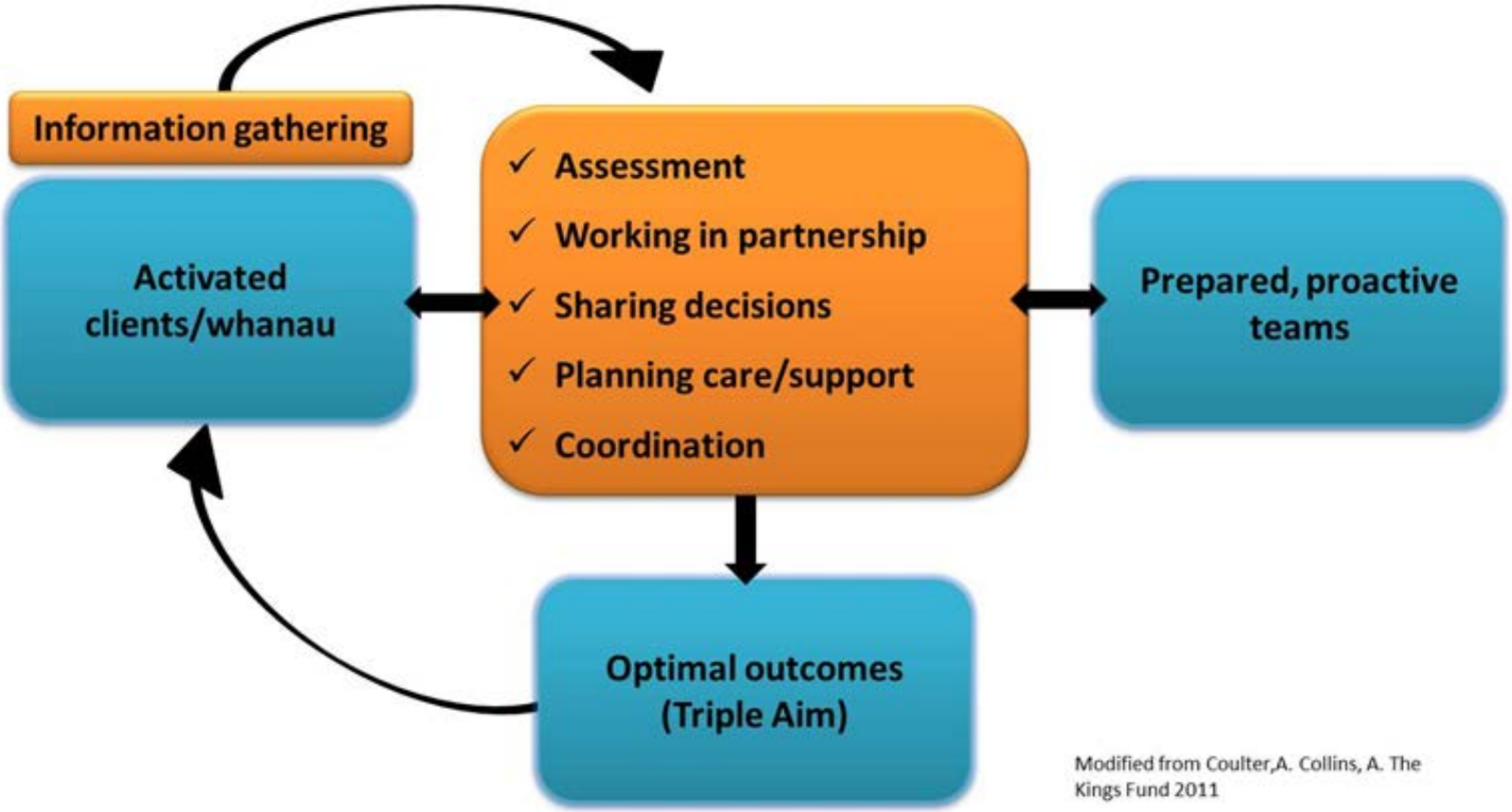
Conceptual model of Integrated care/Support



Modified from Coulter,A. Collins, A. The Kings Fund 2011

Examples of Goals

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TO BE ABLE TO RIDE MY BICYCLE AGAIN

1. To increase physical activity.
   - Referral to physiotherapist for assessment and advice re; suitable exercise programme
   - Implement activity programme with assistance from support work
   - Referral to respiratory educator for development of COPD management plan
2. To improve management of activities of daily living
   - Gained home help from HCNZ through Veterans Affairs.
3. To improve emotional wellbeing and reduce anxiety
4. To complete a will

Examples of Goals

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TO TRAVEL TO AUSTRALIA TO VISIT FAMILY

1. To improve knowledge of chronic conditions
   - Referral to respiratory educator for assessment and advice
   - Provide written information about stroke, high blood pressure,
2. To have review of medications to avoid medication interaction, and have better understanding
3. To be assessed by podiatrist.

Results of the Evaluation

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- Service was implemented Feb 2011
- Analysed the first 250 clients with one year pre- and one year post- data
- Half were Maori, over half were women
- Age range 26-98 (average age 69)
- Average Length of Stay of 5 months

Triple Aim

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Approach to optimising the health system that pursues 3 dimensions:

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

Improving the Patient Experience

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"They've brought me back to where I didn't think I'd ever get back to again"

- Male client, NZ European

Client interviews suggested that Te Whiringa Ora:

- Is appropriate for Māori, non Māori and those disengaged in health services
- Is responsive to clients needs and readiness to engage
- Has a holistic approach and looks at broader needs

Stakeholder Feedback

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"Clients sometimes don't attend their appointment at GP clinic. The Clinic doesn't follow up and 'chase' the client". Whereas with TWO service, if the client is not at home for their appointment when TWO staff arrive, the TWO staff will keep returning until they see the client.

"They cut our workload in half and freed us up to do clinical work."

Improving the health of populations

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Key findings:

10% reduction in bed days for clients

47% increase in bed days for the control group

COPD clients: 22% increase in admission free days

Diabetes clients: 89% increase in admission free days

ED presentations: 88% increase in days between events (COPD clients)

All clients experienced a clinically **significant increase** in their **SF-12 scores** (**quality of life** assessment tool)

Overall, clients spent more time at home and less time using in-patient services

Hospital Visits

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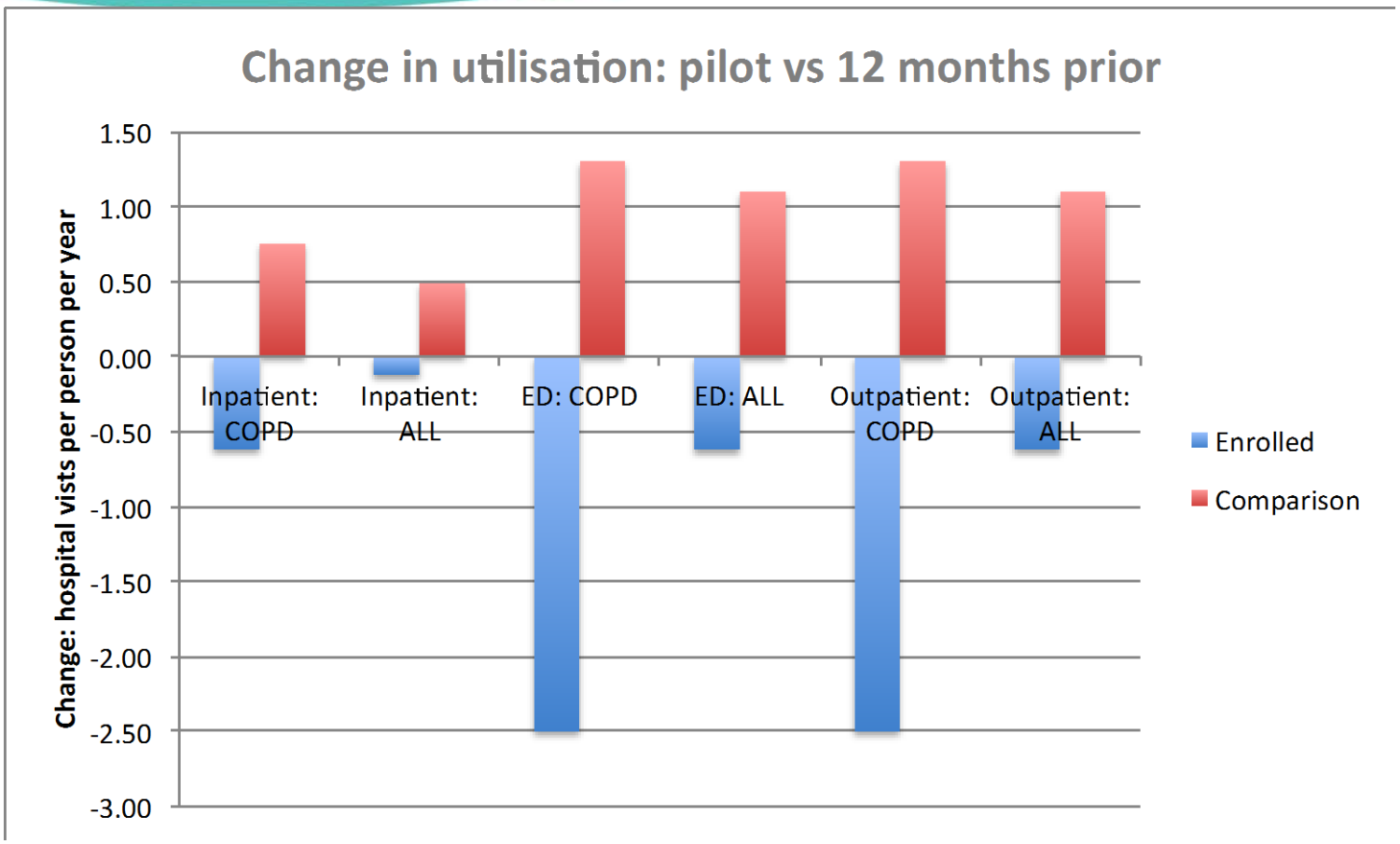

Reducing the per capita cost of health care

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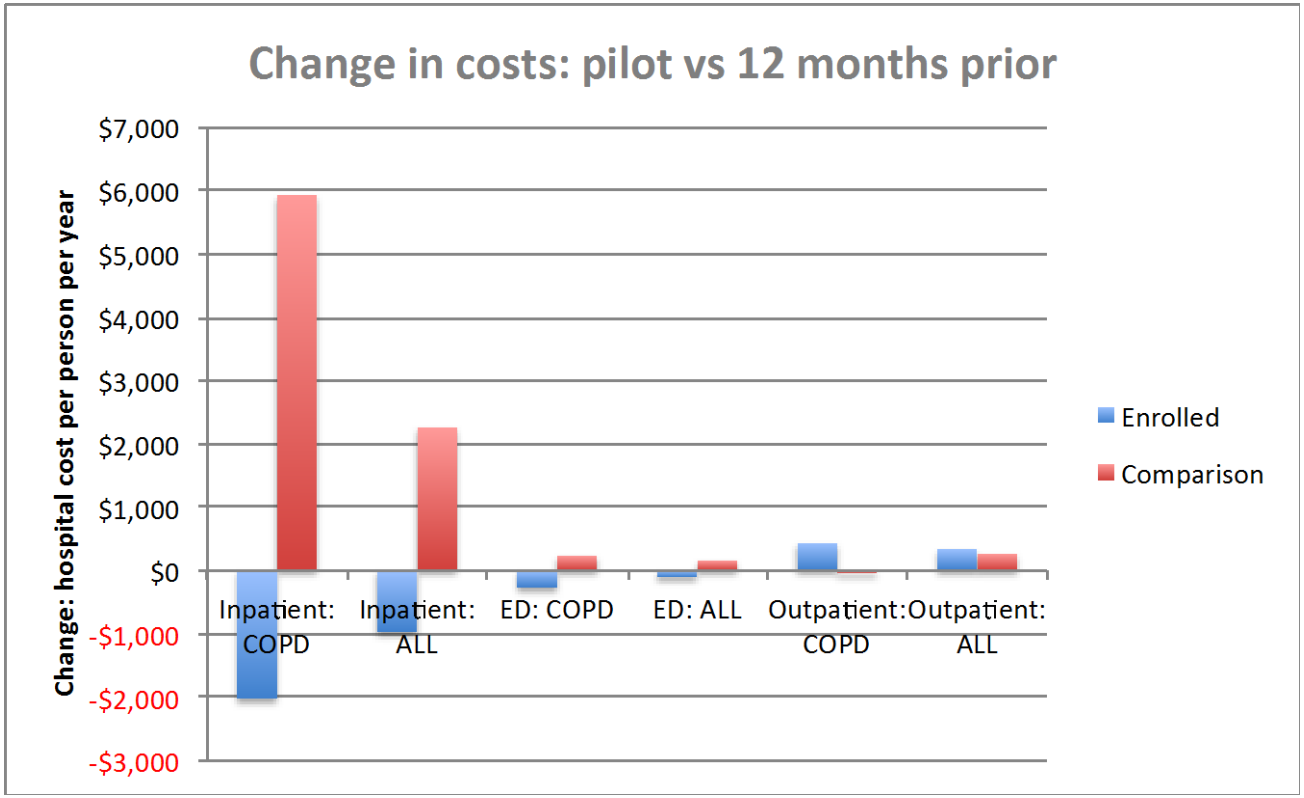
- Cost-minimisation study



Economic value

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- TWO associated with average annual savings of $3,416 per person post enrolment (approx € 2200)
- When extrapolated over 5 year funding horizon, projected savings exceed the cost of delivering the programme
- At full capacity, breakeven was at 1 year

What enabled the Self Management?

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Paradigm shift

- Patient in the drivers seat – their goals (non-medical)
- Quick wins to re-engage
- Self management – non-dependency

Service model - level of client engagement

Holistic view

Health coach support

The setting – services delivered in the home

Telehealth reinforced the lessons

Lessons To Share

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- Huge investment in developing and debating every component of service model
- It takes time for the team to evolve
- Good training & leadership for unregulated workforce required
- Uptake to full capacity (referrals) takes time
- Assessment tool – match to philosophy of service
- Design evaluation framework at the beginning
- Consider what barriers need to be overcome to implement a new service

What happened next?

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- 2013 - proposed service redesign paper was tabled
- Contract as it was, to be terminated 31 March 2014
- Extended until 30 June 2014 – model not ready
- New contract and modified service model July 2014
- May 2016 – notification from the funder they would bring service ‘In-house’ by end of the year
- Staff moved to PHO at the end of December 2016

What Changed in the Model?

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- PHO reduced funding and took over the administration and to some extent management
- Referrals had to come through GP (became gate keeper)
- No capture through ED, hospital ward, community providers
- Barrier of having to pay to see GP
- Care Plan had to be started by the GP ie GP goals
- HCNZ lost ability to monitor and collect the results
- No evaluation – focus on outcomes reduced

Outcomes

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- Referrals dropped
- Type of client changed – younger, often already self-managing
- Less of the ‘disengaged’
- Focus on self-management or just management?
- Assessment tool changed
- Less rigor, no evaluation of whether this was the population we should be serving or whether the outcomes met the Triple Aim

My suggestions to you:

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- Stay true to the philosophy of what you are trying to achieve
- Remember: WHO Global Strategy Goal 1 – Empower & Engage people
- Goal setting provides a sense of achievement, empowerment and self-worth (but only if goals of importance to patient?)
- Integrated care puts the patient first – not the organisation, not the health professional
- Use the evidence to develop your model, don't disregard it
- Be brave enough to evaluate what you do

Final words

"The best I found now is that I I'm in control of my life, my health and also anything that pops up I know exactly where to go, what to do."

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Gracias/ Alguna pregunta?

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NZCare Disability
Healthcare Rehabilitation
Mental Health NZ
Explore Specialist Advice NZ
Wellcare Training NZ