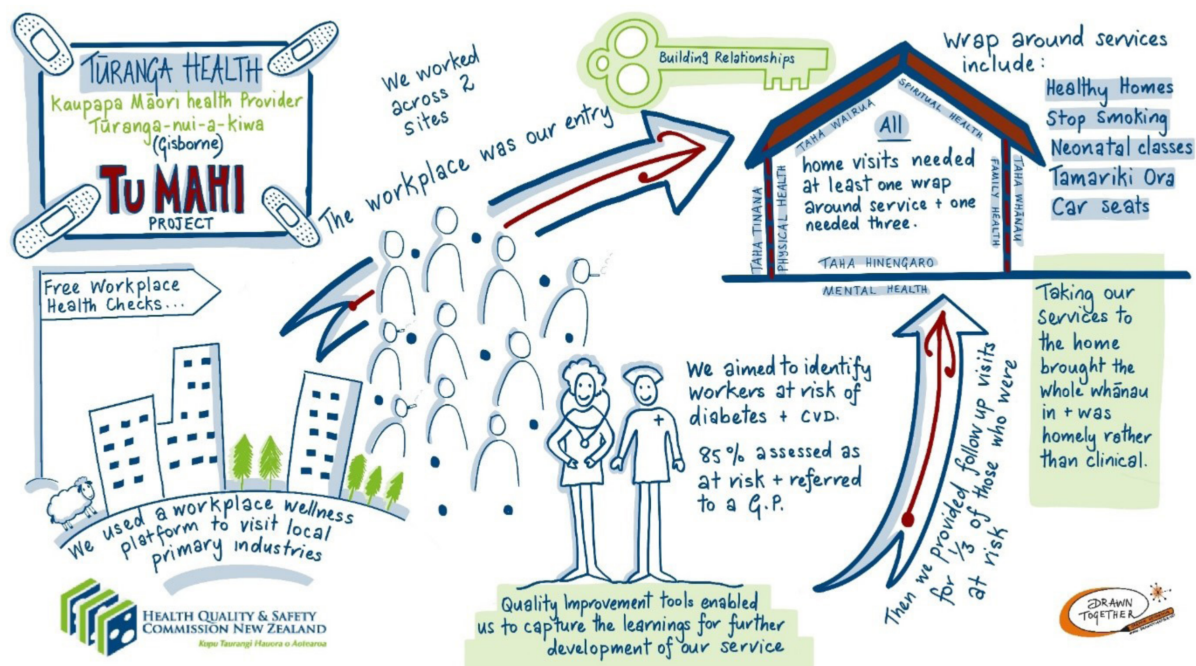
Primary care improvement case study

Turanga Health: Tu Mahi project

A workplace wellness platform that transitions individuals with long-term conditions to whānau-centred care and responsibility in the whare

Number 11 in a series of 18

Project overview



At present, the current literature and research align with our 'at the coal face' experiences that Māori access to primary and secondary care health services is poor. This translates to poor and inequitable health outcomes for Māori.

Turanga Health's intent with this project is to address the issues of poor access and introduce options to facilitate and increase participation of Māori in primary health care and so reduce the demand on secondary care.

HEALTH QUALITY & SAFETY COMMISSION NEW ZEALAND
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Te Hauora o Turanganui a Kiwa Ltd
Turanga Health
TIRAORA

The factors contributing to these disparities are extensive in the Tairāwhiti, Gisborne, region. As indicated in System Level Measures data, compared with non-Māori, Tairāwhiti Māori experience higher levels of: mortality rates, comorbidities, ambulatory sensitive hospitalisations, rheumatic fever, obesity, dental caries and asthma. Their life expectancy is also lower than for non-Māori.

These factors, combined with other socioeconomic and cultural issues, such as poor housing, unemployment, poor education, lack of transport, lack of civic duty, loss of identity and language, have detrimental effects that perpetuate a cycle of poor health for whānau. Turanga Health believes poor access to health care is directly connected to systemic failures over time. Along with this, the inability of health services providers to connect with at-risk vulnerable populations has translated into inequity in health services, disparity of health care and non-responsiveness to consumer engagement. Turanga Health is addressing this disparity through its workplace wellness platform. This project established the evidence base for the programme and identified, streamlined and strengthened our programme processes.

Background and context

Turanga Health is an iwi-owned health company delivering public, primary and personal health services within the Turanganui a Kiwa, Gisborne, district. The company has traded since 1997 and serves a population of mainly Māori, low socioeconomic, rural–urban whānau. Turanga Health is a member of the Midlands Health Network and, through this relationship, has engaged both the very low-cost access and integrated family health care platforms for the region.

The Tairāwhiti population is nearly 45 percent Māori and, of those, 70 percent are welfare beneficiaries with an average income of around $15,000. Three out of ten Māori in the region work in the primary industries, and more than a quarter live outside the main urban areas (New Zealand Census 2013).

In 2012, Turanga Health entered the primary health care space by taking ownership of a rural general practice. This created the potential to canvass co-design features of integrated care and consumer engagement, implement kaiāwhina (non-clinical) roles in general practice, provide wrap-around services, like healthy homes initiatives and car seats, and promote community-based lifestyle activities.

Over the past three years (2015–18), Turanga Health's workplace wellness platform has been piloted with several small-to-medium primary industry businesses, their respective employees and their whānau. It is an early intervention real-time platform that creates an interface for connectivity between a primary health care provider, primary industry employers, employees and their whānau. The workplace wellness platform delivers several screening interventions that focus on smoking, heart disease, blood pressure, weight, blood sugar, general practice connectivity and healthy lifestyle options. The platform is led by clinical and non-clinical staff who can be mobile and flexible with their time and place, for example, they may have 5.00 am starts and/or visit locations such as the bush or squash paddocks. Those employees identified through the screening as high risk are referred to their doctor and/or connected with a general practice alongside whānau- and whare-centred follow up by our service.

The Midlands Health Network is interested in adopting the Tu Mahi model and extending the approach across its network. Involvement in the Health Quality & Safety Commission's quality improvement programme, Whakakotahi, helped us capture learnings from the Tu Mahi project and develop a model for future use.

Diagnosing the problem

Ambulatory sensitive hospitalisations in Tairāwhiti are well above the national average, and one of the highest areas of avoidable hospitalisations, and heart-related diseases account for over 40 percent of deaths in the region. Because mortality- and morbidity-related issues, such as smoking and obesity, are preventable lifestyle factors, this suggests eligible and enrolled Māori in Turanganui a Kiwa have poor access to primary care services.

The (SMART) aim

To increase the access to primary care services by introducing wrap-around services in the home for all at risk whānau identified in two workplaces by February 2019.

Turanga Health's wrap-around services are defined as:

- health checks
- healthy homes
- Tamariki Ora
- lifestyle programmes
- nutritional advice.

The measures

Turanga Health identified the following measurement outcomes (short and long term) for the workplace wellness platform:

- whānau engagement (access to services)
- knowledge and attitudes (health literacy improved)
- management of condition (both individual and whānau health literacy improved)
- access to primary health care (pharmacy, general practitioner (GP))
- access to community care (wrap-arounds – physical activity and so on)
- civic duty (active participation in and awareness of community attachment and cultural obligations).

Outcome measures

Integrated wrap-around services

1 Number of referrals for wrap-around services generated per home visit.
2 Number of services delivered per home visit.

Denominator:
Number of employees identified as at risk.

Process measures

Integrated wrap-around services

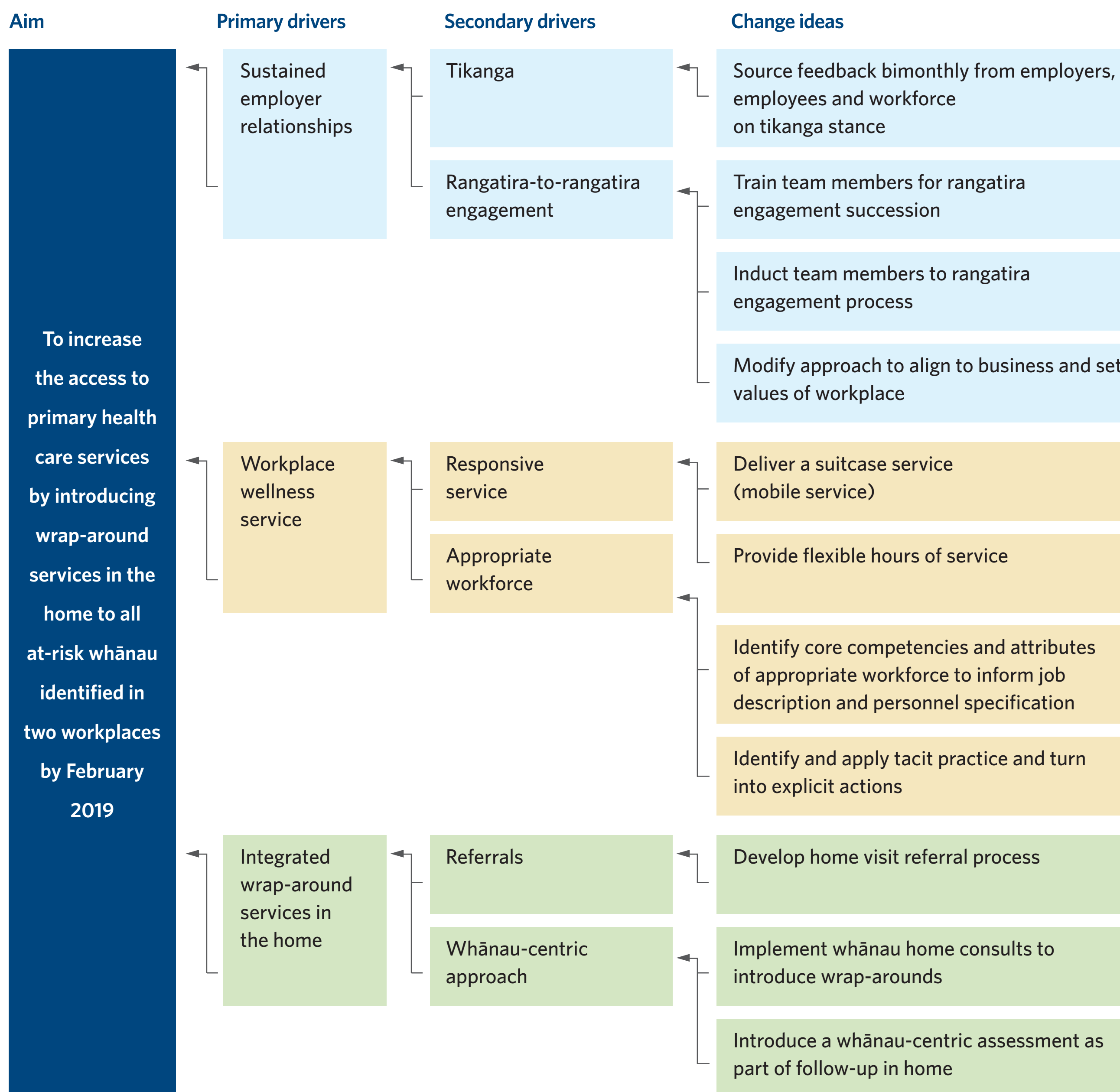
1 Number of accepted home visits.
2 Number of home visits completed.
3 Number of whānau engaged per home visit.

Denominator:
Number of employees identified as at risk.

Drivers of change

The diagram below shows the drivers and change ideas we identified as needed to achieve our aim.

Driver diagram



To achieve our aim, we needed to maintain our relationships with the employers. The workplace wellness service is a range of services that we offer employees to support their wellbeing and includes health checks, flu vaccinations, advice on smoking cessation and nutritional education. Through this service, we identify those at risk and then offer wrap-around services in their home.

What did you do?

1 Were there any ethical considerations to be aware of?

Informed consent was gained from both employers and employees at each stage of the project. We used an engagement letter to obtain formal consent from the employer. We also discussed the need to maintain patient confidentiality and had a formal sign-up sheet that covered consent with the employees. We also gained permission from employees to send any health information to their GP and to visit their homes. We needed permission from their whānau as well.

2 What aspects of the project were co-designed with consumers?

We routinely collect 'Whānau Voice', which informs our service improvements on an ongoing basis. 'Whānau Voice' is collected from both the employer and the whānau on a quarterly basis. Whānau Voice is collected by telephone and face-to-face interviews, and we also have an online survey.

For this project, we collected consumer feedback on the home visits (examples are given below).

"Whānau feedback – home visits"

- *I'd be open to have another home visit*
- *Weekend visit was a good time*
- *My husband enjoyed the experience*
- *Our whare was cold and the nurse connected us to a healthy home programme*
- *Had a positive experience and would open home again*
- *We are expecting a baby and the nurse connected us to antenatal classes*
- *Initially thought a home visit would be helpful*
- *Home visits are important for ongoing support*
- *We felt comfortable being in our home*

Employer feedback:

Employers were worried about their staff and were pleased to see them receiving wrap-around services for the whole whānau. Employers could see the benefits of their staff being well so they could continue to work but also to provide for their whānau.

3 What quality improvement tools did you use that you would recommend?

We used the fishbone diagram and Health Equity Assessment Tool (HEAT) to gain a wider understanding of the problem, but process mapping and the plan-do-study-act (PDSA) cycle were the most useful for getting down to the detail.

Process mapping:

We used process mapping with staff to understand our referral pathway and develop the home-referral process. This involved sticking multi-coloured Post-it notes on a wall to help us track who was doing what and ask why it was being done and was it necessary for the process. A lot of our changes came out of the process mapping. See Appendix 1 for the data collection form we developed from the mapping process. See the diagram over the page for our final Tu Mahi process.

Tu Mahi process

Employee

Kaiawhina
- Fill in CVRA forms (if applicable)
- Basic checks (registration and so on)
- Initial checks (height, weight, WC)

Nurse 1/nurse 2
- CVRA checks
  - Lipids
  - HbA1c
- BP, HR, BSL, smears, mammograms
- Family and personal health (CVRA/basic)
- Risk calculated from data
- Fom numbers, calculated on all – high, moderate, low. Education is still done

Nurse 1/nurse 2
- CVRA checks
  - Lipids
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- BP, HR, BSL, smears, mammograms
- Family and personal health (CVRA/basic)
- Risk calculated from data
- From numbers, calculated on all – high, moderate, low. Education is still done

Basic health check

Wellness check

Basics
- BP, HR BSL, HbA1c and so on
- WT/WC/HT
- Smears, mammograms

Wellness check
- Risks and indicators

Wrap-arounds
- Smoking cessation and so on if needed

Offer
- Follow-up in the home, workplace or Turanga Health if needed

High risk?
- **Elevated readings** + at least 1 + smoker
- **Elevated readings** + LTC
- **Elevated readings** + not regularly seeing GP
- **Elevated readings** + at least 2 + not registered with GP
- On medication + not seeing GP

Moderate risk?
- **Elevated readings** + LTC but registered with GP + meds
- **Elevated readings** + no LTC but registered with GP
- **Elevated readings** + LTC, registered with GP, no meds
- Not registered with GP, no LTC, no abnormal readings
- No elevated readings, registered with GP, smoking

Low risk?
- **Normal readings** + LTC, meds, seeing GP regularly
- **Normal readings** + No LTC, meds, seeing GP regularly

Cardiovascular risk assessment (CVRA)

High risk 15%–20% ► **Educate around numbers** Cholesterol, blood pressure, BSL and so on ► **Educate around diet/lifestyle** Smoking, exercise and so on ► **Offer** Referral to GP > client and information sent ► **Register** with Turanga Health for follow up

Offer wrap-arounds
- Smoking cessation, physical activity and so on

Offer follow-up
- In the home, work or at Turanga Health

Moderate risk 10%–15% ► **Educate around numbers** What makes them at risk? ► **Educate around diet/lifestyle** Smoking, exercise and so on ► **Offer** Referral to GP > client and information sent ► **Offer** Register, if consenting to Turanga Health

Low risk <100% ► **Educate around numbers** What do the numbers mean? BP, BSL and so on ► **Educate around diet/lifestyle** Smoking, exercise and so on ► **No follow-up required**

Note
BP = blood pressure
HR = heart rate
BSL = blood sugar level
HT = height
CVRA = cardiovascular risk assessment
LTC = long-term condition
HbA1c = glycated haemoglobin level
WC = waist circumference
GP = general practitioner
WT = weight
HC = health care

Plan-do-study-act:

PDSA cycles helped us to capture changes and be clear about what we were looking to improve, to review and reflect on those changes, to see if they worked and, if not, to try again. The discipline of putting ideas down on paper was useful, we had been good at 'doing' the PDSA but not capturing the learning. By writing ideas down, we learnt from our PDSA cycles and this helped us to measure our changes to see if they were an improvement or not. It worked well as a team activity so the whole team owned the results.

PDSA cycles:

Developing the whānau script to ask for a home visit.

Cycle one objective:

Develop a script for staff to ask whānau for a home visit.

- **Question:** What will make up the whānau script?
  - **Prediction:** One to three questions will be identified and explored.
  - **Plan:** Scope the whānau script with staff. Review and modify the script with staff.
  - **Do:** Brainstorm the script with staff. Source feedback from other staff and type up the script.
  - **Study:** Whānau script to be delivered by the nurse. Three questions developed:
    1. Follow-up from workplace check.
    2. Organise a time for follow-up.
    3. Invite whānau to be there.
  - **Act:** Test script with Gisborne Fisheries.

Cycle two objective:

Test the script.

- **Question:** How many clients will accept having whānau at home visit?
  - **Prediction:** Fifty percent will accept the home offer with whānau.
  - **Plan:** Test home visit offer in the workplace. Review and modify home offer script.
  - **Do:** Test script in the workplace with staff. Source feedback from staff on use and outcomes.
  - **Study:** Tested script with employees of Gisborne Fisheries. Feedback was that the script was simple and direct. One hundred percent use of the script. Three clients invited to bring whānau and 100 percent accepted having whānau present at home visit. Clients keen to invite whānau.
  - **Act:** Continue testing with other businesses using the same staff.

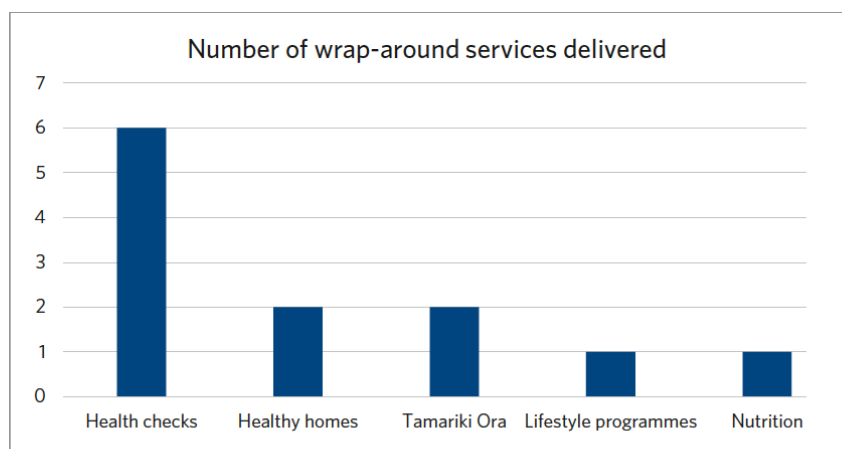
4 What changes did you test that worked? (List below)

- Planned and standardised the face-to-face employer engagement with a form that is jointly signed by employers and Turanga Health (see Appendix 1).
- Developed and standardised the home visit process and script (see Appendix 2).

Results

1 What outcome measures improved?

The number of referrals for wrap-around services generated per home visit increased. Each home visit generated at least one referral and up to three for 'wrap-around' services, as shown below, giving an average of two referrals per visit. All the referrals for wrap-around services were accepted and delivered, achieving 100 percent.



Seventy-two people are employed across the two workplaces that we collaborated with. Of these employees, 15 were identified as 'at risk', following the Heart Foundation Cardiovascular Disease Risk Assessment.

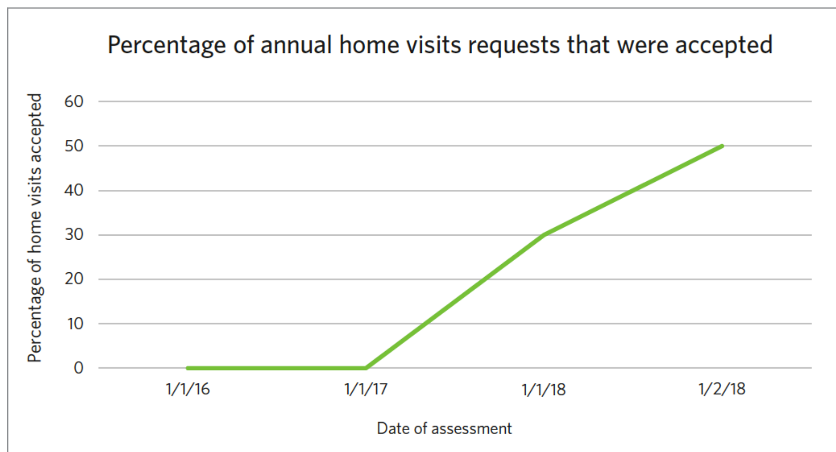
Fifteen whānau were offered home visits and six were accepted. Although the number was low, each involved the wider whānau and generated needed services that contributed to improving the wider determinants of health that would not have otherwise been accessed. This is a fundamental principle of an equity-driven service. We provided more services tailored to those in the greatest need, to close rather than widen the equity gap.

2 What equity measures improved?

The people of Turanganui a Kiwa experience poor access to a range of health-related services. This programme has provided access to primary health care services that they would not otherwise have received.

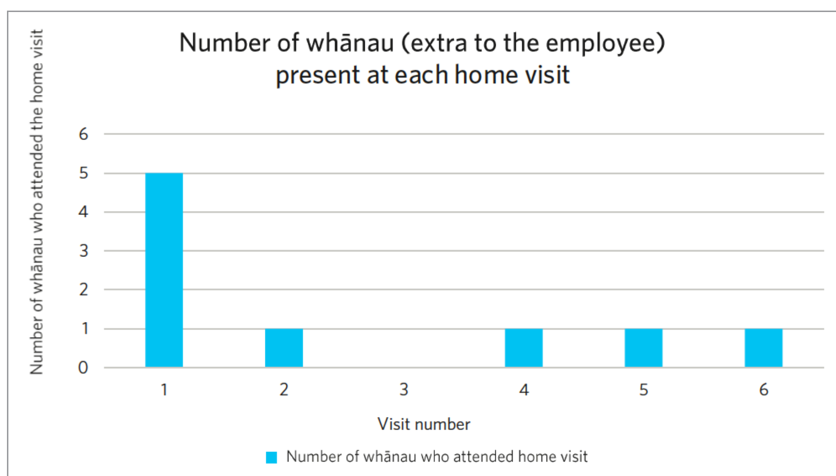
3 What process measures improved?

As shown below, the number of home visits accepted increased after the start of the programme.



Number of home visits completed – this was always 100 percent, so we have not created a chart to represent this.

The figure below shows how many whānau (over and above the employee) were present at each home visit. There was always at least one additional person as well as the employee.



4 Were there any unintended consequences, such as unexpected benefits, problems or costs, associated with this project?

It was difficult at times to ensure that staff used the script to ask whānau for a home visit, and we used briefing and debriefing to help staff adapt to the new process. We also used staff who were better able to stick with the script and so achieve better results.

The positive response we received from going into homes was unexpected, and the whānau involvement was surprising and delightful. The response from the employers to the extended wellbeing service into the homes of their workers was also surprisingly enthusiastic because they had concerns for their staff that they were not able to manage in their role as an employer.

Post-project implementation and sustainability

1 Have the successful changes been embedded in day-to-day practice? How have you managed this?

This home visit process is now business as usual. Every time we brief staff, we talk about the process and about extending the offer of a home visit to anyone who is at risk and inviting their whānau to take part.

In our workplace post-visit debriefs, we talk about how the visit went, how many people were found at risk, how many were offered a follow-up home visit, how many accepted and when that visit will happen.

The staff who went to the home visit discuss with the Turanga Health co-ordinator how many whānau were at the home visit, what wrap-around services were offered and anything else that arose from the visit. The team then starts referrals for the wrap-around services that were offered and accepted by the whānau. We monitor that the referrals are actioned within 10 days.

2 How did you communicate your progress and results to others?

The briefings and debriefings kept the team on the ground up to date with any changes. Any time we had a new test-and-learn phase we made sure to bring the team in to brief and debrief. Sometimes it felt like we were testing and learning all over the place!

We put information on what we were doing on our website and Facebook pages, and we did a few media stories that were picked up in local papers.

We fed back results of our work to staff in our face-to-face meetings and as the data were collated.

Summary and discussion

1 **What were the lessons learnt?**

We learnt to appreciate the quality improvement tools and that they can work for us, and this helped us to incorporate new tools into our way of operating.

2 **What would you recommend to a team somewhere else that wants to take on a similar project?**

Relationships are important, particularly when working with employers. Having an engagement process with employers provides a strong foundation for working together and developing the relationship. We were clear about our expectations and the employers were confident to give us access to their staff.

Being able to offer a suite of services for employees makes it much more attractive for both the employers and employees. Flexibility is important, for example, being able to deliver services outside of normal 9.00 am to 5.00 pm Monday to Friday hours.

It is also important to focus on what works for the whānau rather than what works for you.

But most important is having the appetite and courage to give things a go.

3 **Are there any future steps or ongoing work that you are intending to continue with on this project topic?**

Since the end of this project early in 2019 we have extended the home visit process to all clients of Turanga Health whether or not they are in our lifestyle Tamariki Ora or mental health programmes. We have also developed our own Mauri Ora Assessment tool to help us with this and continue to run the service throughout the COVID-19 pandemic.

The team

Dallas Poi – quality improvement facilitator

Shirley Keown – quality nurse practitioner

Dwayne Tamatea – service delivery manager

Reweti Ropiha – chief executive and project sponsor

Not pictured

- Clinical team member
- Non-clinical team member
- Business owner
- Employee
- Whānau

Appendix 1: Tu Mahi cardiovascular risk assessment process and data collection form

Available to download here.

Appendix 2: Employer engagement letter protocol

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Turanga Health Workplace Wellness | Working protocols

Turanga Health will introduce:

A one on one health assessment that includes:

- Blood pressure
  - Cholesterol
  - Blood sugar level
- Flu vaccination

A range of health promotion/policy

- Smoking cessation
- Nutrition
- Injury prevention
- Physical activity
- Cervical screening
- Breast screening

Service evaluation

- Feedback on service provision

Report detailing

- Numbers engaged
- Services accessed
- Wrap-arounds in the home

The employer will provide:

- Access to worksite
- Access to employees
- Dialogue for policy introduction
- Feedback on service provision

Turanga Health will on engagement provide a set of dates that commit up to a minimum of 18 weeks through a calendar year.

Workplace	
Timeline for service delivery	
Turanga Health signature	
Review date	
Employer signature	

Home visit

Criteria for offering home visit

- Anyone who is eligible for CVRA.
- Anyone who falls outside the normal parameters for basic health checks as per primary care guidelines.

Tu Mahi home visit offer script

- Tell me what your understanding is of what we've talked about today?
- How will this affect or impact on you and your whānau?
- From our kōrero today would it be ok for me to visit you and you and your whānau at your home?

Guiding principles

Respect | Integrity | Reciprocity | Accountability | Honesty