Te Tumu Waiora – three years on

Implementation of the Integrated Primary Mental Health and Addiction programme across metro Auckland is well under way. This article, written by **David Codyre**, **Ainsleigh Cribb-Su'a** and **David Todd**, outlines progress in rollout, challenges faced and what is being learnt, including as a result of implementation through periods of COVID-19 lockdown and then Omicron. A range of data is presented regarding programme outputs, outcomes and patient experience

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The number of people attending GP clinics with mental health and addiction issues, struggles managing lifestyle-related long-term conditions, and/or psychosocial stress have steadily increased decade by decade. The funding and development of primary mental health programmes – in the main, funded extended GP/practice nurse consults and referral-based access to brief packages of evidence-based talking therapies – was in response to this need. These programmes generally delivered good outcomes for those accessing these services. However, funding was often restricted to priority populations (Māori, Pacific and those in quintile 5 areas), and only 40 per cent of those referred for talking therapies were actually seen.

Te Tumu Waiora is a model of care that integrates three new roles into GP teams: health improvement practitioners (HIPs), health coaches and NGO support workers (called "Awhi Ora" in Tāmaki Makaurau/Auckland). It evolved from 2013 in Tāmaki Makaurau and was formally piloted and externally evaluated in 2017/18. Access to the new roles, most often on the day the person presents, was designed to complement GP and practice nurse care, and to better meet patients' holistic wellbeing needs.

The pilot evaluation showed substantially increased access to these wellbeing supports (over 90 per cent), good outcomes sustained at six-month follow-up, and good patient experience. As a result, in the Wellbeing Budget 2019, the Government announced funding to roll this model out to general practice clinics across Aotearoa by June 2023.

Note that after making funding available, the Ministry of Health named this programme the Integrated Primary Mental Health and Addiction (IPMHA) service.

This model was comprehensively described in an earlier article – "Te Tumu Waiora: The integrated primary mental health and addiction model", *New Zealand Doctor*, 17 February 2021. The present article reviews the progress made in Tāmaki Makaurau to date.

The [IPMHA] service allows me to get better outcomes for my patients, particularly the ones who are motivated but struggling to achieve their goals. The health coach and wellness advisor (HIP) are not only able to support you as the doctor, but also delve deeper into the barriers to success for the patient and address these in more detail – often these can be challenging for us to explore in 15 minutes.

I am a firm advocate for providing the best quality of care for my patient and ensuring they have access to the service they need, minimising any obstacles to accessing this. The integrated model allows me to achieve this.

I have also found Awhi Ora to be of great help with some of my less well off financially, refugee or intellectually disabled patients, who need that extra bit of assistance but fall short of criteria for DHB referral/funding eligibility.

It takes two minutes to refer a patient to this wonderful team, who are incredibly friendly and helpful, and there is literally no downside to you, the doctor, in doing it. I would urge my colleagues to think of these services with any and all chronic medical conditions or lifestyle-related problems.

– Joshua Coulter, GP

Definitions

Try this quiz

1. **The Integrated Primary Mental Health and Addiction service integrates three new roles into GP teams. True/False**
2. **Health coaches are expected to make three to four contacts with patients per day. True/False**
3. **The IPMHA service has no access criteria and no limit on number of sessions. True/False**
4. **Wellbeing outcomes for Māori and Pacific patients accessing the IPMHA service are worse than the average. True/False**

Answers on page 36

Implementing at scale required tweaks to ensure cultural safety

Subsequent to the Wellbeing Budget 2019, in late 2019, the ministry tendered a request for proposals from district or regional collaboratives to implement the IPMHA programme.

In bidding for a contract to implement the programme across Tāmaki Makaurau, a collaborative of the three Auckland DHBs, all seven PHOs and 23 NGO's, including Kaupapa Māori and Pacific providers, formed and was gifted the name Tū Whakaruruhau. The collaborative was successful in gaining the contract to implement the programme across the Auckland region.

It is well recognised in the healthcare literature that implementation of promising new programmes or quality improvement initiatives with good early evidence of benefit, at scale, is extremely challenging.[1]

Our local experience with the Te Tumu Waiora pilots was that implementing this programme was a huge change process for the GP teams, even though they were enthusiastic "early adopters", as is typical of pilot sites. Looking back, the clinic teams recognised that it had taken up to two years for the model to be fully embedded.

> "While relationships took time to form...Awhi Ora support did indeed add value and complement the existing Whānau Ora services"

For this reason, when planning for implementation at scale, we in the Tāmaki Makaurau region proposed a significant implementation support resource to ensure success, including roles to manage the implementation process (implementation project managers and implementation clinical leads), workforce practice support roles for all three new workforces, cultural and lived experience leadership, and quality improvement leadership. The resulting enablement team is led by a programme director and clinical director.

A supporting governance structure was agreed upon and established, comprising a programme leadership board to oversee the ongoing progress of programme implementation, and a small strategic sponsor board to maintain the contract relationship with the ministry and maintain a wider strategic view. Each board comprised representatives of the partner DHBs, PHOs, NGOs, and Māori and Pacific providers and leaders. The programme leadership board incorporated regional clinical leaders and included a clinical governance function.

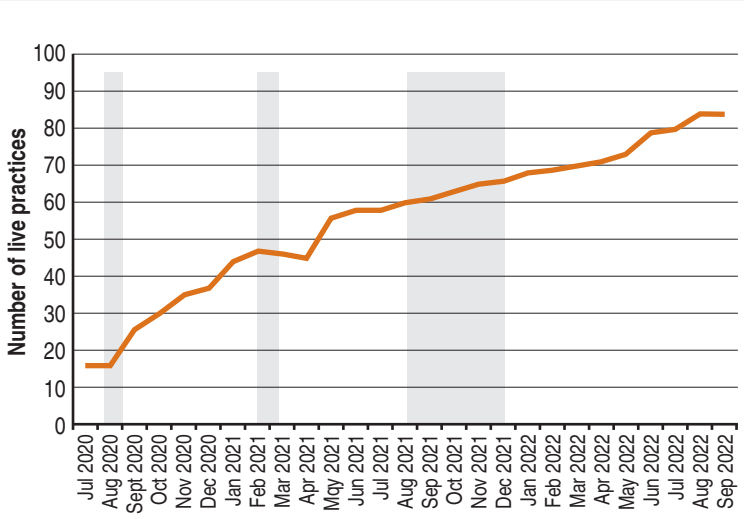

Figure 1. Implementation of the IPMHA programme in Auckland during COVID-19
Shaded areas indicate when Auckland was at Alert Level 3 or 4

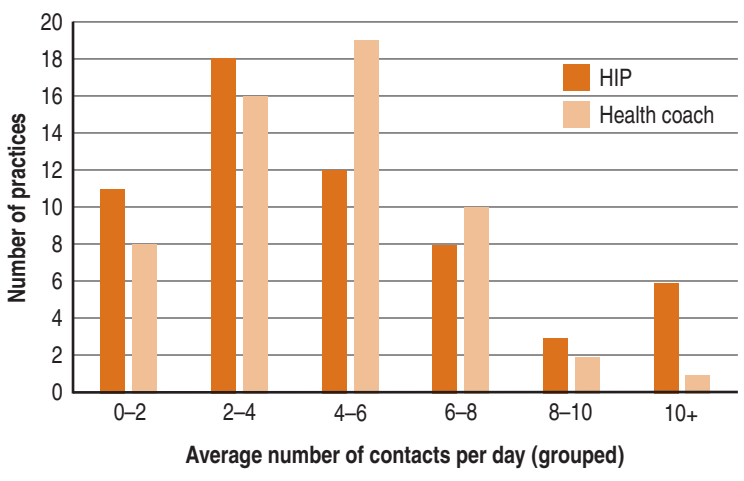

Figure 2. Number of practices grouped by average number of contacts per day
Practices with an average of 0 contacts for any period are not included in the data as this is usually the result of the HIP or health coach role being vacant

Implementation through the pandemic

The team had just formed and was commencing the contracted rollout schedule when the COVID-19 pandemic entered our shores in February 2020.

As Figure 1 demonstrates, with each successive lockdown and spike in community COVID-19 transmission, despite a lot of effort, we had to accept that clinic teams had to prioritise other activity. Implementation slowed considerably through these periods, then picked up once relative normality returned.

With the move from willing pilot sites to a rollout schedule based on number/proportion of priority populations enrolled with a clinic, we faced teams that had heard of the model and were enthusiastic to adopt the programme, but also the reality of those that were sceptical and/or reluctant to make the necessary changes.

As a group of GPs, we had a strong focus on mental health and thought we had it pretty well sussed...we didn't think we had space for extra staff and were unsure how these new roles could help. However, we did then decide to give it a go. Seeing how the HIP and health coach are working for our patients, and with our teams in the clinic, has been phenomenal, and Awhi Ora adds an extra dimension to our offering for patients – ***Daniel Calder, GP***

Looking back, for teams that were already active in recognising and addressing the mental health and addiction needs of their patients (eg, as reflected in rates of referral for talking therapies), the planned implementation process proved sufficient for the programme to embed and thrive. This process consists of two to three months of lead in/team preparation, one month of implementation, then two to three months of consolidation. However, for other teams, this was not sufficient. Some GPs and practice nurses struggled to make the changes to their practice to identify need and hand off to the new roles. Further, the practitioners in the new roles did not feel they were a part of the team, were underutilised, and often left the role, resulting in turnover of workforce.

Once the model is fully embedded and operating as intended, average patient contacts per day are expected to be eight to 10 for HIPs and health coaches. The data in Figure 2 includes average numbers of contacts across the months of the final COVID-19 lockdown and the Omicron surge, with the subsequent disruption to clinic "business as usual". Many HIPs and health coaches were working virtually through this period, and the focus of the clinics was managing acute respiratory illness. In the interests of "being helpful to the team", many were pivoted into other activity required to keep clinics functioning.

Despite this, most clinic teams managed to maintain four or more handovers to their HIP and health coach colleagues per day, and as life has gradually returned to normal in primary care, numbers are gradually increasing.

However, there is a group of clinics where the new roles have not embedded and started functioning as intended, as reflected in continued low numbers of handovers, and often in higher workforce turnover. As a result, the enablement team is working with our PHO partners to engage with, and "refresh", the programme in clinics where it is not functioning as intended.

Māori and Pacific services

Further, this programme was piloted and evaluated in "mainstream" GP settings but was subsequently funded for implementation in GP clinics in Kaupapa Māori and Pacific services. There was understandable concern regarding the extent to which these new roles, and their respective models of practice, would fit in these settings. The enablement team was clear about the need to identify and test variations to the model, to ensure provision of culturally safe and relevant care.

Undertaking to provide a higher level of support through implementation in these culturally based settings, and expressing willingness to identify and test any model adaptations necessary to ensure "fit", has been key to establishing the goodwill of these clinic teams to proceed with implementation.

I respect and pay tribute to all these kaimahi, be they HIPs or health coaches. They might not all be doing their mahi in the same way, but they do what is needed in their own hāpori, ensuring their own particular style of delivery (manaaki and aroha) is adhered to for whānau they serve daily. This approach is tika and pono, whether I am at Tāmaki Health, Turuki Healthcare, Papakura or Manurewa Marae. This supports Patti Robinson's korero at the Kaupapa Māori hui in 2021 – that you will work differently in your own village, but the intent and kaupapa (fidelity) of the model is still adhered to because all the villages have different make ups of whānau, hapū and iwi – ***Pat Mendes, pou taurawiri/ Māori cultural lead, Tū Whakaruruhau (Patti Robinson is the HIP model originator and "train the trainer")***

The overall experience in these settings has been positive, regarding the impact these new roles are having in enabling more holistic support. Three model adaptations have been critical to this:

1. Engagement – whanaungatanga – is important in any health context to establish connection and build trust. This is a key element of the service in Kaupapa Māori and Pacific healthcare settings and does require time. Fitting this within the expected 20–30 minutes of a HIP or health coach consultation is challenging, and we have accepted that consult lengths in these settings (and indeed in mainstream settings with high Māori or Pacific populations and Māori or Pacific practitioners) may be longer. In fact, while session lengths in these settings are often longer, overall "productivity" (ie, numbers of sessions delivered per day worked) seems equivalent to non-Kaupapa Māori settings.

2. Standard practice within the model is the GP or practice nurse doing a "warm handover" of the patient – interrupting the HIP or health coach, if in a session, to introduce their next patient and do a brief handover. Our Māori and Pacific practitioners, irrespective of setting, have conveyed that this process was experienced as being very disruptive to rapport, so it has been discarded. Instead, in different settings, a range of alternate options have been tested and adopted, all involving some form of "virtual warm handover".

3. The prescribed instrument for HIPs and health coaches to track wellbeing outcomes – the Duke Health Profile (DUKE) – is used to give a "snapshot" of the person's physical, mental and social wellbeing context. However, it does not assess wairua/spiritual wellbeing, and it incorporates questions that do not relate well to Māori and Pacific world views. Our Māori and Pacific practitioners found it to be "clunky" and to interfere with good engagement with Māori, Pacific peoples and others. So, a scale already developed and validated in Aotearoa and based on Te Whare Tapa Wha (Hua Oranga; oradatabase.co.nz) was tested. It was found to facilitate engagement and give a much better snapshot of the person's context. Across the collaborative, Hua Oranga is now strongly encouraged for routine use, and specifically with Māori and Pacific whānau. Some practitioners have adopted it for use with all patients and find its utility equal to, or better than, the DUKE, so we are also encouraging its universal use as the preferred instrument.

Kaupapa Māori and Pacific clinics also had access to a range of Whānau Ora and/or social support services, so were uncertain of the Awhi Ora NGO support role and how this might add value. Those clinics were matched with Kaupapa Māori or Pacific NGO providers, and while relationships took time to form, experience over time (and especially through periods of lockdown and the Omicron surge) was that Awhi Ora support did indeed add value and complement the existing Whānau Ora services.

A kaumatua was referred to me as he has a severe respiratory condition. On my initial call, he mentioned he finds it challenging as he has no transport to get to his medical appointments at Middlemore Hospital and the Manukau SuperClinic. I let him know about Awhi Ora and how they can support him. At the start, he was a bit whakamā to get this support, but I reassured him that it would make his life easier and that this is their mahi, so he was happy to be introduced to the Mahitahi Trust team. Mahitahi engaged with him and were able to get him to his latest medical appointments. I am still supporting him now...I do regular check-ins to see how he is doing and to reassure him that if he needs a GP appointment or assistance with kai, I am here to arrange this for him. He feels supported by me and the Mahitahi team – ***health coach***

Outputs, outcomes and patient experience

When the disruption of the past three years is taken into consideration, along with the extent of the change process and learning involved, it is remarkable that we have (as demonstrated in data presented below) succeeded in the implementation process to the extent we have.

Outputs – population coverage

IPMHA service contracts identify three priority populations for access to the programme, based on having higher need or greatest inequity in wellbeing outcomes – Māori, Pacific and young people.

As at September 2022, 653,000 people across the region were enrolled with clinics in which IPMHA support is implemented (39.4 per cent of the total enrolled population). This includes 86,205 Māori (50.3 per cent of enrolled Māori), 128,933 Pacific (52.5 per cent of enrolled Pacific), and 112,315 youth (47.8 per cent of enrolled youth) with coverage.

Outputs – workforce

As at September 2022, 163.7 full-time equivalents (FTEs) of workforce were employed across the region, supporting the 84 live practices. This consisted of 53.4 FTE HIPs, 49.2 FTE health coaches and 61.1 FTE community support/Awhi Ora workers.

While the impact of COVID-19 and lockdowns was a substantial impediment to rollout scheduled through 2020/21, the national/international health workforce shortage is now impacting severely on continued rollout.

Outputs – activity

Since the start of the IPMHA service contract (March 2020) to September 2022, over 74,000 unique people have accessed one or more components of the programme. Over 307,000 contacts have been delivered (see table).

Outputs – contacts

The IPMHA programme was developed for people seen in primary care with moderate to severe needs, but it is intended to have no access criteria and no limit on number of sessions. In keeping with primary care practice more generally, for HIPs and health coaches, the model is centred around a "one-off intervention with an open door to return".

Each session is focused on the problem the patient most wants help with on the day, and ends with the patient leaving with a plan focused on an agreed behaviour change. While follow-up sessions can be booked, the intention for most people is that whether and when they return for a follow-up session is left to their discretion, knowing that if they present, they will be seen on the day.

The contacts data shown in Figure 3 affirms that the models are broadly being practised as intended, with the majority of patients being seen once or twice, knowing they can return at any time.

In contrast, Awhi Ora provides "walk alongside support". As with the HIP and health coach roles, the intention is that this is focused on the one or two most pressing issues for the person. However, Awhi Ora support is framed as being over a number of weeks, with the expectation that most support needs can be met within three months.

Experience over the last two years through COVID-19 has reinforced the critical importance of having access to the more extended social support available via Awhi Ora. As seen in Figure 4, while 80 per cent of support was less than three months in duration, 44 per cent of people accessed Awhi Ora support for between one and three months.

Outcomes – access

While the rollout schedule has prioritised practices with a higher proportion of the three priority populations (Māori, Pacific and young people), it is important to track whether those populations have differentially achieved higher access to IPMHA support.

Figure 5 shows that access rates to both HIP and health coach support are higher than the population percentage for Māori. However, for Pacific, only health coach access is higher than the population percentage. Work is under way to understand the lower HIP access rate for Pacific and whether this requires attention as an equity issue.

Outcomes – DUKE and Hua Oranga

Use of the DUKE wellbeing measure is a requirement of the IPMHA service contract. The DUKE measures change over time across three dimensions (physical, mental and social wellbeing) and also derives an overall score.

IPMHA activity outputs from March 2020 to September 2022

	Unique people seen	Contacts
HIP	32,633	72,953
Health coach + health coach/support worker	25,499	64,699
Awhi Ora	6588	93,573
Wellness support*	24,349	75,784
Total of all components	74,422	307,009

** Wellness support has extended funded GP/practice nurse consults to the whole population for the Counties Manukau area*

Figure 6 shows the percentage changes between initial and final DUKE overall scores, by ethnicity, for those who were seen for follow-up. While over half of all seen had significantly improved wellbeing at follow-up (an increase in DUKE score reflects improved wellbeing), it is potentially reassuring that outcomes for Māori were slightly better than the average, and for Pacific evidently better.

Positively, these results mirror those demonstrated during the pilots that preceded the wider rollout of the IPMHA service. As noted earlier, in large-scale implementation of any new service or programme, outcomes achieved are often less positive than those seen during the pilot phase. Our results suggest that robust and appropriately resourced implementation at scale can sustain the same level of positive shifts in outcomes for populations.

While use of Hua Oranga (see oradatabase.co.nz for more details) as the preferred instrument for measuring wellbeing is increasing, the number of people for whom we have repeat measures (n = 322) is significantly lower than for the DUKE (n = 2355). Nevertheless, similarly positive patterns are being seen when using this measure, with the greatest improvement shifts evident for Māori (Figure 7).

Patient experience – Net Promotor Score

Across service industries, including health, the Net Promotor Score (NPS) is viewed as the best measure of customer experience and satisfaction. This survey rates answers to the question "How likely are you to recommend this service to friends and family/whānau?" on a scale from 0 (extremely unlikely) to 10 (extremely likely). A score of 9–10 is considered a promotor, a score of 7–8 passive, and a score of 0–6 a detractor.

The NPS is calculated by subtracting the percentage of detractors from the percentage of promotors, thus giving a potential score of -100 to +100. For health services in New Zealand, the average NPS is 37 (*2022 NPS Industry Benchmarks*; perceptive.co.nz). More generally, a score of -100 to 0 is interpreted as "room for improvement", from 0 to 30 as "good", from 30 to 70 as "great", and from 70 to 100 as "excellent".

In our IPMHA service context, the approach taken is to text a brief message out of the patient management system the day after the patient is seen, inviting completion of the survey. A link to the survey is provided to the patient along with a guarantee of anonymity, and completed responses are then collated centrally.

Implementing NPS across each collaborative PHO partner is under way and has proven technically challenging, but it has been completed in one of our larger PHO partners who have an integrated PMS and were the "test site" for the past year.

Results in Figure 8 show that before and since the last COVID-19 lockdown, NPS varied month by month from great to excellent. However, through the period of the last lockdown and Omicron surge, when primary care was under pressure and services were largely delivered virtually, experience was significantly poorer.

It is notable, though, that overall NPS ratings for Māori and Pacific are higher than for other ethnicities (Figure 9).

Quiz answers

1. True **2.** False **3.** True **4.** False

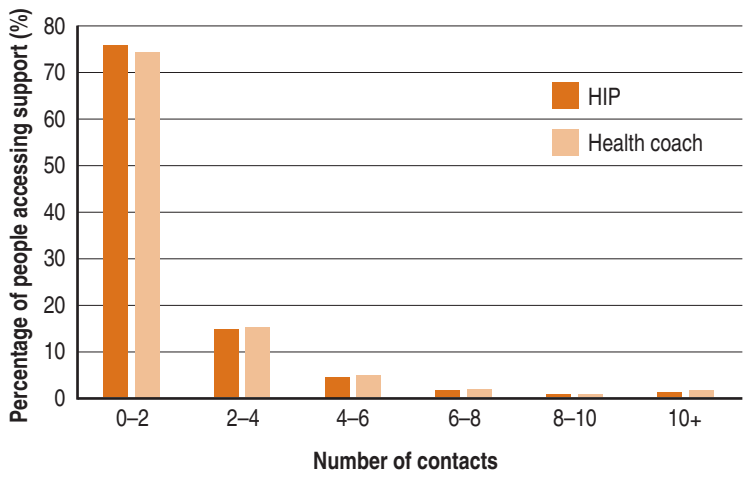

Figure 3. HIP and health coach contacts per person, for the period October 2021 – September 2022

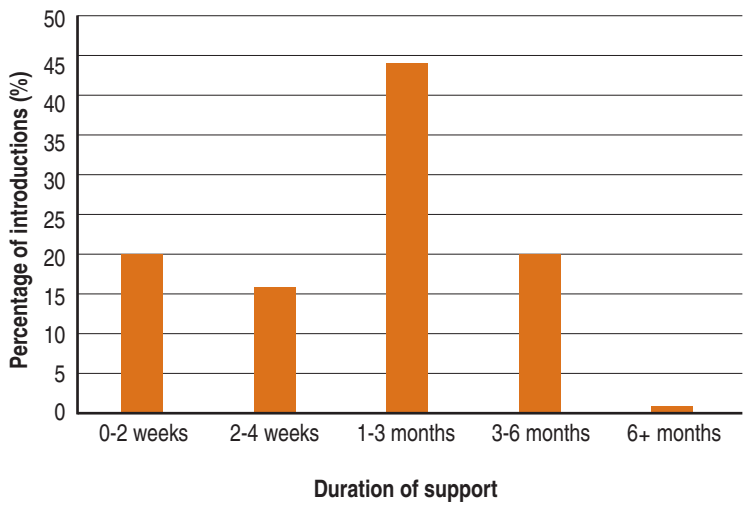

Figure 4. Duration of support for Awhi Ora introductions in 2022

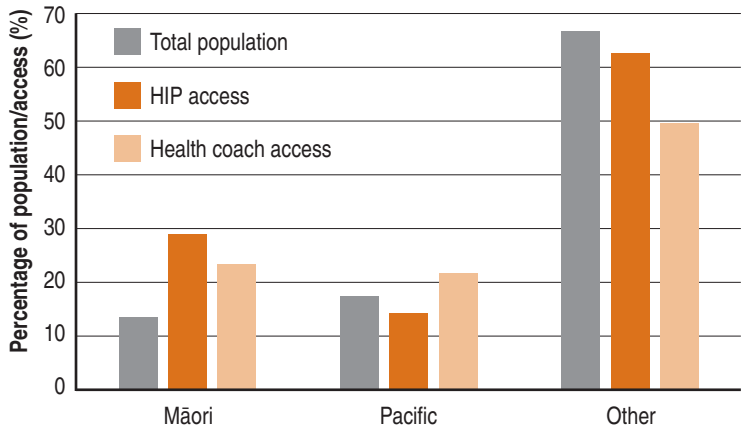

Figure 5. Percentage of service access compared with percentage of total population, by ethnicity

Current and future focus on access and sustainability

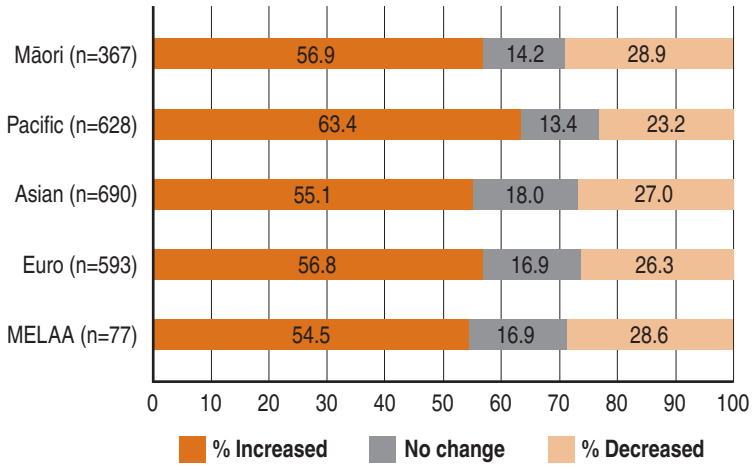

Figure 6. Changes in DUKE overall score, by ethnicity
MELAA: Middle Eastern, Latin American and African

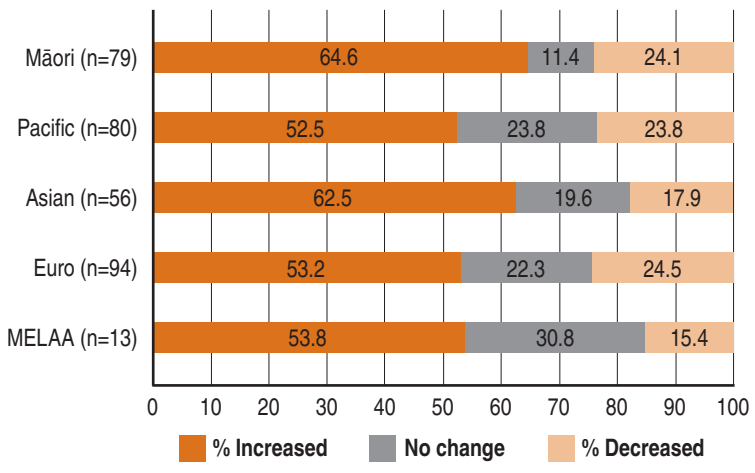

Figure 7. Changes in Hua Oranga overall score, by ethnicity
MELAA: Middle Eastern, Latin American and African

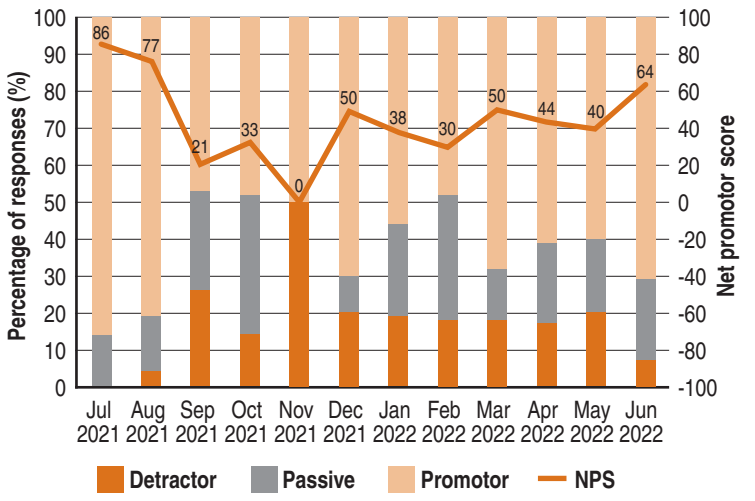

Figure 8. IPMHA Net Promotor Score results for the year ending June 2022

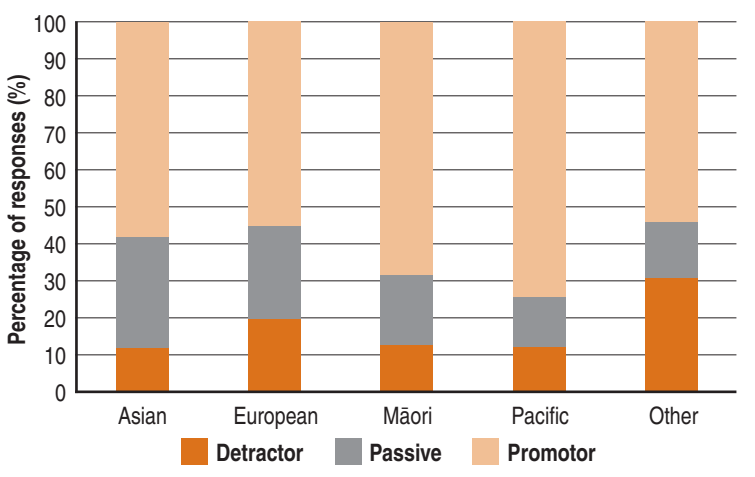

Figure 9. IPMHA Net Promotor Score results, by ethnicity

The focus of IPMHA service implementation in Tāmaki Makaurau is now on working through identified problems to increase access and continually improve the programme. Evaluation of the wider impacts of the programme is also required.

Increasing youth access

The trend of low rates of access seen in young people in the pilots has continued through implementation at scale. Early on in implementation, a series of focus groups were held with youth to explore reasons for this and strategies to overcome any barriers.

The single most important takeaway message from this was that GP clinics are an "adult space" from a youth perspective, and not seen as either youth friendly or safe. They would only attend a GP clinic for acute medical issues or sexual health, or if taken by a parent; in other words, only if they "had to go". Many were clear they would not go to their GP for support with a mental health issue. In contrast, school-based health services were seen as accessible and relatively youth friendly.

In response to this reality, we have planned and now implemented a "proof of concept" test of placing a HIP in a secondary school with significant Māori and Pacific student populations, with access to Awhi Ora services. The initiative has been a learning journey for all involved, but four months from implementation, there is consensus it is successful.

Despite the school having a wide range of health and social services available (nurses, school counsellors, youth workers and access to referral-based support services outside the school), there remained a group of students with moderate to severe mental health needs and/or distress, which existing services struggled to meet.

The HIP has been able to work with these students, identify previously unrecognised significant mental health issues, and provide a pathway to the local Child and Adolescent Mental Health Service when needed. Warm handovers are coming from the school health and support service staff, but as the service is becoming more known and trusted by the students, increasing numbers are self-presenting.

If these promising signs of success are borne out by the evaluation over the first year of operation, funding HIP roles to scale this small pilot will be a challenge to overcome (the IPMHA service has been funded for implementation in GP clinics only). However, initial discussions with the school leadership suggest that by rethinking the current model of health service provision, existing registered clinicians in school health teams could potentially be trained to spend part of their week operating as a HIP, if they had access to appropriate support.

Operating across clusters of smaller clinics

The regional rollout schedule commenced with generally larger clinics and has progressed though middle-sized clinics, but it is now increasingly including small clinics where the FTE allocated may mean the HIP and health coach would only be present in the clinic a few half days per week. To operate as intended – seeing patients on the day they present – requires a presence across most, and ideally all, of the working week.

This has necessitated implementing across clusters of two or more clinics who share the same HIP and health coach, and testing ways of making the service available virtually when the HIP or health coach are not physically present in the service.

As seen in the NPS data above, virtual provision does not seem to provide a good patient experience. So, solving the problem of how to operate virtually in a cluster while delivering good outcomes and experience is a challenge remaining to be solved in this and all other regions.

Formal evaluation

The IPMHA funding has been a significant Government investment. Analysis of the data we have routinely available suggests that, broadly, the investment is delivering good outcomes. Value for money will increase as clinics get back to business as usual and can focus on fully embedding the programme and increasing the number of people who can access the supports provided by these new roles.

However, there is the need to undertake a more in-depth and independent evaluation of the programme, including wider system impacts (eg, reduced referrals to secondary services) and patient/whānau outcomes (eg, sustained improved wellbeing, increased employment rates). We have begun the process of gaining agreement to fund such an evaluation in the coming year.

Sustainability into the future

IPMHA service rollout was scheduled to be completed by June 2023. With the delays caused by COVID-19 and now health workforce shortages, it is likely that, at least in our region, rollout will continue after that time. Beyond completion of the rollout, the question remains of how to sustain support, monitoring and continual improvement and evolution of the programme.

The collaborative has thus been focused on building robust programme leadership within each partner organisation, with a focus on practitioner support, using data to drive continued improvement, and maintaining the equity focus. There is broad regional agreement regarding the need to maintain collaborative-wide leadership and support functions, but with the funding for implementation support having ended, this will require backing from the existing regional funding pool.

Conclusion

Implementing a complex change programme at scale, through three years of COVID-19 disruption to the primary care sector and our communities, has been challenging. However, with significant goodwill from GP teams, and a well-resourced implementation team, the IPMHA programme has successfully been implemented into 84 large, medium and now smaller practices across the Tāmaki Makaurau/Auckland region, serving a combined total of 653,000 enrolled patients.

As at the end of September 2022, 74,422 unique patients have accessed support from one or more of the new roles, of whom almost 60 per cent had significantly improved wellbeing if seen for follow-up. Outcomes for Māori and Pacific accessing the new services were differentially better than the average.

Focus of the Tū Whakaruruhau collaborative supporting implementation across the region is now on continued improvement of the programme, gaining funding for a more in-depth evaluation of programme impact, and on "future proofing" it for continuity beyond the end of the scheduled rollout in June 2023. ■

Reference

1. Massoud MR, Nielsen GA, Nolan K, et al. *A Framework for Spread: From Local Improvements to System-Wide Change*. Cambridge, MA: Institute for Healthcare Improvement; 2006. IHI.org

Patient feedback

After 10 years of first losing my daughter to breast cancer and then my husband one year later being diagnosed with dementia, I became ill with stomach pains, not sleeping, anxiety, high blood pressure and depression, and I was a mess. My clinic offered me so much support and I cannot praise their system enough. They seemed to know how to help me get back to myself much quicker by giving me what I needed – from GPs, to the health coach who helped me with diet and exercise, and the HIP who got me onto an anxiety and depression course that taught me to breathe again. I am forever grateful to have my life well on the way back from the depths of despair. They have all played a part in giving me the tools to cope again.

[The health coach at my clinic] has been very helpful and attentive to my needs. It's been great being able to talk to someone about my health goals and have someone who is genuinely interested in helping me achieve them. They help me work towards achievable goals and stay motivated. I am really enjoying our sessions and look forward to them.

I can't thank my Awhi Ora support worker enough. I recently went to my GP, who introduced me to Awhi Ora to get help with somewhere to stay as I was homeless and didn't have much food. My support worker helped me get into a nice lodge, got me a food parcel and daily dinner directions, all in one week, which I am thankful for.