



Health System Improvement Guide

# KIA KAHA: MANAGE BETTER, FEEL STRONGER

**KO AWATEA**  
HEALTH SYSTEM INNOVATION AND IMPROVEMENT

**COUNTIES  
MANUKAU**  
HEALTH

## ACKNOWLEDGEMENTS

The team would like to thank Counties Manukau Health management teams for supporting this initiative. We have appreciated the willingness to engage in an improvement process and their involvement in every stage from concept to business case.

The Beyond 20,000 Days campaign team have provided a strong platform for this project and we would like to thank them for their guidance and encouragement.

We would also like to thank the Nirvana Health Group (NHG). Kia Kaha is a subset of the NHG Wellness Support Team. We have been fortunate to have access to psychiatric support and referrals for social needs through our primary care organisation.

The use of NHG's facilities was invaluable. Much of what Kia Kaha achieved was made possible by having meeting rooms available to us in two of the large practices in our primary care locality.

Finally, we would like to thank the participants of Kia Kaha, who have taught us how to do things better. They have also confirmed for us that there is always hope in adversity.



Acknowledgements	2
Summary	4
Introduction	5
The problem	6
The aim	7
The measures	8
The drivers of change	9
The change package: Overview	10
The change package: Engagement	11
The change package: Activation	13
The change package: Connection	18
The outcomes	20
Patient story	25
The future direction	26
The collaborative team	27
References	28
Appendix A: Consent form	30
Appendix B: Feedback Form	31
Appendix C: Glossary	32

The Kia Kaha: Manage Better, Feel Stronger collaborative project (Kia Kaha) was launched in 2013 by Counties Manukau Health (CM Health) to develop a model of care in the primary care setting which addresses the needs of people living with two or more long-term conditions who require significant levels of hospital-based care.

People with co-existing long-term conditions need more than medical treatment: they also need support and information to manage the self-care changes that will help them to achieve and sustain the best possible health and wellbeing.

Helping people with two or more long-term conditions to manage their health effectively is important for healthcare providers as well as patients. Complex health issues are associated with increased presentations to emergency departments and admissions to hospital, which increases the pressure on healthcare services and limited resources.

Kia Kaha began as part of CM Health's Beyond 20,000 Days campaign, which aimed to keep people healthy and well in their communities. Beyond 20,000 Days supported a number of projects, each of which related to the overall aim of the campaign.

The Kia Kaha team aimed to achieve a 25% reduction in hospital and general practice use for patients with two or more long-term conditions who were enrolled in the Kia Kaha programme.

We developed a change package based on three key drivers: engagement, activation and connection. Change ideas for each driver were developed and tested using the Model for Improvement.<sup>1</sup>

### Engagement:

- » Home-based, peer-supported assessment

### Activation:

- » Individualised peer support
- » Provision of evidence-based self-management support
- » Provision of psychological support

### Connection:

- » Case co-ordination
- » Collaborative approach

In the first year of Kia Kaha, there was a 41% drop in visits to Emergency Care among our patient cohort.

In addition, we increased our engagement rate with identified patients from 50% to 95% by using a flexible, professional-peer assessment process called 'Patient Choice, Patient Voice'.

This encouraging start has justified further adaption and testing of our original change package. The success of Kia Kaha led to the project being continued after the end of the Beyond 20,000 Days campaign.

The Kia Kaha: Manage Better, Feel Stronger collaborative project was developed by a professional-peer team to create a model of care in the primary care setting which addresses the needs of people living with two or more long-term conditions who require significant levels of hospital-based care.

Kia Kaha developed and tested options for self-management education, health psychology, peer support and care co-ordination. The model of care is based on the principles of engagement, patient activation and connection between patient and service.

The Kia Kaha team includes two health psychologists, a consultant psychiatrist, and two peer support specialists. A project manager and improvement advisor assisted with planning and implementation.

The project was initially developed, funded and implemented in 2013 as part of the Beyond 20,000 Days campaign run by Counties Manukau Health, the district health board that serves the South Auckland and Franklin areas of New Zealand's North Island. Beyond 20,000 Days was an umbrella campaign that supported a range of projects aimed at keeping people well in their communities.

The campaign used the Breakthrough Series (BTS) approach to train and support participating teams in improvement methodology and collaborative working.<sup>2</sup> The BTS was structured as four learning sessions interspersed with action periods. During action periods, project teams in Beyond 20,000 Days used Model for Improvement methodology to develop 'packages' of change ideas which related to the overall campaign aim.<sup>1,3</sup>

This guide describes the development, implementation and outcomes of the Kia Kaha model of care from 2013 to the end of the Beyond 20,000 Days campaign in July 2014, and the ongoing use of the change package developed as a result of that work.



## THE PROBLEM

People living with long-term conditions\* that affect their physical or mental health often need more than just medical treatment. They require support and information to manage lifestyle and make self-care changes to help them stay as healthy as possible.<sup>4</sup> The tasks related to managing long-term health issues become more complicated when individuals are dealing with more than one long-term condition, which may include mental health and mood conditions.

Those experiencing long-term medical conditions are more likely to develop a mental health condition, and vice-versa. This leads to a higher probability of poor health outcomes and the development of avoidable complications, which contributes to the already significant stress involved in living with long-term conditions.

The complexity of multiple long-term conditions often results in increased emergency care presentations and admissions to hospital, creating strain on healthcare services and budgets.<sup>5</sup> There is an inevitable effect on the healthcare workforce as they experience increased demands, and have less time and fewer options for each patient. Clinicians also feel the frustration of working in a reactive, disease-focussed model of care that fails to support patient engagement, activation and a connected, collaborative relationship between patients and healthcare providers.

The increase in numbers of people diagnosed with long-term conditions has put pressure on those working in primary care to use more effective models for supporting patients to manage their health needs.<sup>6</sup>

---

\* Long-term condition: a health condition or illness that lasts for longer than 3-6 months. Many long-term conditions, such as arthritis, diabetes, schizophrenia and heart disease, may last for a lifetime. Others, such as gout and depression, may follow a relapsing/remitting course.





Under the Beyond 20,000 Days campaign, Kia Kaha aimed to achieve a 25% reduction in unplanned hospital and general practice (GP) use for between 125 and 150 individuals with medical and mental health co-morbidities engaged in the programme by 1 July 2014 by supporting engagement, activation and connection.

Related aims were:

- » to work towards an 'activated patient in an activated service'
- » to give our patients choices and to hear their voices
- » to create a change package for patients who have long-term conditions that will be effective, empowering and patient-centred, and can be duplicated in other services and settings.

**"It was really good to be given the right information at the right time. I wasn't ready before."**

Kia Kaha participant



Kia Kaha gathered data relating to healthcare usage and health outcomes from our primary care patient management system, as well as from secondary care. We also gathered a number of self-report measures and qualitative feedback.

## Measures

### Emergency Care visits

Our primary measure was the average number of Emergency Care visits by our cohort per month. This information was obtained from Middlemore Hospital.

### Engagement rates

Patients are eligible to participate in Kia Kaha if:

- » they are enrolled with our primary care service in our identified locality, Otara. We chose the Otara locality as our clinic serves a population there with high health needs and a prevalence of people living with long-term conditions
- » they have at least two long-term conditions identified on their medical records
- » they have had at least two Emergency Care visits/admissions recorded on their medical record in the previous 12 months.

Eligible patients are identified either by referral by the Very High Intensive User (VHIU) team at Middlemore Hospital or a list identifying patients who meet the above criteria generated by our primary care team.

Engagement is defined as patients who meet with us for an assessment of their needs and concerns. Between September 2013 and March 2014, we tracked the proportion of patients who met with us compared to the overall number of eligible patients that we approached.

### Patient Health Questionnaire–Somatisation Anxiety Depression Scale<sup>7</sup>

The Patient Health Questionnaire–Somatisation Anxiety Depression Scale (PHQ-SADS) was developed to reflect that most primary care patients with depression or anxiety disorders also present with somatic complaints. The PHQ-SADS includes PHQ-9, GAD-7, and PHQ-15, as well as panic symptoms. These measure depression symptom severity, anxiety symptom severity and physical symptom severity respectively.

We encourage participants to complete this measure at our first engagement and after completing their chosen interventions or support.

### Health Education Impact Questionnaire (HeiQ)<sup>8</sup>

The HeiQ was developed to capture the effectiveness of health education programmes. It consists of 40 health related items. The 40 items included in the HeiQ measure patient behaviour across eight domains, which are: health directed behavior, positive and active engagement in life, emotional wellbeing, self-monitoring and insight, constructive attitude and approaches, skill and technique acquisition, social integration and support, and health service navigation. Kia Kaha patients who participate in the six-week Manage Better Course complete the HeiQ at the beginning and end of the course.

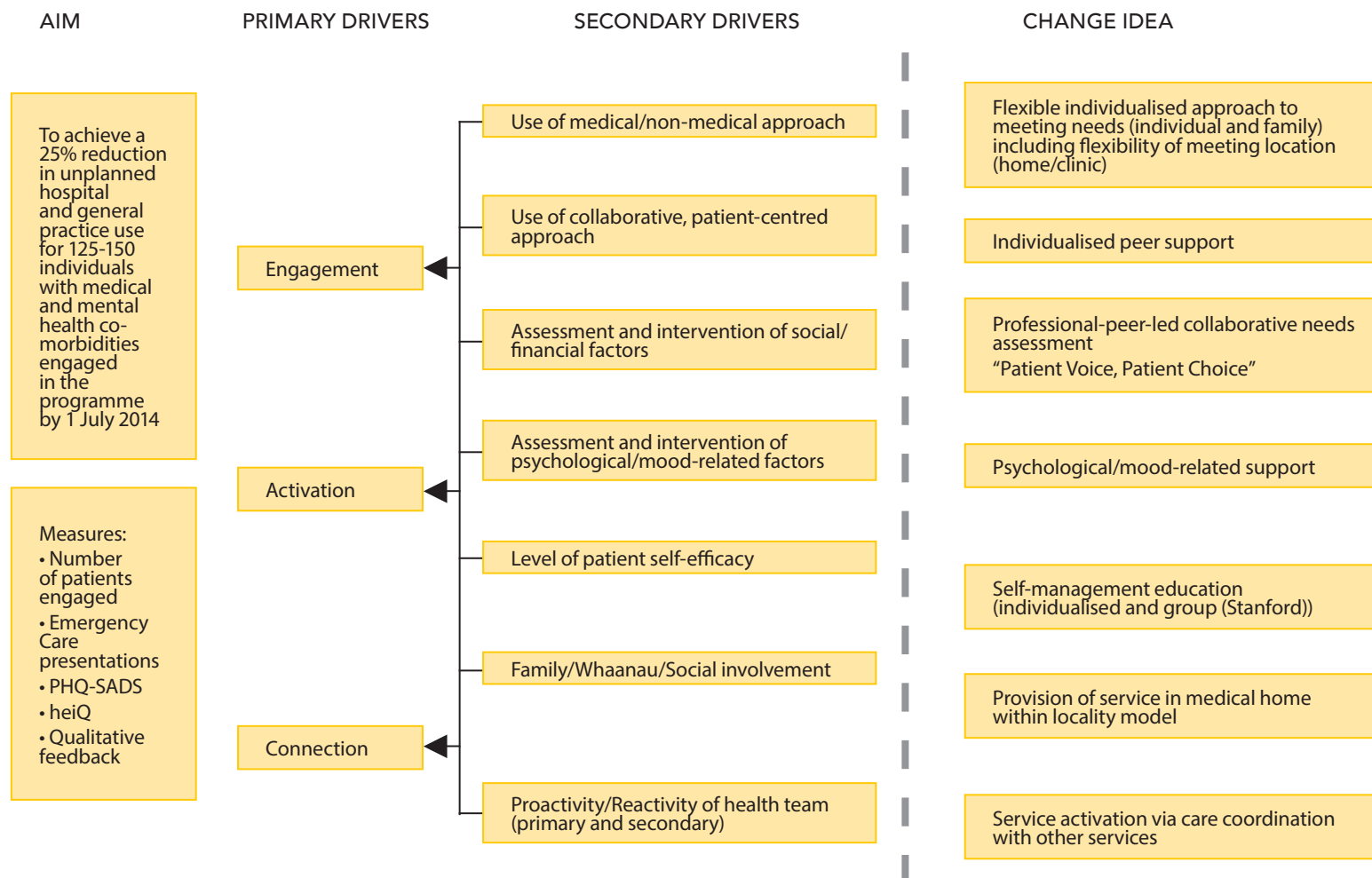
### Qualitative feedback from patients and team

We co-designed a qualitative feedback form with our peer support specialists (Appendix B). Participants fill this in when they complete the aspects of the change package that they have chosen.



# THE DRIVERS OF CHANGE

Figure 1: Driver diagram: Kia Kaha: Manage Better, Feel Stronger



Kia Kaha focussed on three primary drivers: engagement, activation and connection. Change ideas relating to these primary drivers were developed and tested using plan, do, study, act (PDSA) cycles.

### Engagement

The patients who are hardest to reach are often the ones most in need of our care. Many of the patients eligible for our project had previously been labelled in their medical records as 'hard to reach' or 'not responsive'. Helping these patients to engage with our team was a prerequisite for giving them the support they needed.

We identified engagement as our first primary driver.

### Activation

Patient activation refers to the knowledge, skills, confidence and willingness of the patient to manage their own health and to interact within their healthcare setting. Patients with higher levels of activation are more likely to plan an active role in managing their health. They are better at seeking help when needed and are more confident to seek and follow professional advice. Activation also refers to resilience, which is important for managing mood and health.

Activation of the healthcare team is also an important ingredient. A patient is more likely to feel involved in their own care when healthcare teams are proactive rather than reactive.<sup>9</sup>

We identified activation as our second primary driver.

### Connection

Connection is the driver that reminds us that for anything to be sustainable, the pieces and processes need to fit together.

On a micro level, connection refers to the patient's sense of connection within themselves, their personal goals, their families and the support they need to manage their health. For example, we know that people who have long-term conditions are more likely to experience social isolation and depression, which affect health outcomes.

On a macro level, connection of the services available to the patient in their healthcare setting and in the larger community is crucial. Ideally, patients connect to integrated services which provide coordinated care. For example, services which address both physical and mental health needs in the same setting or provide access to primary care, allied health, specialist, and social services within the same facility support the management of long-term conditions.

We identified connection as our third primary driver.

We planned to start with an assessment based on the biopsychosocial model to develop a collaborative treatment plan. The biopsychosocial model is a 'holistic' model where biological and medical issues are seen in the context of psychological and social experience.<sup>10</sup> For example:

- » A person may struggle to manage a long-term condition due to financial and housing needs.
- » Someone with diabetes and co-existing depression may find it increasingly hard to remember to take medication and take care of themselves.
- » An individual might miss a specialist appointment for their medical condition as a consequence of anxiety or transport issues.

Originally, we telephoned potential participants and invited them to the clinic for an assessment. The participants had been either referred to us or were from a list of people in the locality who met our criteria. However, only about half of the people we contacted were interested or able to attend the assessment.

We identified several barriers to engagement based on feedback from individuals and prior experience:

- » Patients were tired of seeing health professionals.
- » Patients were afraid of being given another diagnosis (such as mental health).
- » Patients were afraid of being asked to do something.
- » Patients did not feel comfortable or well enough to go to an appointment at the GP clinic.

At this point we asked ourselves, "Is the patient hard to reach ... or is it us?"

## The change idea: Home-based, peer-supported assessment

The VHIU project run by CM Health as part of the 20,000 Days campaign in 2012 improved patient engagement through home visits.<sup>11</sup>

Evidence from outside CM Health shows that peer support is instrumental in patient engagement in secondary care mental health settings. People who have already gone through a service can act as a bridge in the professional-patient relationship.<sup>12</sup> There are also successful models of peers providing various types of support for people with long-term medical conditions.<sup>13</sup>

Based on this evidence, we hypothesised that a flexible, peer-supported process would address some of the barriers to engagement. We decided to trial offering a home-based peer-supported assessment.

We employed two peer support specialists who were connected to us through their volunteer facilitation of the Chronic Disease Self-Management Program (CDSMP) developed by Stanford University to improve health outcomes and empower patients to achieve better self-management.<sup>14</sup> Working with these peers, we co-designed a telephone script that emphasised our desire to support those called, rather than asking them to do something.

Features of the script include:

- » We offer the presence of a peer support person.
- » Instead of talking about counselling or an assessment, we explain to each person that they are eligible for more support through the primary care team. We say that we want to meet with them to explain the ways that we would be able to support them.

- » We explain that it is their choice whether to meet with us and that we want to hear what is on their mind.
- » We offer to meet with people wherever they feel comfortable – in the clinic, their home or in the local McDonalds.

We also co-designed a brief description of the support available through Kia Kaha and a consent form (Appendix A).

To begin with, we offered 10 patients an assessment in either their own home or at their local clinic. Nine of the patients responded by engaging with us. Most preferred to meet us at home.

A peer support specialist accompanies the health psychologist who conducts the assessment during the first face-to-face meeting with the patient. At the meeting, the peer support specialist engages patient-to-patient while the health psychologist completes an assessment focussing on what matters to the patient. This approach enables a comprehensive evaluation of the patient's mental health needs, as well as social concerns and concerns regarding health.

During the first meeting, we ask for the patient's permission to follow up with other services and offer them the choice to have further contact, peer support, self-management sessions, referrals for social support and psychological support where appropriate.

We call this approach the 'Patient Choice, Patient Voice' assessment.

### Lessons learned

#### People prefer to see us in their home 95% of the time

This also connects us to important family members and gives a clearer idea of social challenges.

#### People respond well to the choice of options

When given an option for various types of support, most people choose at least one option.

#### Listen to the patient voice

Most people do not want to talk about their health issues initially but often share about life stresses, concerns and inadequacies that are directly relevant to the management of their health.

#### The value of the professional-peer team

The peers on our team 'open doors', as people connect with the peers' culture and experience. The professionals create the safety required for an accurate assessment of needs.

Patient activation refers to the knowledge, skills and confidence to manage one's health, including long-term condition management. People who are highly activated are more likely to increase their positive health behaviours and to be more effective in managing their health.<sup>15</sup>

However, it is estimated that between 25% and 40% of the general population have low levels of activation. Characteristics of low levels of patient activation include:

- » feeling overwhelmed with the task of managing health
- » having little confidence to change health behaviours
- » misunderstanding their role in healthcare
- » feeling unable to problem-solve
- » experiencing failures in managing health
- » feeling passive about health
- » not thinking about health.

Imagine a patient feeling like this and then being told that they need to make immediate changes to their diet, to start exercising and to take newly prescribed medications. Unintentionally, the health professional may be setting the patient up to fail due to the patient's existing lack of confidence and low activation levels.<sup>15</sup>

We recognised the need to empower our patients to make the changes they needed to achieve sustainable improvements in their health and wellbeing.

### The change idea: Include individualised peer support

Our peer support workers have been trained in a mental health setting as peer support specialists (mental health peer support training). They have also trained in the CDSMP to support people to manage both physical and mental long term conditions.<sup>14</sup> They use this background to support Kia Kaha patients to become more actively involved in their wellness and health.

Through collaboration and huddles, the peers and health psychologists plan together to provide: self-management support, a bridge between the patient and health professionals, help with navigation of the healthcare system, advocacy with other services when required, emotional support and continuity. We included peers with language and cultural expertise in the team, as we work in a diverse community. We are careful to avoid 'rescuing' people and instead focus on giving support, increasing knowledge about a health condition, teaching self-management skills and instilling confidence. This peer support can be provided over the phone, in the patient's home or in the healthcare setting. We offer this option of peer support in our Patient Choice, Patient Voice assessment.

We ran multiple PDSAs to determine if this support was sustainable and useful. We had concerns about safety issues, appropriate role boundaries, and whether or not the support was acceptable and helpful to patients.

To address these concerns, and to keep improving, we developed a model of weekly case reviews with the peers about their work. The connection within this team has proven to be a key element in creating a sustainable offer of peer support. We aligned this concept of a 'self-management coach' with the Health Coaching curriculum from the Center for Excellence in Primary Care.<sup>16</sup>

## Lessons learned

### Importance of working as a professional-peer team

Working in primary care as a team was new territory for the whole team – professionals and peers. To maintain safety and be faithful to the evidence base, it was important that decisions regarding patient interactions were made together as much as possible. We also had huddles to review interactions together.

### Importance of boundaries and role expectations

In our efforts to support, encourage and validate the peer role, the role of project leadership was sometimes misunderstood. Clarity of roles was of key importance. Some of the confusion related to previous training and expertise. We spent time so that each part of the team was aware of what the other parts of the team were doing and why.

### Importance of training and cross-training

We learned that we could not assume that there was a shared understanding of the different scopes of practice and role definitions. We also realised that the combination of the peer support specialist training and the CDSMP peer leader training did not equal a role equivalent to a health coach. We realised that training and cross-training was necessary to experience a shared language and skill base. We also looked for an evidence-based model for health coaching which could become part of the training shared by the team.

### Importance of creating a culture of feedback

At times we experienced tensions related to the perception that one role was more important than the other. We found it important to have multiple safe opportunities discuss perceptions and give feedback.

## Value of ongoing co-design

By operating as a core team we were able to design all materials and many of the processes together. The peers were able to give instant patient feedback.





## The change idea: Provide self-management education

The concept of self-management is often misunderstood by health professionals. There is a perception that self-management occurs when people follow their health professionals' advice or in other words, the 'doctor's orders'. Based on this understanding, the perception of self-management support is often characterised by advice giving.

Actually, the term self-management refers to a set of specific skills and tools accompanied by the confidence to use them. It is a term borrowed from a business management model.

Following is a business definition:

*Self-management skills are those abilities that allow an employee to feel more productive when doing their daily routine regardless of the working environment. Well-developed self-management skills will help you efficiently communicate with co-workers, management and customers, make right decisions, plan your working time, and keep your body healthy.<sup>17</sup>*

With just a few changes in wording, here is the same definition adapted to health:

*Self-management skills are those abilities that allow a person with long-term conditions to feel more productive when managing daily life regardless of their health issues. Well-developed self-management skills will help you efficiently communicate with others, including health professionals and family, make right decisions, plan your daily schedule, and keep your body healthy.*

With this definition in mind, self-management support can be defined as any support that health care providers and systems provide to assist and encourage patients to become skilled as self-managers.<sup>18</sup> Self-management education can be defined as the provision of information and support that is related to goal setting, action-planning, problem-solving, decision-making and disease-specific information.

We decided to provide the opportunity for Kia Kaha patients and their families to attend Manage Better Courses. This is the six-week CDSMP developed at Stanford University in the Stanford Patient Education and Research Center.<sup>14</sup>

The local license for this programme is held by CM Health, which supports our training. In our setting we call the CDSMP the Manage Better Course. We are aware that someone with a long-term condition may not be able to manage their health perfectly but, with support, they can always find ways to 'manage better'.

We chose this programme for our change package because there are multiple studies that demonstrate positive outcomes for people with long-term conditions and their caregivers.<sup>19-22</sup>

The Manage Better Courses run for six weeks, with a two-and-a-half hour interactive session per week. The programme is based on the following assumptions:

1. People with mental and physical conditions have similar concerns and problems.
2. People with a long-term condition not only have to deal with their condition but also with the impact that it has on their lives.
3. Non-professionals, when given a detailed manual, can facilitate the course effectively.
4. The way the course is taught is as empowering as the information given.

The courses are run as small groups, with 12 to 16 participants per course. The process is guided by the Social Learning Model, which highlights that learning is not purely behavioural; it is a cognitive process that takes place in a social context.<sup>23</sup> The goal of the group process is to enhance self-efficacy, which is defined as a person's belief about their ability to exercise influence over events that affect their lives.<sup>24</sup> A person's self-efficacy influences how they feel, think, motivate themselves and behave. In other words, you are more likely to try something if you think that you can do it, and you see other people like yourself doing it.

We aim to provide the Manage Better Courses with people from the local community through trained volunteers, peers on our team and staff. We also provide the courses in meeting rooms within the Kia Kaha patient's own GP clinics. This creates an opportunity to bring community members into the healthcare setting in a positive way.

### Lessons learned

#### Patients provide peer support

Not only do Kia Kaha patients and their families experience support from the course leaders, they also provide profound peer support for each other. Many participants are still in touch with each other.

#### Sometimes, less is more

Some of the patients choose to participate only in the Manage Better Course. This appears to be all that they need to feel confident to manage better.

#### Inclusion of family and whānau

We invite family to participate in all aspects of Kia Kaha. The participation of caregivers is significant, particularly when the patient is very unwell. Providing the caregivers with support, information and tools to use more confidently appears to make a difference for everyone in the family. We see families start to 'manage better' together.

#### Service activation needs to complement patient and family activation

It is not sufficient to support patient activation without also working on service activation. Some of our patients and family are extremely enthusiastic about using healthcare services more effectively when they complete the Manage Better Course. In some cases, however, their enthusiasm meets with either an unresponsive service or a non-communicative clinician. We continue to look at avenues for activating the services in our locality.

#### The need for language and culturally specific Manage Better Courses

We have had multiple requests from both Kia Kaha patients and families and healthcare providers to provide self-management support in Pacific and Southeast Asian languages. Based on this important feedback, we are working towards the provision of the Manage Better Course using translated manuals in Tongan, Samoan and Hindi.

### The change idea: Provide psychological support

Our original proposal outlined the need to address mental health needs within the primary medical health setting.<sup>25</sup> While not all of our Kia Kaha patients and family require mental health treatment, for those who do, it is a significant intervention for their ability to manage better. It has been well demonstrated that people living with a long-term condition face multiple challenges of adjustment.<sup>25</sup> These include the impact of their health issues on physical abilities, emotions and relationships. Many long-term conditions are characterised by complex mental and physical interactions, creating a greater vulnerability to depression and anxiety.<sup>26</sup>

### Cognitive behavioural therapy

Cognitive behavioural therapy supports adjustment by helping people to deal with adversity, grief and loss, and by working with the patient to identify thoughts and behaviours that support better health and mood.<sup>27</sup>

We offer individual or family cognitive behavioural therapy sessions with a health psychologist if a patient's level of distress indicates that it was necessary, or if the patient or their family members feel that this type of support would be helpful for them.

### Psychiatric assessment

People with long-term conditions often take multiple medications, which may or may not interact well to support mood and sleep. Medication review by a primary care psychiatrist increases the possibility of better mood and pain management, as well as increasing the likelihood of a sound treatment plan for co-existing mental illness.

For patients who need further assessment or medication review, we offer a psychiatric assessment through a consultant psychiatrist who works in primary care or GP registrars who are enrolled in advanced training in primary mental healthcare and are supervised by the psychiatrist.



There are various ways patients can get lost in the health system. The most obvious example is when a patient does not attend an appointment and is considered 'lost to follow-up' or 'hard-to-reach' – but, in fact, the patient may have lacked the transport or resources to attend the appointment. This demonstrates the existing 'disconnect' between what clinicians think is going on when a patient does not attend, and what is actually going on for the patient. As many services lack the resources, coordination or proximity for active follow-up, the service remains reactive rather than proactive.<sup>28</sup>

Another way patients can get lost in the health system is when referrals between services are not made or followed up. Unfortunately, sometimes this occurs when a service refuses to accept a referral for various reasons. Patients assume that the healthcare system is connected and that each health professional they meet knows what is going on and has access to a shared medical record. In reality, this is not the case. There remains a disconnect between primary, secondary and tertiary services.

A focus on connection throughout the system – from the connection between professional and patient in each interaction to the connection between primary, secondary and tertiary services – would support better outcomes for providers and patients.

## The change idea: Case co-ordination

In order to support more collaborative interactions for and with Kia Kaha patients, we worked on our relationship to other services that connect to them. We prefer to call this case co-ordination rather than case management, as we believe that use of the word 'management' maintains the concept that the health professional is primarily responsible for managing the patient's healthcare, rather than the patient engaging in self-management.

We observed the work of our health service's discharge co-ordinator and of the CM Health VHIU team.<sup>11</sup> We learned that care co-ordination needs to be directed by the patient as much as possible. It is important first to identify what the patient's needs are, what they want to address, and seek their consent to co-ordinate their care. We also learned the importance of case co-ordination meetings involving a multidisciplinary, multi-service model.

We established regular case co-ordination meetings with the VHIU team to discuss mutual cases. These meetings include our consultant psychiatrist, GP registrars, and peer support specialists.

We met with other secondary care teams. The best teams to meet with are those that share patients and resources and which are committed to patient-centred care. By developing good relationships with secondary and tertiary care, we obtain more knowledge and better access to support our patients. We are able to explain the patient perspective and advocate for our patients, reducing any barriers to service access.

We work closely with the Clinical Family Navigator Team within our primary medical home, Nirvana Health Group, to advocate for patients' social needs, and with our primary mental health team to access any additional mental health support our patients need.

## Lessons learned

### Working together brings services closer to the patient

Bridging the various 'arms' of the health services involved with a patient makes it possible to get a more complete picture of the patient's situation. We are able to provide supportive care that is more timely, appropriate and patient-centred. Connecting to other services and clinicians to clarify what they can offer gives us more confidence to offer those options to Kia Kaha patients and families.

### Model collaboration

In order for the patient to experience a more collaborative model, we need to work together collaboratively within our team and other teams. We also try to have a collaborative approach in every interaction with the patient and their families.

### Work within limitations

We have developed a deeper empathy for patients through this process. Even though we work within the healthcare system, we encountered our own barriers to access to various services and clinicians. We realised that we still work in a setting where there are multiple limitations. We learned to work with the services that respond and to continue to encourage collaboration wherever possible.

“The Manage Better Diabetes course gave me perspective. I realised that some people are worse off than me and they are still making an effort. We were all diabetic so we shared that.”

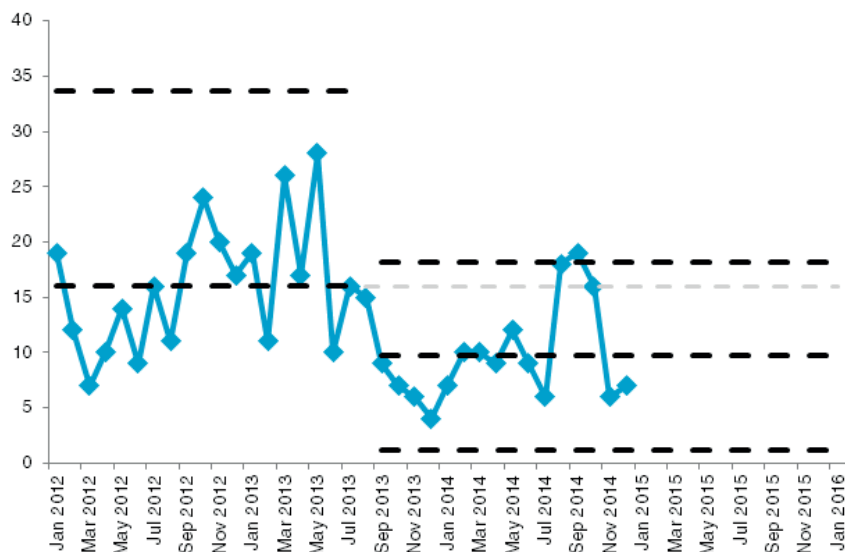
Kia Kaha participant



## Reduced presentations to Emergency Care

In its first year, Kia Kaha achieved a 41% drop in Emergency Care visits among its patient cohort (Figure 2). This drop has been sustained. Figure 2 represents the first cohort of 41 patients who enrolled in the Kia Kaha service between August and December 2013.

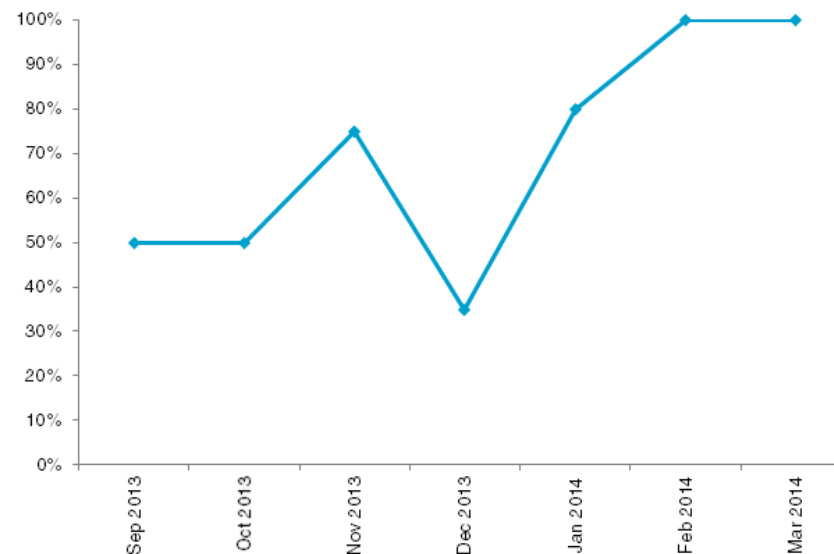
Figure 2: Reduction of EC presentations from the start of Kia Kaha



## Improved engagement

Initially, Kia Kaha engaged with patients by offering an appointment with a health professional. This achieved an engagement rate of about 50%. Peer support specialists were introduced into the engagement process in December 2013. Following the introduction of a flexible, professional-peer assessment, Kia Kaha successfully engaged with almost all patients (Figure 3).

Figure 3: Improved engagement



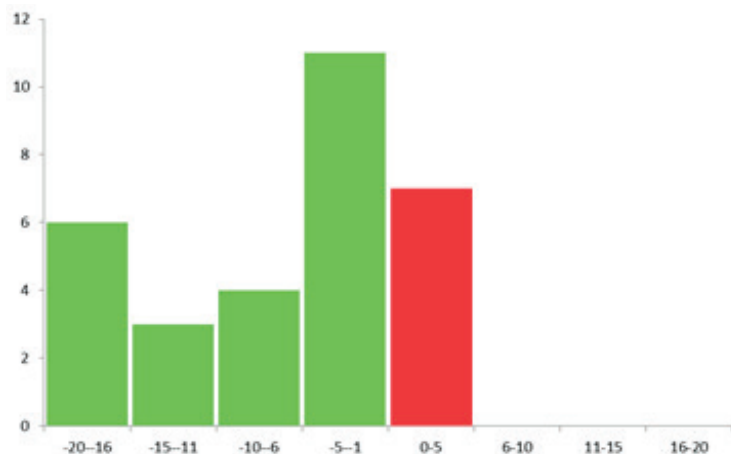


## Reductions in psychological distress

Scores on the PHQ-SADS rise according to the severity of symptoms. Negative changes therefore represent a reduction in symptom severity and an improvement for the patient.

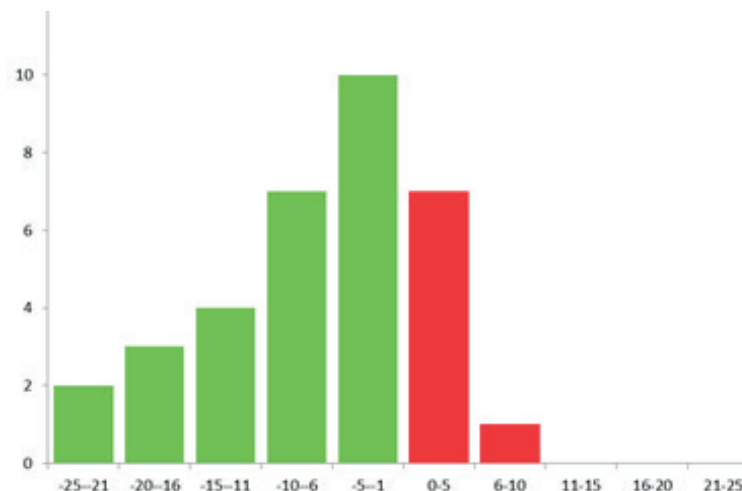
The PHQ15 measures somatisation, or how bothered people are about various symptoms. PHQ15 scores improved for 77% of participants. The average change in score was -6.2. The average PHQ15 score of patients as they entered Kia Kaha was 14.2, which indicates moderate to severe somatisation. The average PHQ15 score of patients as they completed Kia Kaha was 8, which indicates mild to moderate somatisation.

Figure 4: Changes in physical symptom severity (PHQ15) score from pre- to post-intervention



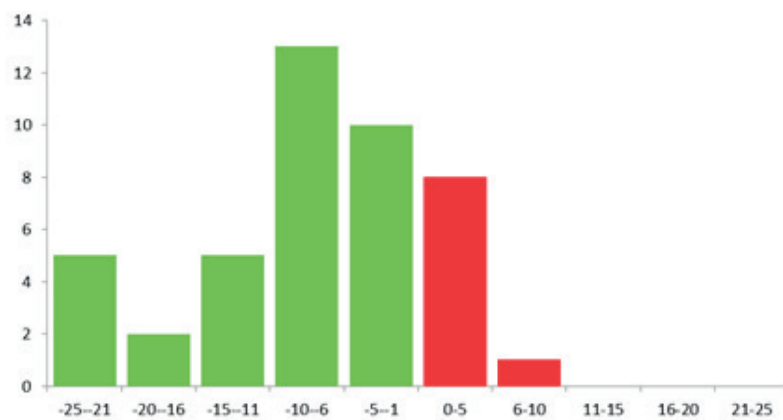
The GAD7 measures the amount of anxiety a person is experiencing. GAD7 scores improved for 76% of participants. The average change in score was -6.4. The average GAD7 score of patients as they entered Kia Kaha was 12, which indicates moderate anxiety. The average GAD7 score of patients as they completed Kia Kaha was 5.6, which indicates mild anxiety.

Figure 5: Changes in anxiety symptom severity (GAD7) score from pre- to post-intervention



The PHQ9 measures depression. PHQ9 scores improved for 79% of participants. The average change in score was -7.1. The average PHQ9 score of patients as they entered Kia Kaha was 15, which indicates moderate depression. The average PHQ9 score of patients as they completed Kia Kaha was 7.9, which indicates mild depression.

Figure 6: Changes in depression symptom severity (PHQ9) score from pre- to post-intervention



## Improved activation

### Improved activation with peer support

Sixty-seven patients have chosen to have peer support in our project so far. While not everyone chose to have continuing peer support, those who did were more likely to participate in other aspects of our change package. As we were able to integrate language and cultural peers into the change package, there was a much better engagement rate with communities that were previously hard for us to reach. For example, when we added a Tongan peer, connection to Tongans became much more successful and similarly when we added a Samoan peer support specialist.

We collected feedback from the patients about the impact of peer support on their experience with Kia Kaha:

*"Having the support at home was very good. I felt comfortable and safe."*

*"Nice to have a peer in (my) community and to meet on a regular basis."*

*"Peers were easy to talk to. Warm and friendly smiles."*

*"Peers have been helpful and supportive as well."*

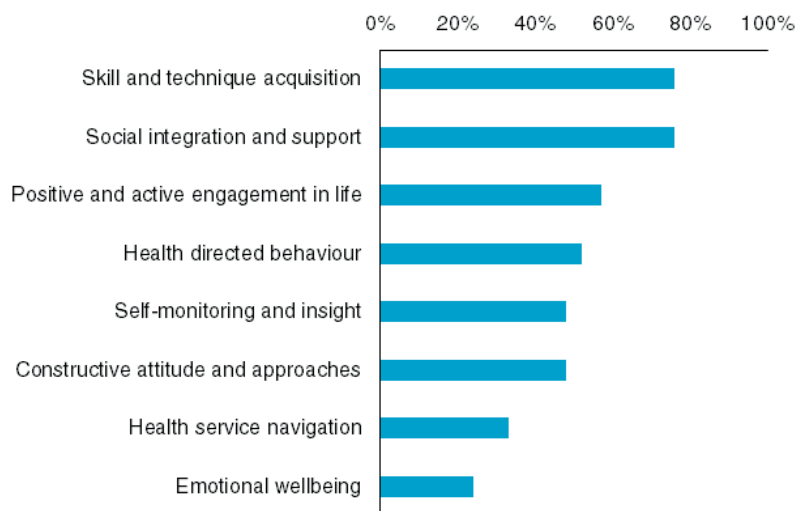
*"The peer support made me feel a lot better about myself."*

## Improved activation through Manage Better Courses

We noticed positive changes in the Kia Kaha patients who completed the Manage Better Course. The changes observed include countenance, posture and conversations that suggest increased confidence, empowerment and hope. It surprised and delighted us to see patients coming into their healthcare clinic in a state of confidence and wellbeing – often in spite of their serious long-term conditions.

These changes have been further captured by improvements in the eight scales identified as important for self-management in the HeiQ (Figure 7). Twenty-one Kia Kaha participants completed the HeiQ at both beginning and end of the Manage Better Course.

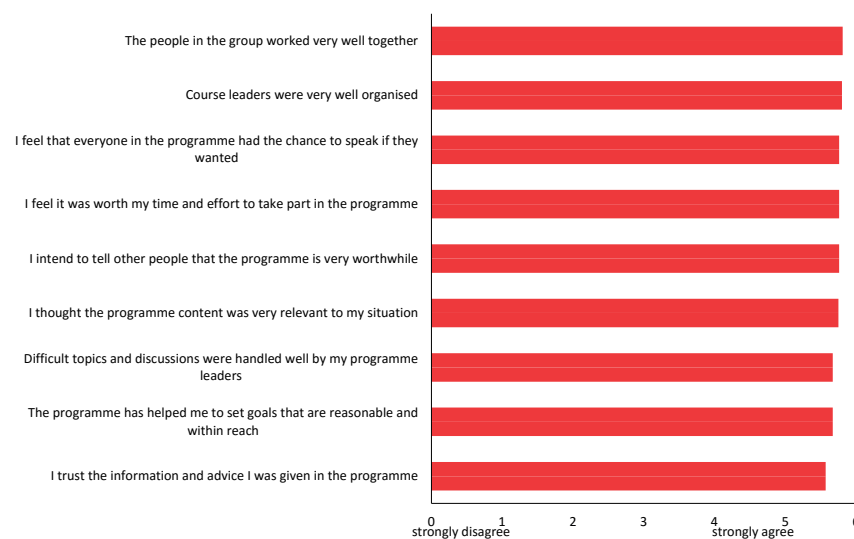
Figure 7: Percentage of Kia Kaha patients showing substantial change on each dimension of the HeiQ



The rate of attrition was estimated to be less than 30%, which is in keeping with the Stanford guidelines for facilitating self-management programmes. This means that the vast majority of these people who attended the first session of a programme ended up completing the programme. This was seen as a success given the broad complexity of the Kia Kaha patient population, all of whom have at least two long-term health conditions.

In line with this, participants rated the Manage Better Course highly (Figure 8).

Figure 8: Kia Kaha participants' ratings of the Manage Better Course

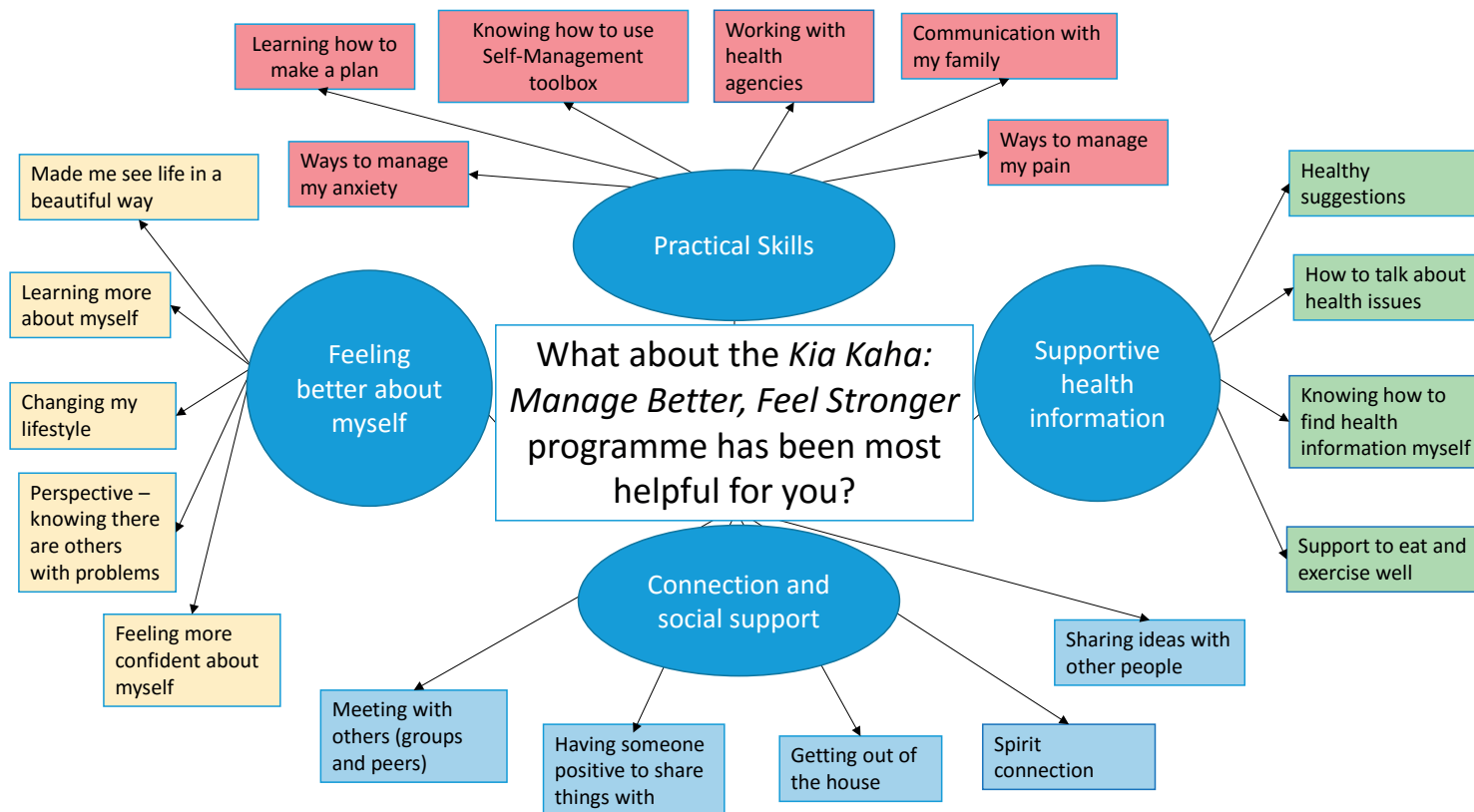


## Positive patient feedback

We obtained feedback from Kia Kaha participants about the interventions they had chosen. This included the Manage Better Courses and peer support for most patients and also case coordination, psychology and/or psychiatry for others. Overall, our comments were positive.

We grouped the responses to the question “What about Kia Kaha has been most helpful for you?” on to the four major feedback categories of practical skills, supportive health information, connection and support and feeling better about myself (Figure 9).

Figure 9: Themes from participant feedback



## PATIENT STORY

In order for me to change, we all needed to change. My wife is no longer worried about me dying, my whaanau is reconnected, and we have a toolbox. My goal was to get healthier. I feel I have achieved that. Now I have to maintain it.

-Diva

We all started doing some health eating – cooking food at home and eating more greens.

-Daughter

Kia Kaha helped us to learn about pain management and make a strategic plan as a family.

-Wife

Dad was a lot less grumpy. I noticed that his attitude changed. He became more approachable.

-Daughter

Diva was referred to me for assessment. However, he completed the Manage Better Course before seeing me and his psychological distress scores were all very low, suggesting psychiatric review is no longer necessary.

-Dr David Codyre, Consultant Psychiatrist

Diva's wife, Rena, was showing scores of 10 and 8 on the PHQ-15 and GAD-7 respectively pre-Kia Kaha. Post-Kia Kaha, her scores were zero.

-Leona Didsbury, Health Psychologist



We are heartened by our experience of supporting patients and families with both physical and mental health conditions in their primary care clinics. Based on our initial successes, we have had encouragement from our primary healthcare organisation to:

- » specifically offer the entire change package to patients who have more than one long-term condition and are having significant challenges managing that impact on their lives
- » generally offer the peer supported Manage Better Course options to anyone with a long-term condition in our service.

We are fortunate to have the opportunity to continue to work with Ko Awatea in the subsequent self-management support campaign, Manaaki Hauora – Supporting Wellness. To spread our learning, we have identified options for creating further support for people with long-term conditions. In particular, we want to continue to adapt and test evidence-based self-management support processes in the NHG clinics in Counties Manukau, with the goal of creating a reproducible 'Wheel of Support' which can be provided by a professional-peer team in partnership with primary care clinics.

Our intention is to continue testing models of peer support for people with long-term conditions. We will strive to refine our working relationship as a professional-peer team. As a team we plan to train and cross-train in self-management programme delivery, health coaching, and self-management care planning. Our hope is to also train other collaboratives and services within the Manaaki Hauora campaign and Counties Manukau in these self-management support models. To achieve this, we have established collaborative relationships with the Patient Education Center at Stanford University, the Center for Excellence in Primary Care at University of California, San Francisco and the Mental Health and Behavioural Unit at Flinders University, Adelaide.





## THE COLLABORATIVE TEAM



Back row: Ian Hutchby, Improvement Science Advisor; Leona Didsbury, Health Psychologist; Pam Low, Health Psychologist.

Front row: Jacqueline Schmidt-Busby, Project Manager; Gary Sutcliffe, Peer Support Specialist; Merle Samuels; Peer Support Specialist; David Codyre, Consultant Psychiatrist.

1. Langley GL, Moen R, Nolan TW, Nolan KM, Norman CL, Provost LP. The improvement guide: a practical approach to enhancing organizational performance (2nd ed.). San Francisco: Jossey-Bass; 2009.
2. Institute for Healthcare Improvement. The Breakthrough Series: IHI's collaborative model for achieving breakthrough improvement. IHI Innovation Series white paper. Boston: IHI; 2003. Available from <http://www.ihl.org/resources/pages/ihlwhitepapers/>
3. Middleton L, Villa L, Mason D, Cummings J, McDonald J. 20,000 Days and beyond: evaluation of CMDHB'S quality improvement campaigns. Wellington, New Zealand: Health Services Research Centre, Victoria University of Wellington; May 2015. Available from <http://koawatea.co.nz/project/beyond-20000-days/>
4. Bayliss EA, Bonds DE, Boyd CM, Davis MM, Finke B, Fox MH, et al. Understanding the context of health for persons with multiple chronic conditions: moving from what is the matter to what matters. *Annals of Family Medicine*. 2014;12(3):260-269.
5. Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A. Long-term conditions and mental health: the cost of co-morbidities. London: The King's Fund and the Centre for Mental Health; 2012. Available from <http://www.kingsfund.org.uk/publications/long-term-conditions-and-mental-health>
6. Weel C, Schellevis FG. Comorbidity and guidelines: conflicting interests. *Lancet*. 2006; 367(9510):550-551.
7. Patient health questionnaire including PHQ, PHQ 9, PHQ-Brief and PHQ-SADS. *Psychiatric Times*. UBM Medica; c1996-2015 [cited 2013 March 11]. Available from <http://www.psychiatrictimes.com/clinical-scales-patient-health-questionnaire>
8. Osborne HR, Elsworth GR, Whitfield K. The health impact questionnaire (heiQ): an outcomes and evaluation measure for patient education and self-management interventions for people with chronic conditions. *Patient Education and Counseling*. 2007;66(2):192-201.
9. Hibbard J, Gilbert H. Supporting people to manage their health: an introduction to patient activation. London: The King's Fund; 2014. Available from <http://www.kingsfund.org.uk/publications/supporting-people-manage-their-health>
10. Fava AF, Sonino N. The biopsychosocial model thirty years later. *Psychotherapy and Psychosomatics*. 2008;77:1-2.
11. The 20,000 Days Campaign: Health system improvement guide: VHIU Link (Very High Intensity User) Collaborative: Enabling patients at high risk of hospital readmission to self-manage and remain well at home. Auckland, New Zealand: Ko Awatea; [2014]. Available from <http://improvementmethodology.govt.nz/improvement-resources>
12. Laderman M, Mate K. Community health workers for patients with medical and behavioral health needs: challenges and opportunities. *Healthcare*. August 5, 2015. [Epub ahead of print].
13. Heisler M. Building peer support programs to manage chronic disease: seven models for success. Oakland, CA: California Healthcare Foundation; 2006. Available from <http://www.chcf.org/publications/2006/12/building-peer-support-programs-to-manage-chronic-disease-seven-models-for-success>
14. Chronic Disease Self-Management Program (CDSMP). Available from [www.patienteducation.stanford.edu](http://www.patienteducation.stanford.edu)

15. Hibbard JH, Cunningham PJ. How engaged are consumers in their health and health care, and why does it matter? Research Brief. 2008 Oct;8:1-9.
16. Bennett HD, Coleman EA, Parry C, Bodenheimer T, Chen EH. Health coaching for patients with chronic illness. Family Practice Management. 2010 Sep-Oct;17(5):24-29. Available from <http://www.aafp.org/fpm/2010/0900/p24.html>
17. Linman D. Self-management skills for employees, or how to be a productive employee [Internet]. My Management Guide; c2010-2015 [cited January 2016]. Available from <http://www.mymanagementguide.com/self-management-skills-for-employees-or-how-to-be-a-productive-employee/>
18. Wagner EH. Chronic disease management: what will it take to improve care for chronic illness? Effective Clinical Practice. 1998;1(1):2-4
19. Lorig KR, Ritter P, Stewart AL, Sobel DS, Brown BW, Bandura A, et al. Chronic disease self-management program: 2-year health status and health care utilization outcomes. Medical Care. 2001;39(11):1217- 1223.
20. Lorig KR, Sobel DS, Stewart A, Brown BW Jr, Bandura A, Ritter P, et al. Evidence suggesting that a chronic disease self-management program can improve health status while reducing hospitalization: a randomized trial. Medical Care. 1999;37(1):5-14.
21. Griffiths C, Motlib J, Azad A, Ramsay J, Eldridge S, Feder G, et al. Randomised controlled trial of a lay-led self-management programme for Bangladeshi patients with chronic disease. British Journal of General Practice. 2005;55(520):831-837.
22. Ahn SA, Basu R, Smith ML, Jiang L, Lorig K, Whitelaw N, et al. The impact of chronic disease self-management programs: health savings through a community-based intervention. BMC Public Health. 2013;13:1141. Available from <http://bmcpublichealth.biomedcentral.com/articles/10.1186/1471-2458-13-1141>
23. Bandura A. Social learning theory. Oxford, England: Prentice-Hall; 1977.
24. Bandura A. Self-efficacy. In: V. S. Ramachaudran (Ed.), Encyclopedia of human behavior (Vol. 4, pp. 71-81). New York: Academic Press; 1994 (Reprinted in H. Friedman [Ed.], Encyclopedia of mental health. San Diego: Academic Press; 1998).
25. Lau A. The case for inclusion: mental health and the National Service Framework for long-term conditions. Advances in Psychiatric Treatment. 2005;11:385-387.
26. Silver A, Surawy C, Sanders D. Physical illness and disability. In: Oxford guide to behavioural experiments in cognitive therapy. Oxford, New York: Oxford University Press; 2004. p.309-327.
27. White J. Cognitive behavioural therapy for chronic medical conditions. NY: Guilford; 2001.
28. Manaaki Hauora – Supporting Wellness Campaign [Internet]. Ko Awatea; c2015 [cited February 2016]. Available from <http://koawatea.co.nz/project/manaaki-hauora-supporting-wellness-campaign/>
29. Bodenheimer T, Laing BY. The teamlet model of primary care. Annals of Family Medicine. 2007;5(5):457-461.

## APPENDIX A: CONSENT FORM

Through your doctors at East Tamaki HealthCare, you are able to take part in the Kia Kaha Programme. The goal of the Kia Kaha programme is to link you with our team who will offer you support and information related to managing your health.

Our goal is to work alongside you and your doctor to help you to **manage better and feel stronger**:

- » through attending one of our supportive and informative six week health programmes
- » through booking appointments in your clinic or in your home with a health psychologist (a health psychologist is trained to support people when they are dealing with long term illness)
- » through meeting with a support person who can help you to problem solve to get the help you need.

We know that looking after yourself as well as managing your family relationships and work can be stressful and challenging! However, you don't have to do it alone!

### **Your voice, Your choice**

In the Kia Kaha programme we make sure you have the opportunity to tell us what is important to you and what kind of support you would like. You can ask us questions at any time. We will try to make sure you have the information you need.

It is your choice to take part in the Kia Kaha programme.  
If you choose not to take part, this will not affect your normal medical care.  
If you do choose to be involved, you can choose to stop taking part at any time.

When you are in the Kia Kaha programme, we will record information about how things are going for you. This information will only be shared with your medical team. We will add your information (without your personal details attached to it) to the information of all the participants in the Kia Kaha programme, so that we can study and see if the support we are offering is helpful.

If you would like to take part in the Kia Kaha programme and are happy with what has been explained, please sign your name below:

### Kia Kaha Programme: Your Feedback

Your feedback is very important to us. We appreciate you taking the time to answer these questions. You are welcome to write your answers below or talk with us, and we will fill out the sheet while we talk.

1. How comfortable did you feel:
  - » a) being part of the self-management health programme?
  - » b) being visited at home?
  - » c) meeting with the health psychologist (Leona or Pam)?
  - » d) meeting with the peer support specialist (Merle or Gary)?
2. What did you find most helpful? What has made the biggest difference to you?
3. Was there anything that didn't help you? Was there anything you were uncomfortable with?
4. How has our time spent with you made a difference?
5. What matters most to you? What is the most important thing to you at this time?
6. What other information/service do you still need help with?

Any other comments:



**Teamlet:** Small connected team in primary care which increases one-on-one time with the patient and supportive coaching.<sup>29</sup>

**Self-management:** All that a patient with a long-term condition does to manage their health and live their life as fully as possible.

**Self-management support:** A process for educating and empowering patients that is different from traditional information-focussed education strategies.

**Peer support specialists:** People with lived experience of recovery, who are trained to become specialist providers of intentional peer support.<sup>14</sup>

**Peer support:** Support from someone with a similar experience or cultural background to the patient.

**Biopsychosocial model:** In contrast to the biomedical model which focuses primarily on biology, the biopsychosocial model recognises that psychological and social factors also determine health and health outcomes.

**Health psychology:** Health psychology is informed by the biopsychosocial model, acknowledging the impact of psychology, behaviours and social circumstances as well as biological processes on health.

**Stanford Chronic Disease Self-Management (CDSMP) peer leader:** Someone who is not a health professional who has trained to be a facilitator in this programme.<sup>14</sup>





