# Managing long-term conditions with peer support

## The challenge of long-term conditions

The number of people diagnosed with long-term conditions is increasing.

People living with long-term conditions that affect their physical or mental health often need more than medical treatment alone. They usually also need support and information to manage lifestyle and self-care changes to help them stay as healthy as possible.

In addition, people with long-term medical conditions are more likely to develop mental health problems, and vice versa. This leads to higher risk of poor health outcomes and the development of avoidable complications, which add to the stress of having a long-term illness. It also results in presentations to emergency care and admissions to hospital, which puts strain on healthcare services and budgets.

Like many healthcare organisations, Counties Manukau Health (CM Health) serves an ageing population with an increasing rate of long-term conditions. It faces increasing demand for healthcare services and limited resources. The traditional reactive, disease-focussed approach to providing healthcare for people with long-term conditions is unsustainable.

## A new approach to managing long-term conditions

In 2013, CM Health launched the Beyond 20,000 Days Campaign. The campaign aimed to reduce demand on hospital services by helping people to stay healthy and well in the community. Sixteen collaborative teams from across Counties Manukau Health ran projects to improve their services under the campaign.

CM Health followed up the success of Beyond 20,000 Days with another campaign, Manaaki Hauora – Supporting Wellness. Manaaki Hauora – Supporting Wellness aims to provide self-management support for 50,000 people living with long-term conditions in Counties Manukau by 1 December 2016. By providing people with the tools and resources they need to take better care of their health, the campaign helps them to stay out of hospital, feel healthier, do more, get back to work sooner and feel more confident. Sixteen collaborative teams are running projects across primary and secondary healthcare services in Counties Manukau under the campaign.

Beyond 20,000 Days and Manaaki Hauora – Supporting Wellness use the Collaborative Model for Achieving Breakthrough Improvement (BTS) as an improvement methodology. The BTS is structured as learning sessions interspersed with action periods. During action periods, teams use Model for Improvement methodology to develop change packages which related to the overall campaign aim.

A key theme of the campaigns is the use of peer support as an intervention to improve self-management among people with long-term conditions. Effective peer support can increase patient confidence, perceived social support and understanding of self-care, as well as improve mood. For patients with long-term conditions, peers can provide cost-effective sustained support.2 Peer support emerged as important in Beyond 20,000 Days and has developed further in Manaaki Hauora – Supporting Wellness.

## Kia Kaha: Manage Better, Feel Stronger

The collaborative project Kia Kaha provides an example of peer support in action. Kia Kaha began in July 2013 under Beyond 20,000 Days as Kia Kaha: Manage Better, Feel Stronger. Following the end of Beyond 20,000 Days in July 2014, Kia Kaha continued to evolve as Manage Better Together: Kia Kaha ki te Hauora under Manaaki Hauora – Supporting Wellness.

Kia Kaha began with the aim to reduce hospital and general practice use for patients with two or more long-term conditions who were enrolled in the Kia Kaha programme by 25 per cent. To achieve this, the project team aimed to:

* work towards an ‘activated patient in an activated service’
* give patients choices and hear their voices
* create an effective, empowering and patient-centred change package which could be duplicated in other services and settings.

Kia Kaha works with patients enrolled with East Tamaki Healthcare in Otara. Otara is a community within the catchment area of CM Health that has a high prevalence of long-term conditions. The community has a high rate of socio-economic deprivation and a high proportion of Pacific Island people, some of whom face language and cultural barriers to accessing healthcare.

Patients are eligible for Kia Kaha if they have two or more two long-term conditions and two or more visits to emergency care or hospital admissions within the last 12 months.

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| **Box 1: Kia Kaha measures** |
| **Emergency Care visits**  The primary measure was the average number of visits to Middlemore Hospital Emergency Care by the patient cohort per month. This information was obtained from Middlemore Hospital. |
| **Engagement rates**  Engagement was defined as patients who agreed to meet with the Kia Kaha team for a health psychology assessment. The total number of eligible patients approached and the number of patients who met with the team were tracked and compared. |
| **PHQ–SADS (Patient Health Questionnaire – Somatisation Anxiety Depression Scale)[[1]](#endnote-1)**  The PHQ–SADS detects depression or anxiety disorders in patients who present with somatic complaints. Participants completed it when they first engaged with the Kia Kaha team and again after completing their chosen interventions or support. |
| **HeiQ (Health Education Impact Questionnaire)[[2]](#endnote-2)**  The HeiQ measures the effectiveness of health education programmes. Participants who participated in the six-week Manage Better Course completed it at the beginning and the end of the course. |
| **Qualitative feedback**  Participant satisfaction was measured using a qualitative feedback form co-designed with Kia Kaha peer support specialists. Participants filled it in after completing the aspects of the change package they had chosen. |

### The change package

Kia Kaha focusses on three primary drivers: engagement, activation and connection.

Engagement focusses on getting the patients who are hardest to reach – often those most in need of care – to engage with the Kia Kaha team. Activation refers to a patient’s knowledge, skills, confidence and willingness to manage their health and interact in the healthcare setting. Connection means integrating services to provide coordinated care.

Change ideas relating to these primary drivers were developed and tested using plan, do, study, act (PDSA) cycles. Successful ideas were adopted to create a change package.

**Figure 1: Overview of Kia Kaha change package**

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| **Two or more long-term conditions and two or more EC admissions in past year** |

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| **Flexible peer and professional outreach** |

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| **Patient Choice, Patient Voice** |

**Case**

**co-ordination**

**Health psychology**

**intervention**

**Peer support**

**Self-management education**

#### Engagement

To support patient engagement, Kia Kaha offers a flexible, home-based approach to assessment called ‘Patient Choice, Patient Voice’ to eligible patients.

Peer support is instrumental in patient engagement and forms a key part of the Patient Choice, Patient Voice approach.[[3]](#endnote-3),[[4]](#endnote-4) The Kia Kaha team worked with two peer support specialists to co-design a telephone script and a summary of the support Kia Kaha offers for the first contact with eligible patients.

The telephone script emphasises that Kia Kaha is an offer of support, not a request to do something. It offers the presence of a peer support person for the first meeting, explains that the patient is eligible for more support than they are receiving, expresses an interest in hearing what is important to the patient and makes it clear that it is the patient’s choice whether to meet or not. Patients are also offered the choice to meet at home or at the clinic. Most prefer their homes.

A peer support specialist accompanies the health psychologist, who conducts an assessment in a conversational style 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 formulates a biopsychosocial assessment focusing on what matters to the patient. This approach enables a comprehensive evaluation of the patient’s mental health, social and physical health concerns.

During the first meeting, the health psychologist and peer support specialist seek 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. Patients respond well to this choice of options, and most choose to take up at least one type of support.

Using a professional-peer team approach to engagement works well. The peer support specialist provides a connection with the patient’s culture and experience, and the health psychologist formulates what may be helpful for the patient.

#### Activation

Kia Kaha increases patient activation through two change ideas: individualised peer support and self-management education. In addition, psychological support including cognitive behavioural therapy and psychiatric assessment is offered to patients who need mental health treatment.

Patients can choose to receive individualised peer support from peer support specialists trained as peer workers in mental health and in the Stanford Chronic Disease Self-Management Programme. Peer supporters collaborate with health psychologists to:

* provide patients with self-management support
* act as a bridge between the patient and healthcare professionals
* help the patient to navigate the healthcare system
* advocate with other services
* provide emotional support and continuity.

Peer support may take place over the phone, in the patient’s home or at the clinic. As Otara has high numbers of Pacific Island people, peer supporters with Samoan and Tongan language and cultural expertise were added to the Kia Kaha team. This improved engagement and connection with communities that were previously difficult to reach.

The health psychologist conducts a weekly case review with the peer supporter to address safety issues, role boundaries, and whether the support given is acceptable and helpful to patients. This connection is valuable in creating sustainable, effective peer support.

In addition to individualised peer support, patients have the opportunity to attend self-management education. Self-management education covers goal setting, action planning, problem solving, decision making and disease-specific information.

Kia Kaha delivers self-management education through its Manage Better Course. This course is based on the Stanford University Chronic Disease Self-Management Programme, which has demonstrated positive outcomes for people with long-term conditions and their caregivers.[[5]](#endnote-5),[[6]](#endnote-6) The courses run for six weeks, with a two-and-a-half hour interactive session each week. There is a small group of 12-16 participants per course. When possible, trained volunteers from the local community provide the courses in the patients’ own general practice (GP) clinic.

Patients and their family members experience support not only from course leaders, but also from each other.

Family members of patients are invited to participate in all aspects of Kia Kaha, including the Manage Better Course. Providing caregivers with support, information and tools appears to make a difference for everyone in the family, particularly when the patient is very unwell.

There was a demand for language and culture-specific self-management support, particularly in Pacific and Asian languages. Based on this feedback, the Kia Kaha team have accessed the course manual in Tongan and Hindi and are waiting for latest Samoan translation.

Patient activation needs to be complemented with service activation. Some patients and families found that their newfound enthusiasm for using healthcare services more effectively as a result of the Manage Better Course met with an unresponsive service or uncommunicative clinician.

#### Connection

Kia Kaha works on relationships with other services that patients need to connect with to support more collaborative interaction. The team established regular case co-ordination meetings with the Very High Intensity Users team and other secondary care teams at CM Health. Kia Kaha also works closely with the Clinical Family Navigator Team and Primary Mental Health Team in primary care.

Developing good relationships with other services gives the Kia Kaha team a more complete picture of each patient’s situation, which enables timely, appropriate, patient-centred care. It also improves access to other services for patients.

It is important to involve patients in directing care coordination as much as possible by identifying their needs, their priorities and obtaining consent to coordinate their care.

### Outcomes

In its first year, Kia Kaha achieved a 41 per cent drop in Emergency Care visits among its patient cohort, exceeding its aim to reduce hospital use by 25 per cent (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 in presentations to Emergency Care**

Number of presentations to Emergency Care

Initially, Kia Kaha engaged with patients by offering an appointment with a health professional. This achieved an engagement rate of about 50 per cent. 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: Effect of peer outreach on engagement**

Percentage of people contacted who made a first appointment

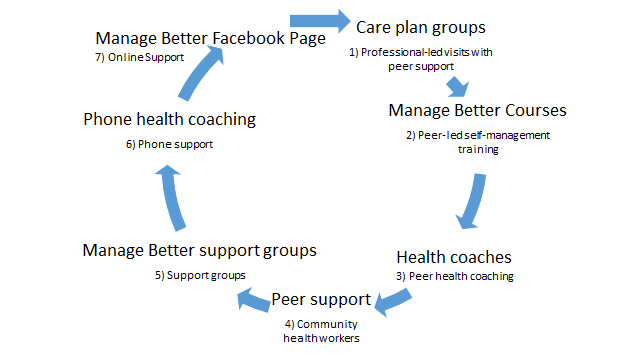
## Manage Better Together: Kia Kaha ki te Hauora

Following its success under the Beyond 20,000 Days campaign, Kia Kaha continues to develop under Manaaki Hauora – Supporting Wellness.

Under Manaaki Hauora, Kia Kaha aims to extend its support to 5,000 East Tamaki Healthcare patients with long-term conditions who live in Otara by 1 December 2016.

To do this, Manage Better Together: Kia Kaha ki te Hauora is working to improve engagement, activation and connection through a 'wheel of support' that comprises seven types of peer-led self-management support (Figure 3).

**Figure 3: Wheel of support – professional and peer team2**

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The pairing of professionals and peer supporters worked well to engage and activate Kia Kaha patients in Beyond 20,000 Days, and the team are developing it further under Manaaki Hauora – Supporting Wellness. ‘Wheel of support’ interventions include professional-led visits with peer support, peer-led self-management training, peer health coaches,[[7]](#endnote-7) community health workers, support groups, telephone-based peer support and web- or email-based programmes. The Kia Kaha project team are currently developing and testing change ideas to formulate a change package based on the ‘wheel of support’ (Table 1).

**Table 1: Manage Better Together: Kia Kaha ki te Hauora change package development**

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| **Theory of change** | **Purpose and delivery of change** | **Change ideas** | **Evidence of improvement and current status** |
| Professional-led visits with peer support | Professional-peer-led care planning   * Provide further self-management training and support * Give patients tools to connect to medical team * Support ARI (At Risk Individuals) teams | * Consider people in the same system * Move steps in the process closer together * Standardisation * Conduct training | * Training of ARI teams and peer supporters in Flinders programme[[8]](#endnote-8) *(Developing a change)* * Observation and licensing prior to testing with patients *(Developing a prototype)* |
| Peer-led self-management training | Manage Better Courses   * Support self-efficacy * Social and emotional support * Health information * Peer support | * Give people access to information * Coach patients to use a product or service * Focus on the outcome to a patient * Develop alliances and cooperative relationships | * Thematic analysis of feedback about the courses *(Implementing)*. Feedback related to positive changes through Manage Better courses in practical skills, illness perceptions, self-improvement and social aspect. * HeiQ *(Implementing)*. Observed improvement in eight health-related scales measured on pre/post HeiQ. * Overall self-management education PHQ–SADS *(Implementing)*. Reductions in psychological distress observed in pre/post PHQ-SADS. * Tongan, Hindi and Samoan courses *(Prototyping a change)* |
| Peer health coaches | Peer health coaching   * Self-management support * Connection to medical home * Patient-family centred approach * Individual approach | * Conduct training and cross-training * Coach patients to use a service * Match the amount to need * Move steps in the process closer together * Develop alliances and cooperative relationships | * Active testing *(Developing a change)* * Feedback from participants *(Developing a change)* |
| Community health workers | Referral pathways to existing services plus peer health coaching/peer support   * Advocacy * Patient/family-centred care * Social and emotional support | * Move steps in the process closer together * Focus on the outcome to a patient * Match the amount to need | * Connection to Manage Better Courses * Connection to services in the community *(Developing a prototype)* * Peer health coaching to connect to GP *(Developing a change)* |
| Support groups | Patient organised, peer-supported groups   * Support self-management * Support self-efficacy * Social and emotional support | * Develop alliances and cooperative relationships * Listen to patients | * Two groups established * Action plan at every session *(Developing a prototype)* |
| Telephone-based peer support | Peer health coaching   * Weekly action plans * Follow-ups and reminders * Connection to medical home | * Standardisation * Develop alliances and cooperative relationships * Match the amount to need | Active testing *(Developing a prototype)* |
| Web/email-based programmes | Manage Better Together Facebook page   * Connection * Promotion of concepts and programmes * Social and emotional support | * Give people access to information * Coach patients to use a product or service * Invest more resources in improvement * Develop alliances and cooperative relationships | Facebook page started but project stalled due to internet connectivity *(Developing a change)* |

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