

HEALTH SYSTEM IMPROVEMENT GUIDE

Folau I Lagi-Ma – Journey to Wellness





The Folau I Lagi-Ma project is an excellent example of the change we can achieve with collaborative improvement methodology.

The Folau I Lagi-Ma collaborative project brought together project manager and improvement advisor expertise from Ko Awatea with the clinical expertise of frontline healthcare staff. Together, they created an innovative new model of self-

management support that integrates occupational therapy and peer support into primary care to help people living with long-term conditions in Counties Manukau to manage their own health and achieve a better quality of life.

Folau I Lagi-Ma formed part of the wider Manaaki Hauora – Supporting Wellness campaign, which was structured according to the Breakthrough Series Collaborative Model for Achieving Breakthrough Improvement. A collaborative brings together groups of practitioners to work in a structured way to improve aspects of the quality of their service. It involves meetings to learn about best practice in the chosen area, quality improvement methods and change ideas, and to share experiences of making change in local settings.¹ This structure enabled Ko Awatea to engage clinical staff in project teams and build their capability to deliver improvement.

The Breakthrough Series approach incorporated learning sessions where project teams learned how to use quality improvement tools, such as driver diagrams and the Model for Improvement. These tools enabled project teams to understand the factors that drive success in clinical systems and to develop and test change ideas to learn what works in practice to create improvement.

Throughout the Manaaki Hauora – Supporting Wellness campaign, healthcare staff and members of our community have been excited about getting the chance to try things they think will improve care and being given the time, skills and resources they need to do it. Patients and their families are telling a different story about their quality of life now. We are proud to have made a difference for people living with long-term conditions in Counties Manukau.

Diana Dowdle
Delivery Manager

We would like to acknowledge Tess Ahern and Peter Watson from Mental Health and Addictions Services for approving the project.

To the rest of the Folau I Lagi-Ma team, Leigh McCabe, Fionna Sutherland, Alofa Leilua, Rachel Forrest, Cassandra Laskey, Krishna Narayan, Dr Tim Hou, Harriet Pauga, Ian Hutchby and Danielle Farrell, thank you for your dedication and teamwork.

We also thank the Manaaki Hauora – Supporting Wellness campaign team for overseeing the project and assisting Folau I Lagi-Ma to grow from an idea into an established health service within primary care.

Finally we would like to acknowledge Shelley Kennedy. Thank you for initiating this project; your passion for occupational therapy and its establishment in primary care is outstanding. Your support, ideas and research during this journey have been invaluable. We also thank you for your large contribution to the writing of this guide.



"Folau I Lagi-Ma has made a huge difference from the beginning to now. Life is great. I feel mentally stronger for the support I received from being with Folau I Lagi-Ma. I am grateful and thankful for everything."

Patient, Folau I Lagi-Ma

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Folau I Lagi-Ma is an innovative project which integrates occupational therapy and peer support into Mangere Health Centre, a primary care practice in Counties Manukau, to deliver better care to people living with long-term conditions.

The project was developed as part of the Manaaki Hauora – Supporting Wellness campaign led by Ko Awatea, the centre for healthcare improvement, education and innovation at Counties Manukau Health. The Manaaki Hauora – Supporting Wellness campaign was launched in 2015 to provide self-management support for people living with long-term conditions.

The campaign included 16 project teams, each with a unique aim that related to the overall campaign. It was structured according to Institute for Healthcare Improvement Breakthrough Series methodology.² Project teams used the Model for Improvement to develop and test change ideas.³

Folau I Lagi-Ma helps to bridge the gap in primary care in Counties Manukau for a holistic service to support people who experience both physical and mental health symptoms. It is particularly important for Mangere Health Centre because the practice serves a high-needs population with large numbers of people who have long-term conditions.

The vision of Folau I Lagi-Ma is to support people with long-term conditions to:

- understand their health conditions and how their lifestyle is able to positively impact on their conditions
- make behavioural changes to integrate their health information into their daily activities, through improving knowledge, problem-solving and practical support
- understand that engaging in meaningful activities can promote health and wellbeing.

Our aim was to work with 45 people with long-term health conditions by December 2016 to improve their overall EUROHIS quality of life score by four points.

To achieve this aim, we used Model for Improvement methodology to create a change package aligned around three primary areas of focus. Change ideas were developed and tested for each one.

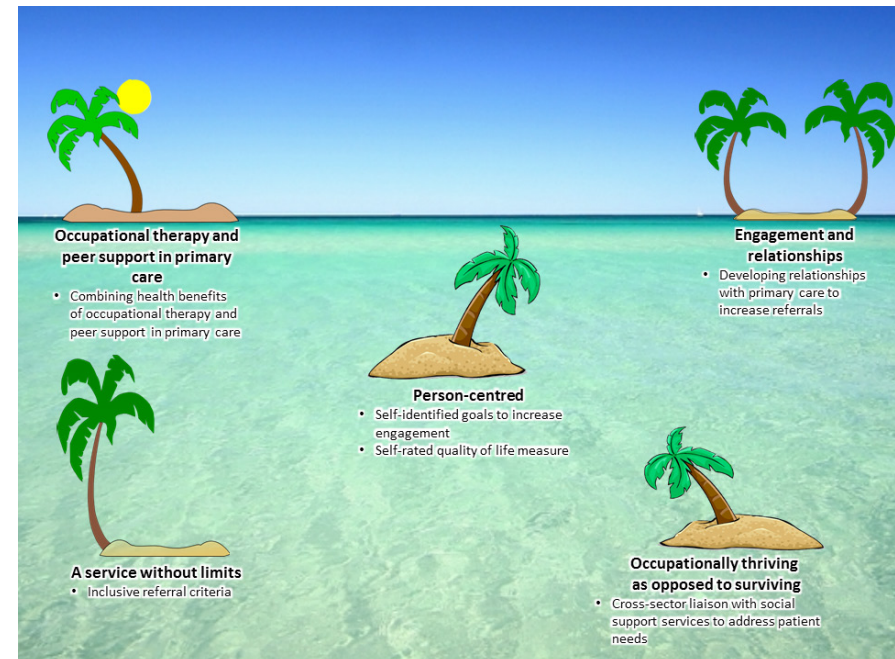
1. Activated service users
 - Initial interview
 - Tailored number of sessions
2. Activated general practitioners
 - Referral process
 - Nurses' forum

3. Self-management

- Working with physical health occupational therapist
- Occupational therapist and peer support specialist intervention to support self-management of health conditions

Using the EUROHIS-QOL (Quality of Life) 8-item index,⁴ the Folau I Lagi-Ma team collect pre- and post-intervention scores to measure the outcome of their interventions on patient quality of life. We found that, on average, patients experience an increase of 7.8 points in their EUROHIS-QOL score, indicating a better quality of life after participating in Folau I Lagi-Ma.

Figure 1: The Folau I Lagi-Ma 'Journey to Wellness' – key elements



Folau I Lagi-Ma is an innovative new project which integrates an occupational therapy and peer support service into a primary care practice in Counties Manukau to deliver better care for people living with long-term conditions.

Traditionally, occupational therapists are employed in secondary healthcare services to help people manage their health conditions, engage in meaningful everyday activities that support health and wellbeing, and to promote recovery. In Folau I Lagi-Ma, we wanted occupational therapists to work with patients earlier, when the patient is less affected by their condition, and to promote recovery and wellness before the condition has a detrimental effect on the patient's physical and mental health and their quality of life.

Similarly, the benefits of peer support in secondary services have been reported by patients and clinicians at Counties Manukau Health,⁵ and we believed that it could also provide positive outcomes cost effectively in primary care.

Folau I Lagi-Ma was developed in the Mangere Health Centre, which is part of the primary health organisation (PHO) group, Pro Care. The centre is a multipurpose facility that houses 10 doctors and associated nursing and administrative staff. It serves a growing high-needs population where poverty is an issue and access to care is problematic. The ethnic mix of the population is 42 per cent Pacific Islander, 20 per cent Māori and 20 per cent European, with the remainder of Asian or other ethnicity.

The project was developed, funded and supported as part of the Manaaki Hauora – Supporting Wellness campaign led by

Ko Awatea, the centre for healthcare improvement, education and innovation at Counties Manukau Health. Manaaki Hauora – Supporting Wellness was an umbrella campaign that supported a range of projects by providing funding and training and expertise in improvement methodology. The campaign had a unifying goal to provide self-management support for 50,000 people living with long-term conditions in Counties Manukau, which all of the collaborative project teams shared. In addition, each collaborative team had a unique aim and change ideas, which ultimately contributed to the overall campaign goal.

The Manaaki Hauora – Supporting Wellness campaign used the Breakthrough Series (BTS) approach to train and support participating teams in improvement methodology and collaborative working.² The BTS was structured as five learning sessions interspersed with action periods.

During learning sessions, collaborative teams learned how to use Model for Improvement quality improvement methodology.³ The Model for Improvement asks three questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

During action periods, teams tested their theory of change using plan, do, study, act (PDSA) cycles.

This guide describes the development, implementation and outcomes of the Folau I Lagi-Ma project.

An estimated 24 per cent of New Zealanders live with disability, which is defined as ‘... long-term limitation (resulting from impairment) in a person’s ability to carry out daily activities.’⁶ Forty-two per cent of disabled adults, aged between 15 and 44 years, are affected by more than one type of impairment. Many experience both mental and physical health symptoms, but there is often little access to coordinated mental and physical health support in primary care.

As a result, many people with multiple health conditions are provided with information about their conditions but do not understand it (it is not provided in a way that they understand it) and cannot or do not apply the information to their lifestyle. Often people are able to make short-term changes but do not sustain them long-term.

Occupational therapy and peer support services can help to bridge the gap between mental and physical health support in primary care, and there is international evidence supporting the development of occupational therapy roles in primary care.⁷

Despite this, there are few occupational therapists working in general practices in New Zealand.⁸ District health boards have been slow to understand the role of occupational therapists and the potential to apply their skills in a primary care setting.

In Counties Manukau, there is currently limited mental health-specific education and support for people with mild to moderate mental health conditions in PHOs and general practices. There

is no service that provides holistic support for people with co-existing mental and physical health conditions, no service that helps people to self-manage and understand how their conditions interact, and no known primary care occupational therapy service.

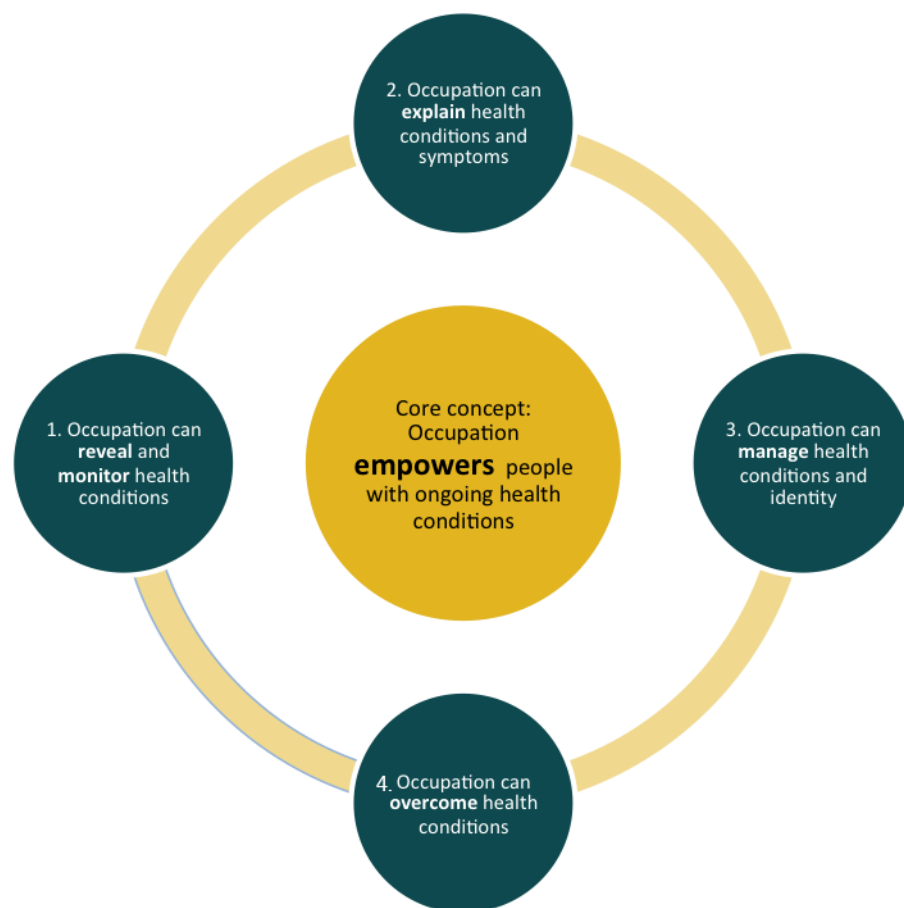
For Mangere Health Centre, finding a better way to support patients with co-existing long-term conditions was imperative. The centre has large numbers of patients with long-term conditions. Of an enrolled population of about 12,000 people, 1,200 have diabetes, including 250 to 300 with HbA1c of over 74.9. Chronic obstructive pulmonary disease, mental health conditions and chronic heart failure are also over-represented in the practice population.

Research by White, Lentin and Farnworth shows that engaging in occupations can reveal, explain, manage and overcome long-term health conditions (Table 1).⁹

Table 1: Key findings by White et al., with hypothetical examples

Role	Finding	Example
Reveal	Participants became aware of symptoms in the context of doing their normal occupations.	"Usually I walk to and from the bus, but this is harder now."
Explain	Participants reflected as to whether doing the occupation had caused their health conditions, helped to make sense of what caused them and why.	"Did my smoking cause my shortness of breath?"
Manage	Participants managed their health conditions through their choice of occupations and activities to maintain wellness.	"Do I cook this dessert? How will it affect my blood sugars?"
Overcome	Participating in occupations enabled people to overcome the challenges created by their health conditions. It helped people continue to engage in favourite activities, set goals and find new opportunities.	"I can still walk with my friends to the beach for a picnic." "I have made new friends since going to the gym."

Figure 2: The roles and meaning of occupation



In line with this research, the vision of Folau I Lagi-Ma is to support people to:

- understand their health conditions and how their lifestyle is able to positively impact on their conditions
- make behavioural changes to integrate their health information into their daily activities, through improving knowledge, problem-solving and practical support
- understand that engaging in meaningful activities can promote health and wellbeing.

The specific aim of the project was to work with 45 people with long-term health conditions by December 2016 to improve their overall EUROHIS-QOL (Quality of Life) score by four points.

EUROHIS-QOL 8-item index

Folau I Lagi-Ma uses the EUROHIS-QOL (Quality of Life) 8-item index, a shortened version of the World Health Organization Quality of Life Instrument – Abbreviated Version (WHOQOL-BREF), to measure changes in quality of life pre- and post-intervention for individual people.⁴

This index is self-assessed and measures changes across eight domains:

- overall quality of life
- satisfaction with health
- energy level
- activities of daily living
- satisfaction with self
- personal relationships
- finances
- satisfaction with living conditions.

The maximum score on the EUROHIS-QOL 8-item index is 40 and the minimum score is eight. We aim for patients to increase their overall score by at least four points at the end of the intervention, indicating an improvement in their quality of life.

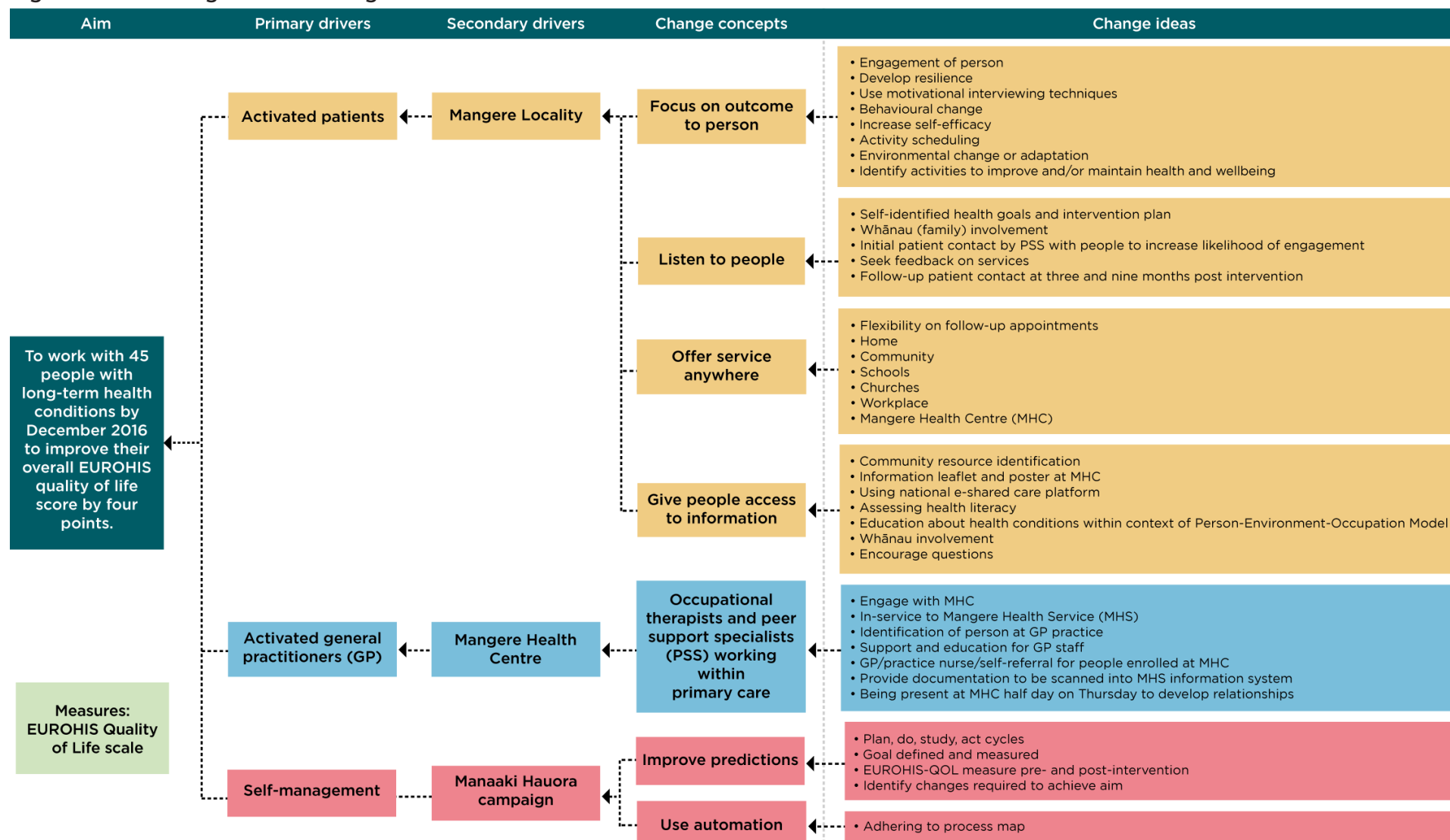


Folau I Lagi-Ma team meeting

“My body and my health feel so much better. Having someone come to my house and understand my life has helped me. I am happy now to have clothes to exercise in and I can move a lot more now.”

Patient, Folau I Lagi-Ma

Figure 3: Folau I Lagi-Ma driver diagram

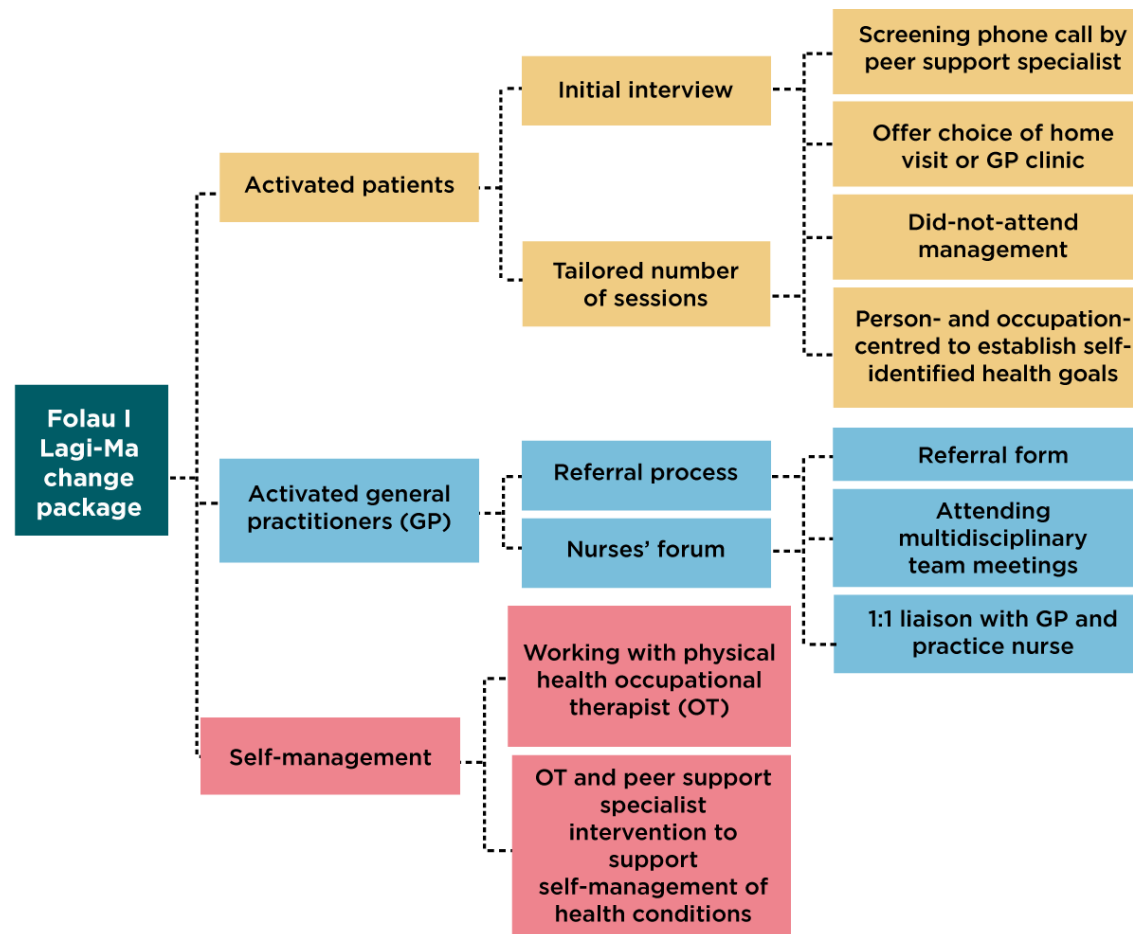


The Folau I Lagi-Ma change package focused on three primary drivers:

1. Activating patients
2. Activating general practitioners (GP)
3. Supporting self-management

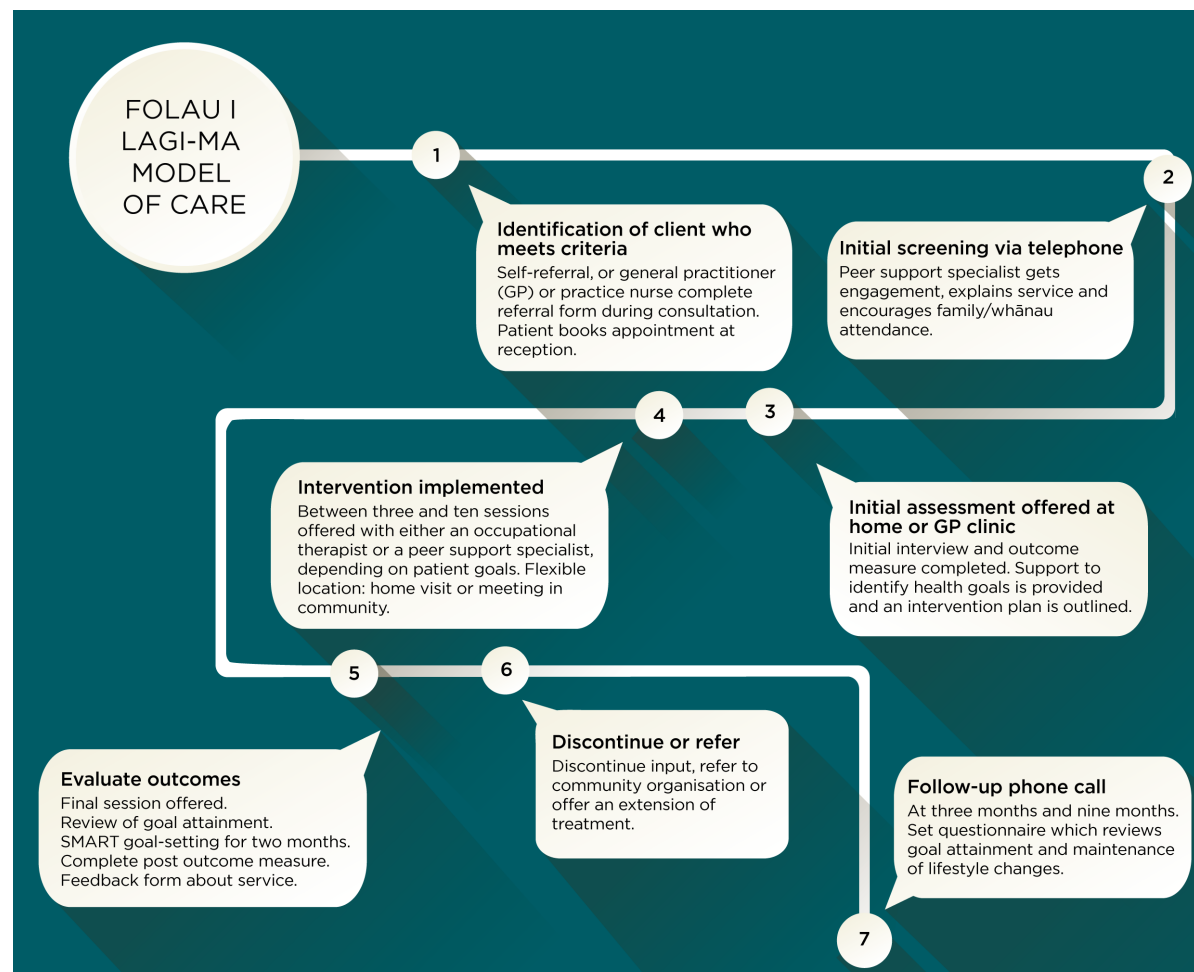
We identified change concepts and developed and tested specific change ideas that supported the primary drivers (Figure 4).

Figure 4: Folau I Lagi-Ma change package



Using the ideas in our change package, we created a model of care for the Folau I Lagi-Ma service (Figure 5).

Figure 5: Folau I Lagi-Ma model of care



INITIAL INTERVIEW

The purpose of the initial interview is to establish rapport, gather information and identify what is important to the person to determine a self-identified health goal.

The peer support specialist is integral to this step, as peer support provides:

- a way of being in relationships that shows people they have the power to recover
- an attitude that values each person's experience
- a way of offering help and support as an equal
- a way of teaching learning and growing together
- a shared personal experience of recovery that inspires hope.

Screening telephone call by peer support specialist

Once a referral has been received, the Folau I Lagi-Ma peer support specialist makes contact with the patient by telephone. The peer support specialist explains and introduces the service, gains consent for further input and makes an appointment for the initial interview.

"I find this [the telephone call] has been very beneficial in establishing the rapport with the person from the outset. Usually a general conversation about their day and how they are getting on occurs."

Alofa Leilua, Peer Support Specialist

Offer choice of home visit or GP clinic

Patients can choose to hold the initial interview at home or at their GP clinic. Some patients also choose to meet in the community at a local café to provide a neutral environment or have a respite from home. Meeting in a place where the patient feels comfortable helps to promote engagement. For the clinician, home visits are of particular benefit in understanding the patient in their context, particularly from an occupational therapy perspective when assessing the physical environment.

DNA (did-not-attend) management

The referrals Folau I Lagi-Ma receives are often patients who are considered to have complex needs and to be difficult to engage. One of the challenges we experienced during the implementation of the Folau I Lagi-Ma service was difficulty managing non-attendance at the initial interview.

We initiated a reminder system facilitated by the peer support specialist to manage DNAs. Depending on the patient's preferred communication channel, the peer support specialist contacts the patient by text message or telephone call with a reminder the day before the appointment.

The difference the reminders made became most apparent during a period in late 2015, when the peer support specialist took annual leave. Without the screening call and reminder system, the DNA rate increased significantly.

TAILORED NUMBER OF SESSIONS

Following the initial interview, an intervention plan is developed. Folau I Lagi-Ma offers between three and ten sessions with either an occupational therapist or a peer support specialist, depending on patient goals and needs. Sessions may be held at home, at the GP clinic, or at a third location in the community.

Person- and occupation-centred to establish self-identified health goals

Folau I Lagi-Ma encourages patients to set self-identified health and occupational goals. This increases the likelihood of engagement by enabling us to offer interventions that are meaningful to the patient.

During the initial interview and intervention process the person is at the centre of everything we do. We listen to what they need and want. We seek to understand what is important to them to live a **self-defined** well life.

We use the EUROHIS-QOL scale, which is self-rated, to support the establishment of self-identified health and occupation goals. We then use it as an outcome measure to ensure goals are achieved.

"You always listen to me and are non-judgemental. It brightens my day when you visit."

Patient, Folau I Lagi-Ma

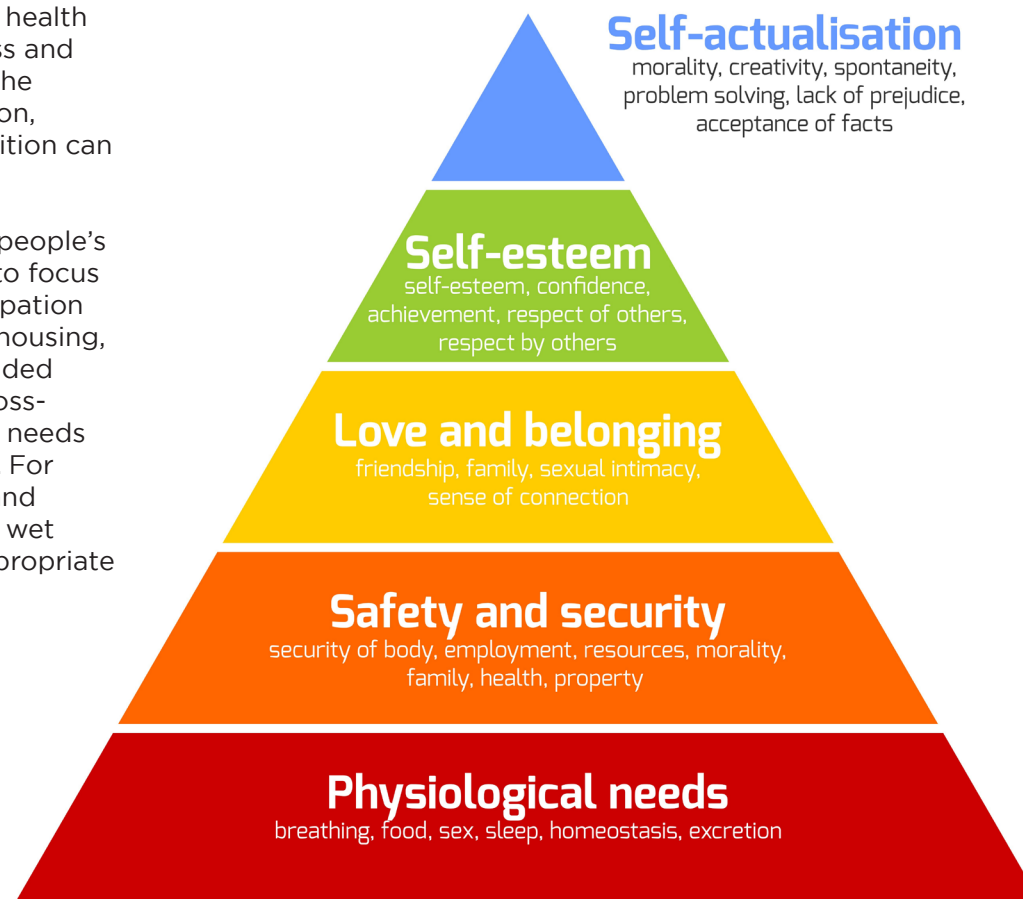


From left: Rachel Forrest, Occupational Therapist; Tiffany, patient; and Alofa Leilua, Peer Support Specialist, celebrating Tiffany's victory in the Fight for Life charity boxing challenge

Supporting people to improve their ability to engage in meaningful occupations already in their routine or assisting them towards newly identified occupations can improve overall health outcomes. For example, teaching people about their illness and equipping them with skills to self-manage their health in the context of their daily routine, improve mood and motivation, increase engagement in activity and overcome their condition can lead to an improved quality of life.

In line with Maslow's Hierarchy of Needs, we learned that people's basic needs have to be addressed before they can begin to focus on improving their health or engaging in meaningful occupation (Figure 6).¹⁰ Because these needs include factors such as housing, which are beyond the scope of services traditionally provided by healthcare organisations, we needed to co-ordinate cross-sectorially with social services to meet our patients' basic needs before they could engage with self-management support. For example, we liaised with Housing NZ to arrange housing and housing modifications, such as installing ramp access and wet room showers, for patients who lacked affordable and appropriate accommodation.

Figure 6: Maslow's Hierarchy of Needs



REFERRAL PROCESS

Folau I Lagi-Ma initially faced a challenge obtaining referrals and consent. There was limited understanding of the role of occupational therapy and peer support. In addition, many different initiatives and projects were underway at the Mangere Health Centre, resulting in change fatigue among practice staff.

It was therefore important to create an easy referral pathway and increase understanding of the Folau I Lagi-Ma service. Face-to-face relationship building with general practitioners (GPs) was essential. The GPs needed to understand how Folau I Lagi-Ma's approach differed from other services. We also needed to be well oriented to, and understand, the culture of the practice to support GP engagement.

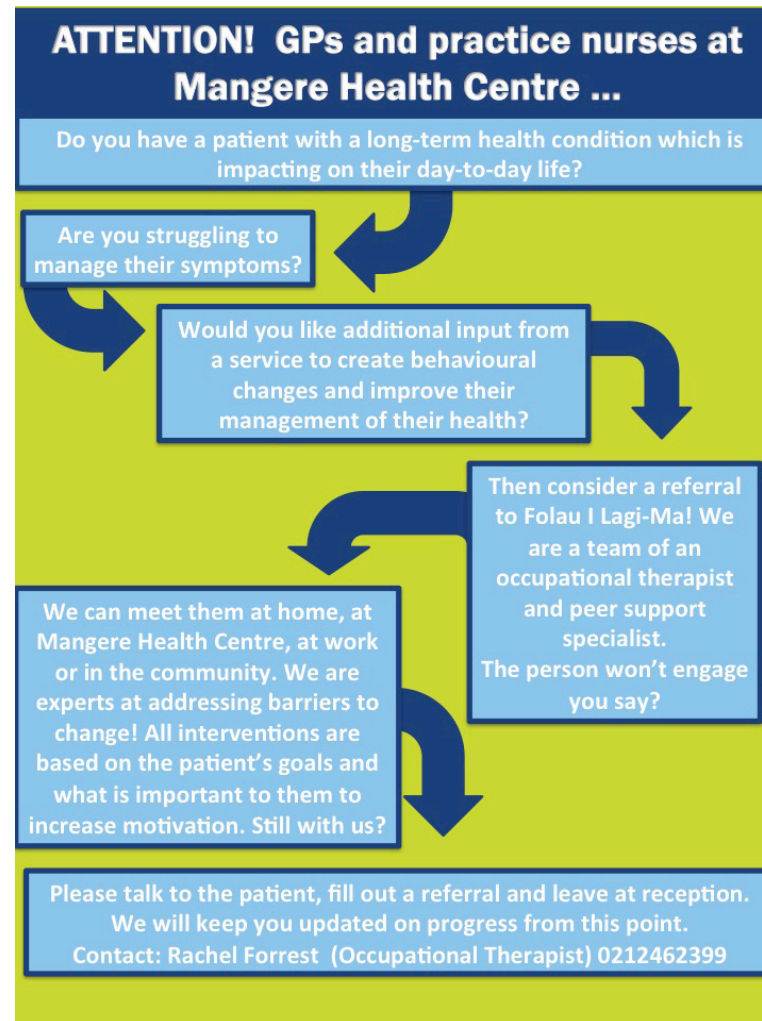


Mangere Health Centre

Figure 7: Folau I Lagi-Ma promotional poster

"Folau I Lagi-Ma is a quick and reactive service that has created a health pathway for patients. We've seen results and things getting done. Service provision is more integrated, and other services in the community are being utilised. The feedback from patients has been good, too."

Dr Tim Hou, GP, and Harriet Pauga, practice nurse, Mangere Health Centre.



Referral form

A referral form (Appendix A) was created and circulated to Mangere Health Centre for feedback before being finalised. The form included clear criteria for referral and prompted the referring GP or practice nurse for information on the patient's long-term physical and mental health conditions, ability to function in daily life, potential risk issues for home visits, and other information, such as language and cultural preferences. The form was incorporated into the Mangere Health Centre information system for easy access by clinicians.

Attending multidisciplinary team meetings

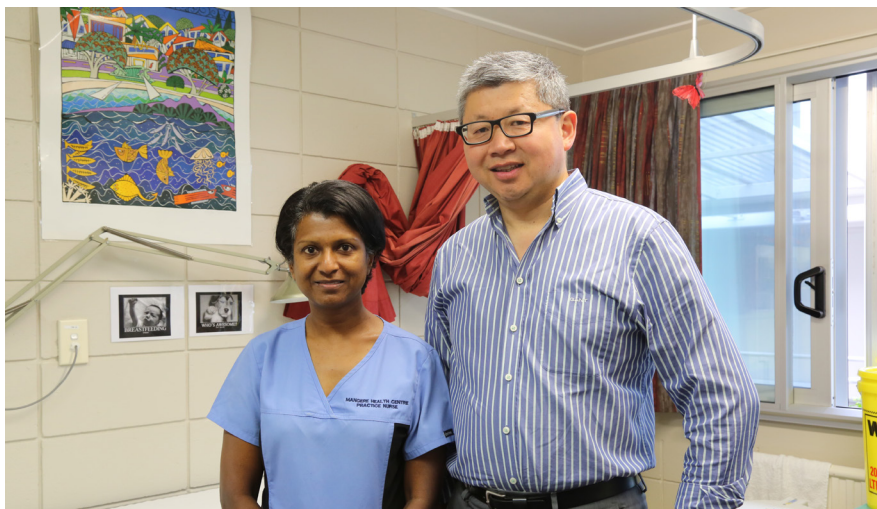
Holding regular multidisciplinary team meetings is crucial for referrals, providing feedback, and increasing team members' knowledge and understanding of the self-management support services offered. Meetings include representatives from Mangere East Family Services, district nurses, allied health, Needs Assessment Service Coordination, self-management education services, primary care and integrated support, Folau I Lagi-Ma and practice nurses. An average of one or two referrals were received from each monthly meeting.

1:1 Liaison with GP and practice nurse

The Folau I Lagi-Ma team found face-to-face interaction to be the most effective method of relationship building. To build the relationship with GPs and practice nurses at the Mangere Health Centre, the Folau I Lagi-Ma occupational therapist and peer support specialist dedicated time to be present at the centre to collect informal feedback on referrals through 'corridor conversations'. This helped to establish trust and demonstrate what interventions and outcomes were being achieved.



Dr Tim Hou (left) and practice nurse, Harriet Pauga, at Mangere Health Centre



Dr Tim Hou (right) and practice nurse, Mala Beermathy, at Mangere Health Centre

Folau I Lagi-Ma and Mangere Health Centre staff used the National Shared Care Plan to access each other's clinical information and remain integrated in otherwise separate information systems. This documentation style also fit with being person-centred, as the care plans are written in the patient's words and identify their goals and what is important to them. Patients can also have electronic access to their plan if they wish, although there was limited interest in this, with patients often preferring hard copies.

NURSES' FORUM

Initially, referrals to Folau I Lagi-Ma were made only by the GP and nurse manager at Mangere Health Centre. The Folau I Lagi-Ma team wanted to encourage practice nurses at the Centre to refer patients to the programme.

A nurse manager at Mangere Health Centre acted as a champion for Folau I Lagi-Ma. Having a champion within the team who understood the service and could encourage others to refer was hugely beneficial.

Part of the nurse manager's role was to facilitate a regular nurses' forum for practice nurses at Mangere Health Centre. The forum offered an opportunity to demonstrate the benefits of Folau I Lagi-Ma, develop relationships with practice nurses and encourage them to refer.

In addition, Folau I Lagi-Ma did not receive any self-referrals and often edification of the service from the nurse during consultations was vital for patient engagement.

WORKING WITH A PHYSICAL HEALTH OCCUPATIONAL THERAPIST

Folau I Lagi-Ma has been able to provide a holistic occupational therapy intervention from both mental and physical health perspectives. A physical health occupational therapist provides consultation and supervision to the mental health occupational therapist as required for patients who have physical health conditions that impact on their ability to engage in daily occupations. In the project's first year, five out of 18 patients (28 per cent) referred to Folau I Lagi-Ma needed input from the physical health occupational therapist. The physical health occupational therapist also attends Manaaki Hauora – Supporting Wellness campaign learning sessions and Folau I Lagi-Ma team meetings.

Table 2: Year One input from physical health occupational therapist

Patient	Physical health occupational therapist input
Patient 1	<ul style="list-style-type: none"> • Consultation about housing modifications and whether patient meets criteria for Housing NZ assistance. • Support to complete Housing NZ recommendation letter.
Patient 2	<ul style="list-style-type: none"> • Consultation about equipment prescription/ordering and arranging equipment installation. • Three joint home visits. • Liaison with inpatient occupational therapists when patient admitted to hospital. • Discussion pre/post team meetings.
Patient 3	<ul style="list-style-type: none"> • Assessment for equipment prescription/ordering and arranging equipment installation. • Liaison with inpatient occupational therapists when patient admitted to hospital. • Two joint home visits. • Three independent home visits. • Telephone and email support. • Liaison with practice nurse at Mangere Health Centre.
Patient 4	<ul style="list-style-type: none"> • Assessment of physical function and mobility, peer supervision and support to apply for special funding for adaptive kitchen equipment. • Consultation about referral to physiotherapy to improve mobility and reduce falls risk. • Two joint home visits. • Two meetings with mental health occupational therapist for peer supervision and to apply for Ministry of Health special funding for equipment.
Patient 5	<ul style="list-style-type: none"> • One meeting for peer supervision around intervention for anxiety management.

OCCUPATIONAL THERAPY AND PEER SUPPORT INTERVENTIONS TO SUPPORT SELF-MANAGEMENT OF HEALTH CONDITIONS

Folau I Lagi-Ma delivers self-management support by integrating occupational therapy and peer support approaches. Both approaches are well suited to promoting self-management.

Occupational therapy has a philosophy which mirrors principles of self-management. It is a holistic approach to health which puts the person at the centre of their care. Occupational therapists work to support healthy lifestyles, prevent illness and disability, and promote and restore health through supporting participation in occupation.¹¹

The role of an occupational therapist in supporting self-management is to:

- teach new ways of doing things following illness or injury, such as dressing or cooking
- adapt home, work or school environments
- acknowledge and develop the person's abilities so they can participate in the things that are important to them
- help the person to develop new skills, abilities, or interests at work, school, and home or in social situations
- access support available in the community
- assist the person to feel better about themselves and what they do
- help the person to develop a healthier lifestyle.



The Folau I Lagi-Ma team at a Manaaki Hauora – Supporting Wellness campaign learning session

The benefits of peer support are wide-ranging. It has been shown to improve engagement, decrease depression, and reduce the use of emergency departments and hospitals for patients in mental health services.¹² It can improve self-care and a sense of community belonging, as well as increasing patients' sense of hope, control and ability to effect change in their lives.¹²

Peer support works because it is a way of offering help and support as an equal, of teaching and learning together and of showing people they have the power to recover. It values sharing personal experiences of recovery to inspire hope. In addition, patients can identify with peer supporters and share common experiences, which help to forge a bond of understanding, empathy and mutual help.

Peer support helps patients to understand and apply the five key recovery concepts – hope, personal responsibility, education, self-advocacy and support – which motivate people to take control of their overall health and wellbeing. This leads to developing coping strategies, linkage to clinical care and sustained self-management of their health conditions.

For healthcare providers, well-designed peer support models offer a means for delivering self-management support that is economical as well as effective. Peer support interventions are less resource-intensive than traditional models of support because they can use volunteers or staff members who are not trained healthcare professionals. In this way, peer support reduces the burden on clinicians of providing self-management support for the burgeoning number of people with long-term conditions.¹³

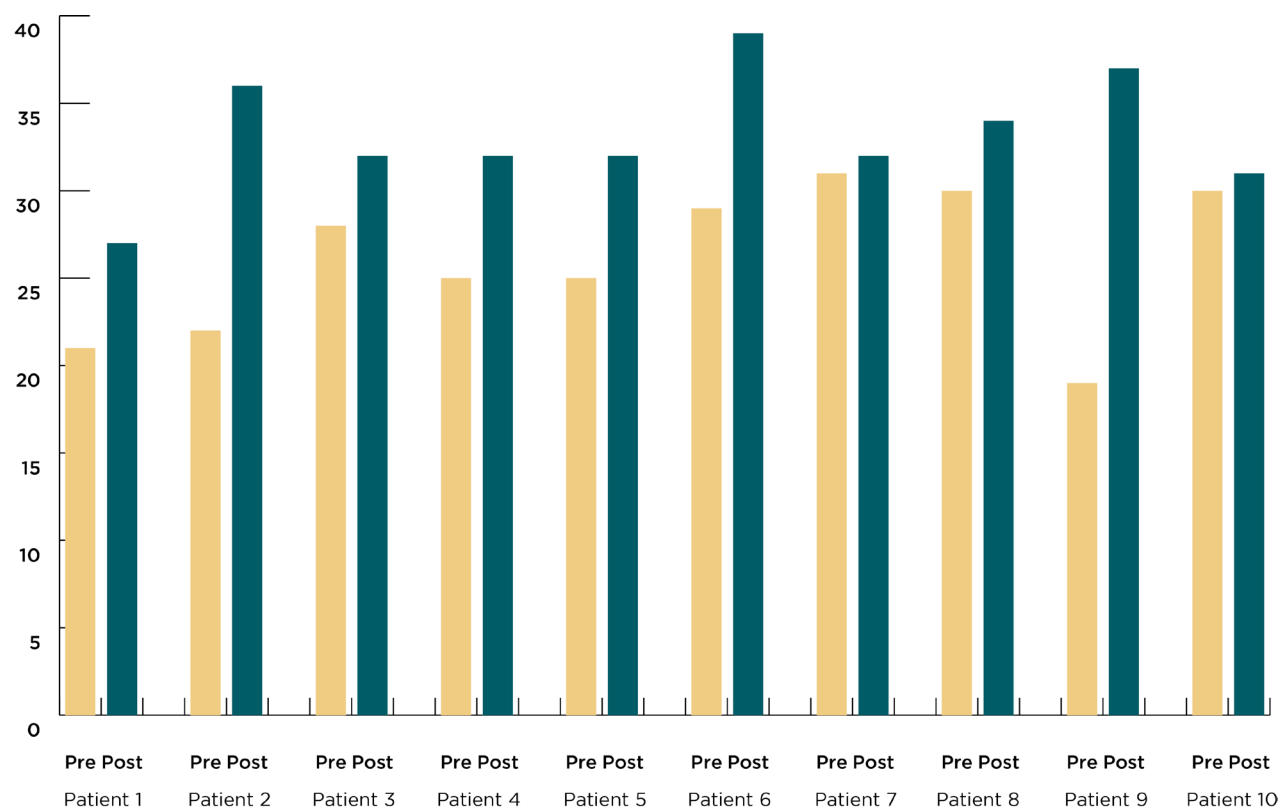


Rachel Forrest, occupational therapist (left) and Alofa Leilua, peer support specialist (right) planning the use of improvement methodology at a Manaaki Hauora – Supporting Wellness campaign learning session

IMPROVED PATIENT QUALITY OF LIFE

Our aim was to increase each patient's EUROHIS-QOL overall scores by four points. Ten out of 18 Folau I Lagi-Ma patients completed pre and post EUROHIS-QOL index scores. All patients experienced an improvement in their overall EUROHIS-QOL score, and eight out of 10 patients achieved an increase of four points or more (Figure 8).

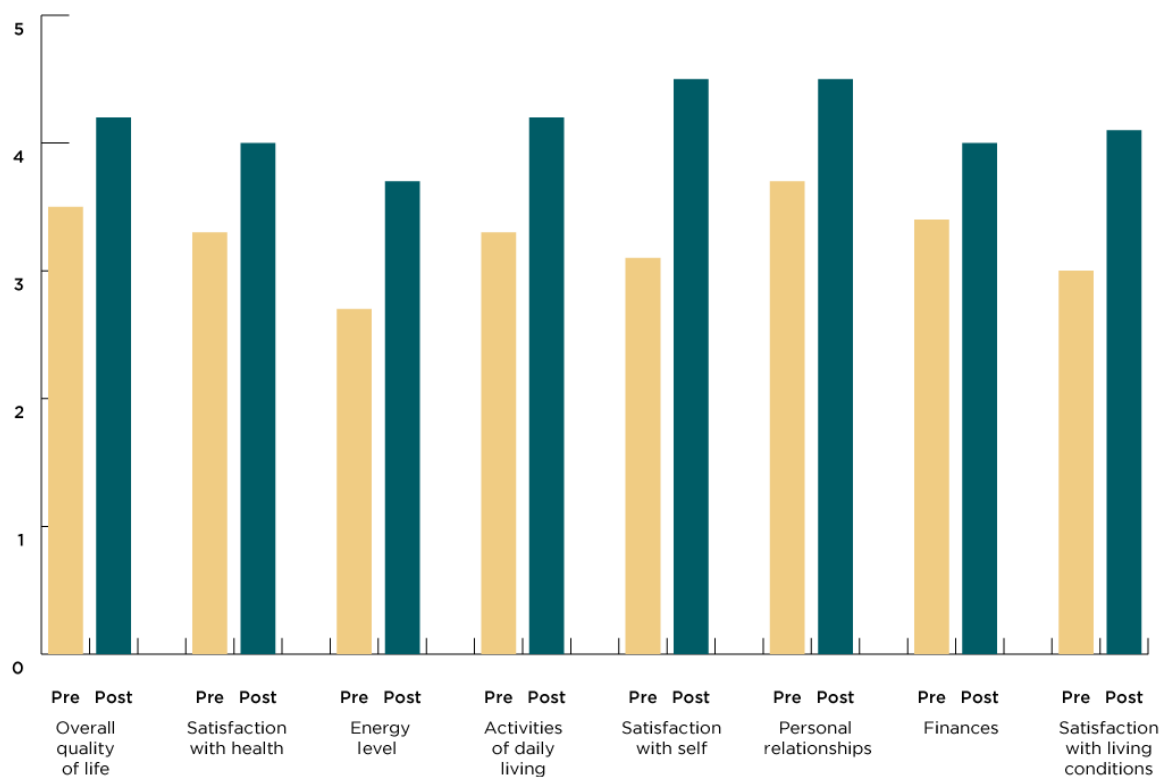
Figure 8: Pre- and post-intervention EUROHIS-QOL overall scores by patient



The average score for each of the eight domains on the EUROHIS-QOL improved among the 10 patients who completed pre and post scores (Figure 9).

Our outcomes demonstrate a preventive care model. There is anecdotal evidence of reduced need for secondary services in the short term among Folau I Lagi-Ma patients. However, these outcomes need to be measured in the longer term to demonstrate long-term impacts.

Figure 9: Average of pre- and post-intervention scores for all patients with both scores available



LAGIANNE'S STORY

Lagianne is a 36-year-old Samoan woman who lives in a Housing New Zealand home with her husband and extended family. She has multiple physical health issues, including type II respiratory failure, obesity hypoventilation syndrome, obstructive sleep apnoea, morbid obesity (starting weight 240kg), type II diabetes and chronic obstructive pulmonary disease.



The issues Lagianne faced were difficulty coping with stress and using food as a coping strategy, weight-related anxiety when leaving the house, lifestyle-related low mood and hopelessness, difficulty attending to activities of daily living, falls risk when entering or leaving home, and difficulty attending to self-care due to the shower cubicle and toilet in her home being too small for her.

Folau I Lagi-Ma worked with Lagianne to help her identify and reach a health goal.

Lagianne's health goal

"In six weeks' time I would like to have reduced the barriers to weight loss and have lost 8kg."

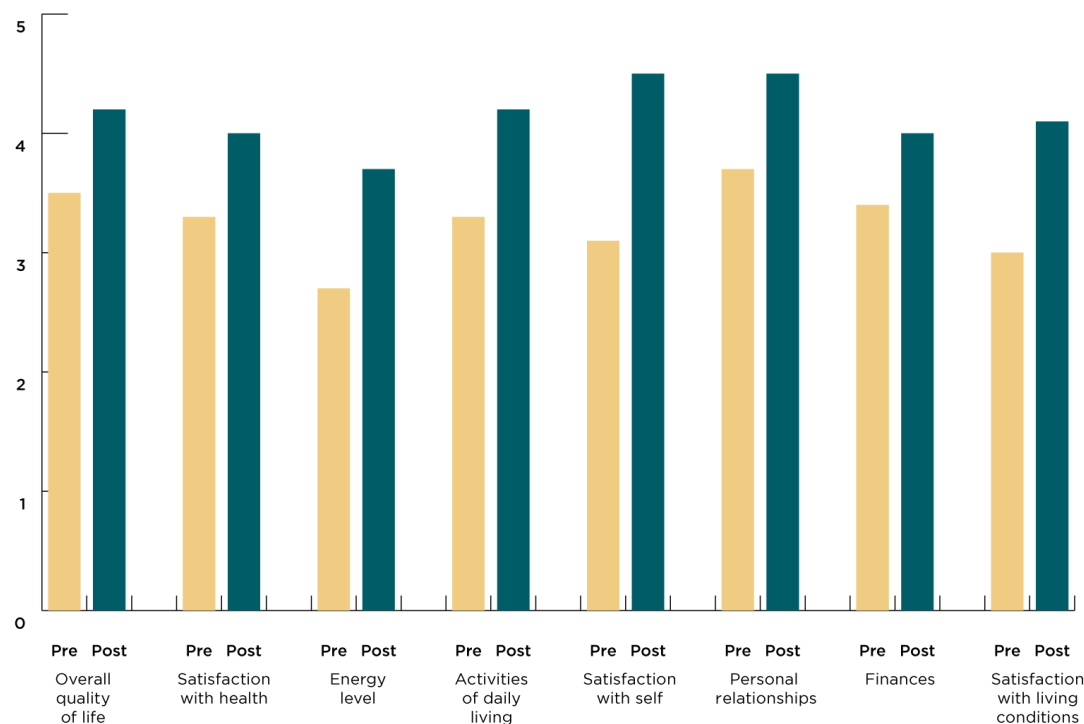
Folau I Lagi-Ma interventions

- SMART goal-setting and activity-planning
- Using visual tools to increase motivation
- Teaching alternative coping strategies to eating when stressed
- Recommendation for housing modifications (ramp access, wet area shower, larger toilet space) and liaison with Housing New Zealand, which approved the alterations
- Family education about nutrition
- Increasing engagement in meaningful activity
- Close liaison with general practitioner and practice nurse, who were providing education and follow-up for diabetes management

Outcomes

Lagianne has lost 36kg, and her HbA1c has dropped from 84 to 53. She reports improved mood and self-efficacy, and she is sleeping well. She has improved ability to engage in meaningful occupation, and is attending to activities of daily living independently, walking, dancing at home and aqua-jogging.

Figure 10: Lagiannes's pre- and post-intervention EUROHIS-QOL scores



"I used to eat lots and drink lots of fizzy drinks. I would feel angry about it and this would make me eat more. I would sleep a lot and needed my husband to help me get out of bed, shower, dress and go anywhere. I used to feel ashamed of going out in public. I went through services and lost weight for three months or so but then put it back on.

When I met with Folau I Lagi-Ma it was different. They have been a big help. They gave me ideas and knowledge around food, meals and health. They supported and advocated for me around housing. They encouraged me with my goals. They helped me to do things step-by-step at my pace instead of pushing me. It has been helpful to have someone who speaks my language.

I have maintained the changes I've made with Folau I Lagi-Ma for a year and two months. I feel very knowledgeable about meals and balance what I'm eating. I am mindful of portion sizes, I eat vegetables and read food labels.

My blood pressure, cholesterol and blood sugar levels have all improved. I used to use my oxygen machine all the time; now I only wear it at night. I am more active – I go for walks and love swimming. I can get up by myself and dress, shower and cook independently. Being able to do these things makes me feel better.

I feel lighter within myself. I am happy. I talk to others at church and in my family about what I've learned and how Folau I Lagi-Ma has helped. I am grateful for their support. I will keep going. I know I can change my life. I can do it."
Lagiannes

The long-term vision for Folau I Lagi-Ma is to embed the principles of our approach to self-management support in other practices and services. The most fundamental of these principles is a focus on individual patient goals. Folau I Lagi-Ma encourages patients to set goals that matter to them, and care plans are tailored to help patients reach these goals. The project also emphasises flexibility in its approach to care delivery and an inclusive ethos without strict exclusion criteria. We would like to see general practices and primary health organisations use these principles to integrate occupational therapy and peer support roles into their model of care to provide preventive interventions to improve health outcomes.

We aim to duplicate the principles of the Folau I Lagi-Ma project to support integration with primary care as part of the Counties Manukau Health Localities model. This model aims to develop people-centred services delivered by community teams that work in collaborative clusters with general practices and other healthcare providers. The Counties Manukau area covers four locality clusters that aim to work in an integrated way to support their enrolled populations.

In addition, we plan to address the existing knowledge and skill gap in occupational therapy. The skills used by occupational therapists in mental and physical health differ, and practising occupational therapists use a 'compartmentalised' approach based on the way services are designed. We plan to upskill both physical and mental health occupational therapists to deliver holistic interventions at a primary care level.



The campaign team and frontline staff of the Manaaki Hauora - Supporting Wellness campaign



From left: Danni Farrell (Collaborative Project Manager), Fionna Sutherland (Team Manager – The Cottage Community Mental Health Centre & Regional Dual Disability Service), Rachel Forrest (Occupational Therapist), Faye Batttrum (Occupational Therapist), Ian Hutchby (Improvement Advisor), Leigh McCabe (Associate Professional Lead, Occupational Therapy), Harriet Pauga (Nurse Manager, Mangere Health Centre), Dr Tim Hou (General Practitioner, Mangere Health Centre).

Absent: Alofa Leilua (Peer Support Specialist), Krishna Narayan (Lead Equipment Physician), Cassandra Laskey (Professional Leader – Peer Specialist).

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Appendix A: Folau I Lagi-Ma referral form

Name:	NHI:	
DOB:		Telephone:
Address:		
GP:		
Emergency contact:		
Consent obtained for referral?	Yes/No	
Referrer name:		

Criteria:

Long-term physical health condition(s) or mental health symptom(s) that are impacting on daily activities.

Please indicate long-term physical health condition(s).

Are there any mental health symptoms being experienced?

- ☐ Recent changes in mood
- ☐ Anxiety
- ☐ Difficulty coping with stress
- ☐ Psychotic symptoms (hearing voices, unusual beliefs out of character)
- ☐ Disorganised thoughts
- ☐ Poor concentration
- ☐ Poor sleep
- ☐ Change in appetite

- ☐ Recent changes in behaviour
- ☐ Poor motivation
- ☐ Tearfulness

How is this impacting on their ability to function in day-to-day life?

Other information/specific requirements: e.g. language, cultural, preference for contact:

Any potential risk issues for home visits:

Ko Awatea is a centre for health and social systems improvement, innovation and education embedded in Counties Manukau Health, the district health board that serves East and South Auckland.

Ko Awatea and Counties Manukau Health are committed to the Triple Aim:

- Improved health and equity for all populations.
- Improved quality, safety and patient experience of care.
- Best value for public health system resources.

To achieve the Triple Aim, Ko Awatea leads practical system transformation projects underpinned by proven methodological approaches.

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