

# Enabling **Self-management Support**



A guide to programme options that support self-management and the patient, clinician and service activators that enable them

# Acknowledgements

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# What is self-management support?

Self-management support can improve quality of life, clinical outcomes and self-confidence for people with long-term conditions. It refers to any interaction, programme or process that supports the skills involved in managing the tasks that people must undertake to live with one or more chronic conditions. The Institute of Medicine describes these tasks as, '... having the confidence to deal with the medical management, role management and emotional management of their conditions.'<sup>1</sup> In this way, self-management support motivates and empowers people to manage their own health and wellbeing without direct assistance from healthcare professionals.<sup>2</sup>

Self-management support also represents better value for healthcare providers than the traditional disease-focused approach to care. Presently, the management of long-term conditions puts an unsustainable burden on health services. Self-management support makes managing long-term conditions more sustainable by reducing hospital admissions and shifting care into the community. Primary care plays a leading role in giving people with long-term conditions access to self-management support.

Helping people to manage their own health has benefits for individual clinicians and healthcare teams, as well as for patients and healthcare organisations. Healthcare practitioners get greater job satisfaction when they are helping people to improve their health and wellbeing and live a more fulfilled life in a sustainable, empowering way.<sup>3</sup>

Typical approaches to self-management support include helping people to set and reach goals that are meaningful to them, promoting healthy lifestyles, using a multidisciplinary shared care approach which actively involves people in decision-making and care planning, proactive follow-up and helping people to monitor and manage their symptoms.

Self-management support needs to be tailored according to the needs of the individual to be effective. Support interventions have greater impact if they are meaningful to the patient and linguistically and culturally appropriate. The nature of the clinical condition or conditions present may also affect the type of support that is most beneficial for the patient.<sup>2</sup> Many people have two or more co-existing long-term conditions, which often include co-existing physical and mental health problems.<sup>4</sup>

Designing and delivering collaborative, patient-centred care that helps people to manage their own health means:

- inspiring people to learn more about their condition and take an active role in their health
- enabling people to manage their health on a day-to-day basis by providing tailored support, information, tools and techniques
- coordinating resources – people, services and partnerships.



## Patient story: Arthur, Exercise for Life

*"On discharge from hospital I was extremely obese and breathless with every single step I took. I would walk 10 steps then collapse onto the seat of my walker, puffed and sweating. It got too hard and I wouldn't go anywhere.*

*Then I was referred to the Otara Better Breathing group. I loved it straight off because there was free parking and the people there were just like me. The physiotherapists and nurses are amazing and friendly, and if you want to know what support feels like, this is it right here.*

*Each person completes an individual exercise plan over eight weeks and there is no rushing or pressure, you just do as much as you can and they give you advice on how to get the best out of every breath you take.*

*To me it meant I got my healthy life back; maybe not 100 per cent, but getting there. It might not happen right now, or tomorrow; but it will happen, and I am prepared to help myself and give it my all.*

*I can now walk a half-hour without stopping and I know what my heart and lungs are doing. I have also lost a sizeable amount of weight and I have made many life-time friends – Irish, Samoan, Tongan, Māori, and Kiwis from all walks of life.*

*What impact has this had on me? I am fitter, thinner, cheekier, and I am looking good, baby!"*

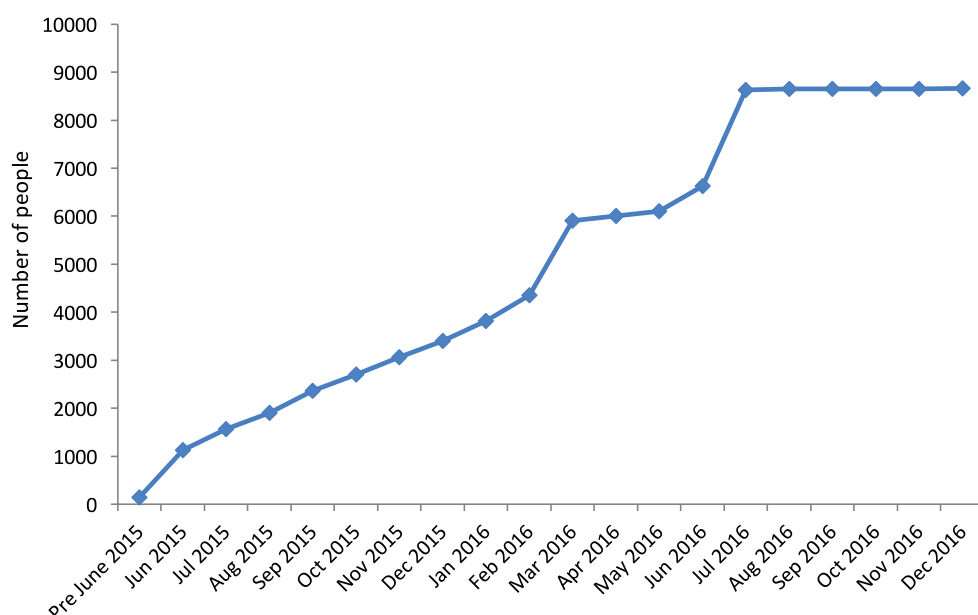


## The purpose of this guide

This guide identifies specific self-management support interventions which have demonstrated reach and impact, and identifies the factors that activate patients, clinicians and the healthcare system to engage with these interventions.

The interventions presented in this guide reflect learning from working with approximately 9,000 patients in the Manaaki Hauora – Supporting Wellness campaign (Figure 1).

**Figure 1:** Total direct reaches\* recorded by the project teams in the Manaaki Hauora – Supporting Wellness campaign



\*Reach is defined as patient referral to a Manaaki Hauora–Supporting Wellness service or Planned Proactive Care.



## The Manaaki Hauora – Supporting Wellness campaign

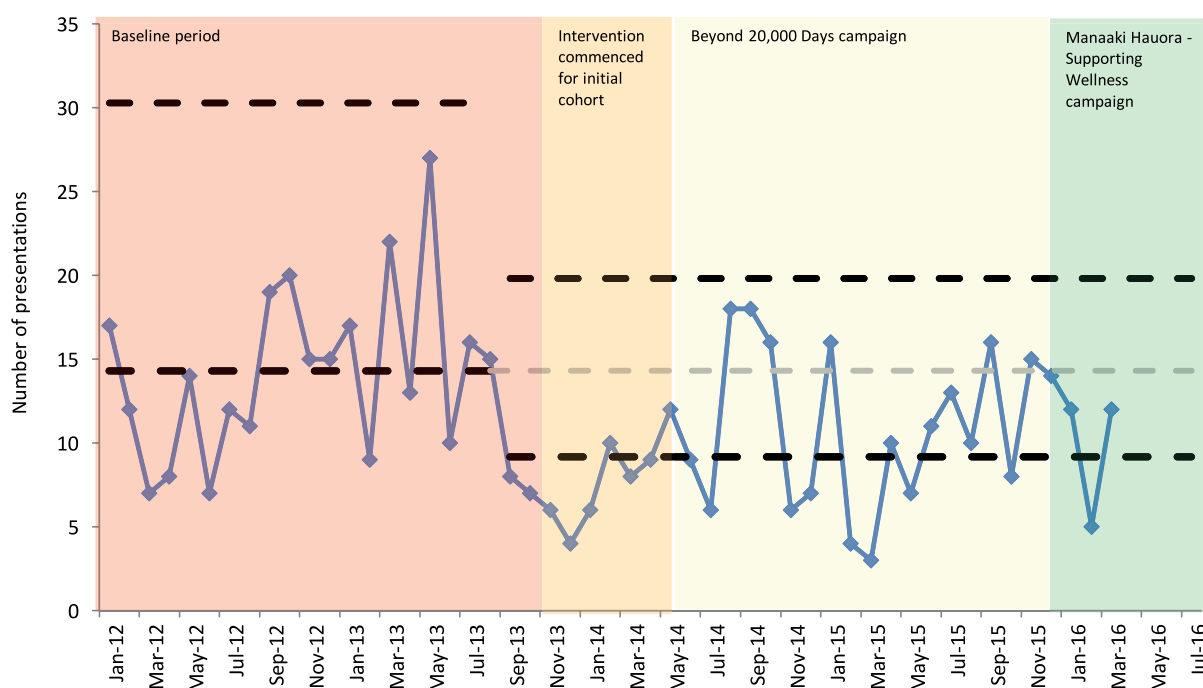
Counties Manukau has over 67,000 people with long-term conditions. More than half of these have diabetes, and more than quarter have two or more co-existing conditions.

The Manaaki Hauora – Supporting Wellness campaign led by Ko Awatea, the centre for healthcare improvement and innovation at Counties Manukau Health, aimed to provide self-management support for people living with long-term conditions in Counties Manukau.

The campaign covered 16 collaborative teams working in different settings and clinical contexts. Each team had a unique aim which contributed to the overall campaign aim. Ten of the teams, whose projects best illustrate the interventions with the greatest reach and impact, are featured in this guide (*Appendix A*).

The Manaaki Hauora – Supporting Wellness campaign aligned with and built upon two previous campaigns to help people stay healthy and well in the community, 20,000 Days and Beyond 20,000 Days. It specifically sought to build on the results achieved by Kia Kaha: Manage Better, Feel Stronger, a self-management support-focused collaborative in the Beyond 20,000 Days campaign. This collaborative team demonstrated improved outcomes and significantly reduced service use among people with multiple long-term conditions and complex needs. These results were sustained into the Manaaki Hauora – Supporting Wellness campaign by Manage Better Together: Kia Kaha (*Figure 2*) and were applied in different contexts by other Manaaki Hauora – Supporting Wellness collaborative teams.

**Figure 2: Emergency department presentations for initial Kia Kaha cohort (n=38)**



The campaign also aligned with Counties Manukau Health’s Planned Proactive Care programme (formerly At Risk Individuals), which helps primary care teams to identify people at risk of poor outcomes as a result of long-term conditions, and to provide patient-centred, coordinated care.

*“Our community deserves access to proven self-management support. This campaign is about learning from and with our communities to develop innovative approaches that ensure no one is left behind and patients are actively engaged in managing their own care.”*

Jonathon Gray, Director, Ko Awatea







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

## Campaign methodology

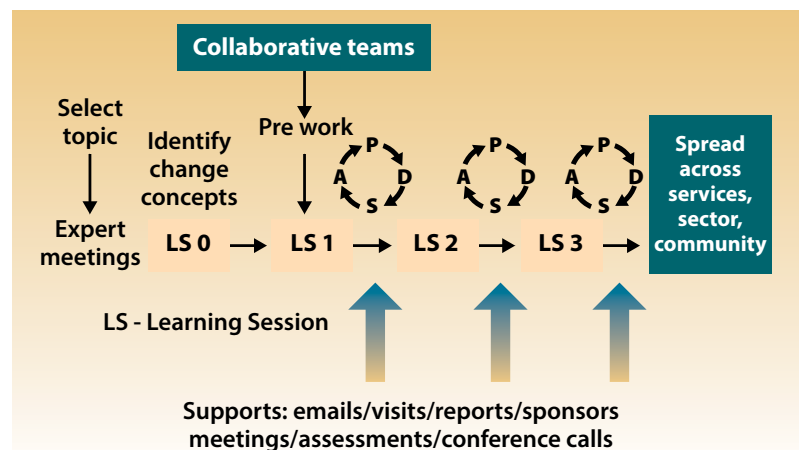
The campaign was structured using the Breakthrough Series Collaborative Model for Achieving Breakthrough Improvement developed by the Institute for Healthcare Improvement (*Figure 3*).<sup>5</sup> This methodology is a short-term learning system that brings different collaborative project teams together to seek improvement in a focused topic area. It is a proven method for implementing evidence into practice. The Breakthrough Series approach includes learning sessions, where teams build capability in improvement methodology and share ideas; and action periods, where teams develop and test ideas for change.

During action periods, project teams used the Model for Improvement to develop and test change ideas (*Figure 4*).<sup>6</sup>

The Model for Improvement asks:

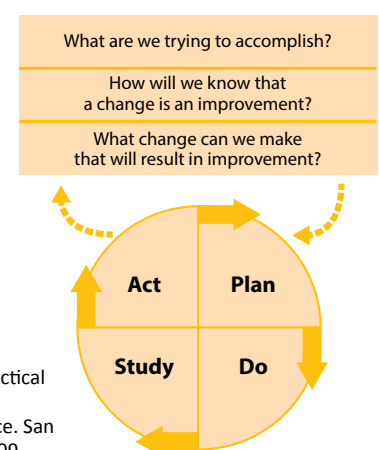
- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

**Figure 3: The Breakthrough Series Collaborative Model for Achieving Breakthrough Improvement**



**Source:** Institute for Healthcare Improvement. The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. Boston: IHI; 2003.

**Figure 4: The Model for Improvement**



**Source:** Langley GL, Moen R, Nolan KM, et al. The improvement guide: A practical approach to enhancing organizational performance. San Francisco: Jossey-Bass; 2009.

Once teams had a clear aim and effective measures in place, they used plan, do, study, act (PDSA) cycles to develop and test their ‘theory of change’ – the change ideas they thought would result in improvement. Change ideas were adopted, adapted or abandoned, and the final set of implemented change ideas were formulated into a change package. The self-management support strategies presented in this guide represent the ideas with the greatest impact and reach.

## The Chronic Care Model

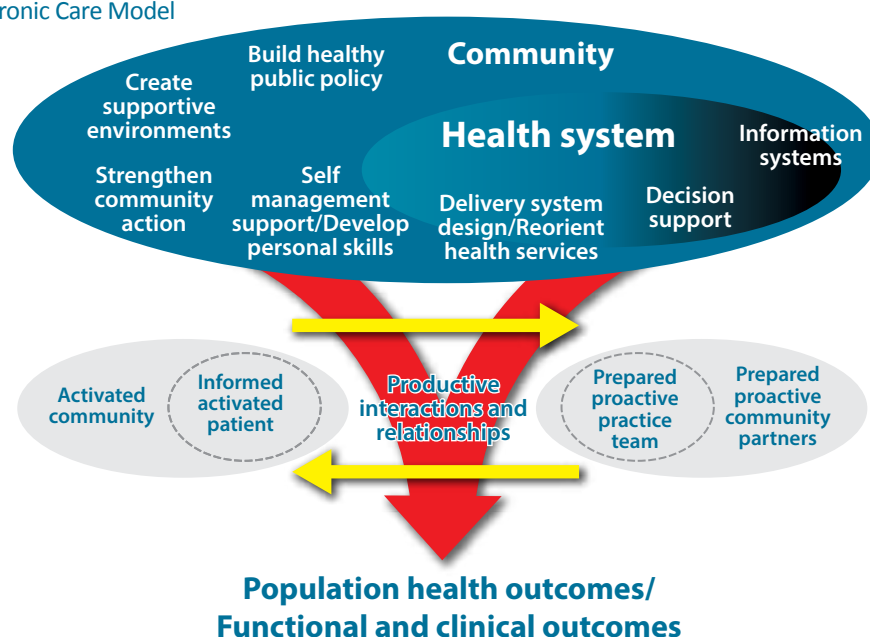
Current healthcare models evolved in the early 20<sup>th</sup> century, when most healthcare need was acute. In the 100 years since, the impact of public sanitation, and healthcare innovations such as antibiotics and modern surgical procedures, have greatly reduced demand related to acute health needs. However, over that time, and particularly over the last 20 to 30 years, there has been a substantial increase in demand due to lifestyle-related long-term conditions, such as diabetes, gout, and heart disease. Long-term conditions now account for nearly half of the global burden of disease.<sup>7</sup>

A number of models of care have evolved to better meet the needs of people with long-term conditions. The best known of these is the Chronic Care Model developed by Ed Wagner and colleagues, which was subsequently expanded to integrate population health promotion by Barr and colleagues (*Figure 5*). This evidence-based model requires a fundamental reorientation of healthcare delivery systems, in parallel with a focus on engaging patients in managing their conditions better. Health systems globally have struggled to achieve these twin goals of system redesign and self-management support.

Counties Manukau Health has a series of initiatives to address this fundamental quality gap. Two initiatives have focused on the required system redesign – the Planned Proactive Care programme, which has implemented a risk-based register of patients with poorly managed long-term conditions, a ‘case management’ system of care, and a shared care plan; and Enhanced Primary Care, which is working towards the required redesign to achieve team-based primary care for patients with long-term conditions.

The Manaaki Hauora – Supporting Wellness campaign complements these initiatives by building a sustainable system of self-management support for people with long-term conditions in Counties Manukau.

**Figure 5: The Chronic Care Model**



**Reproduced with permission from:** Figure 2: The Expanded Chronic Care Model: Integrating Population Health Promotion. In: Barr V, Robinson S, Marin-Link B, et al. The Expanded Chronic Care Model: An integration of concepts and strategies from population health promotion and the Chronic Care Model. Hospital Quarterly. 2003; 7(1): 73-82.



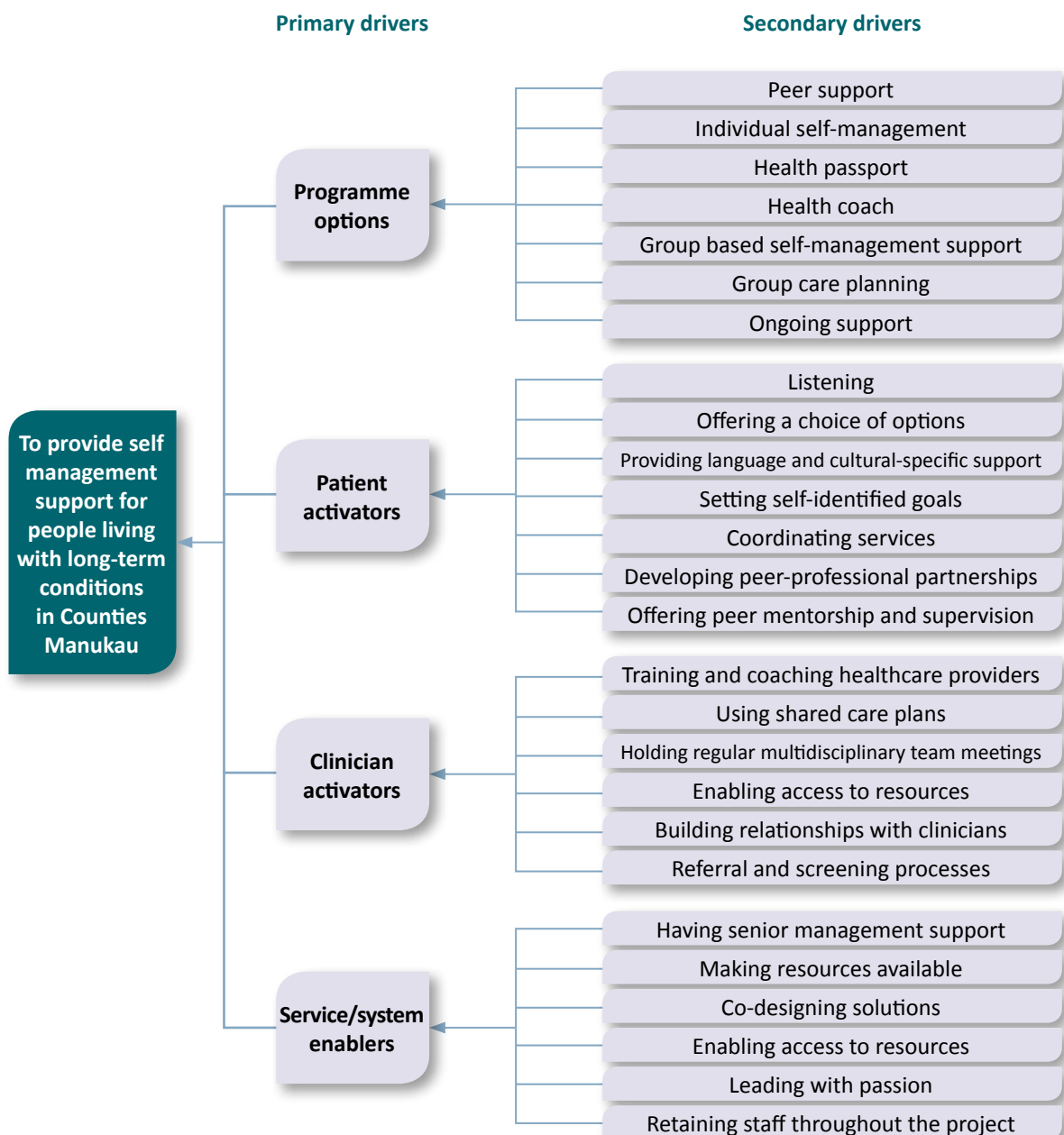
## Campaign driver diagram

The Manaaki Hauora – Supporting Wellness campaign driver diagram is a visual representation of how the campaign built a sustainable system of self-management support.

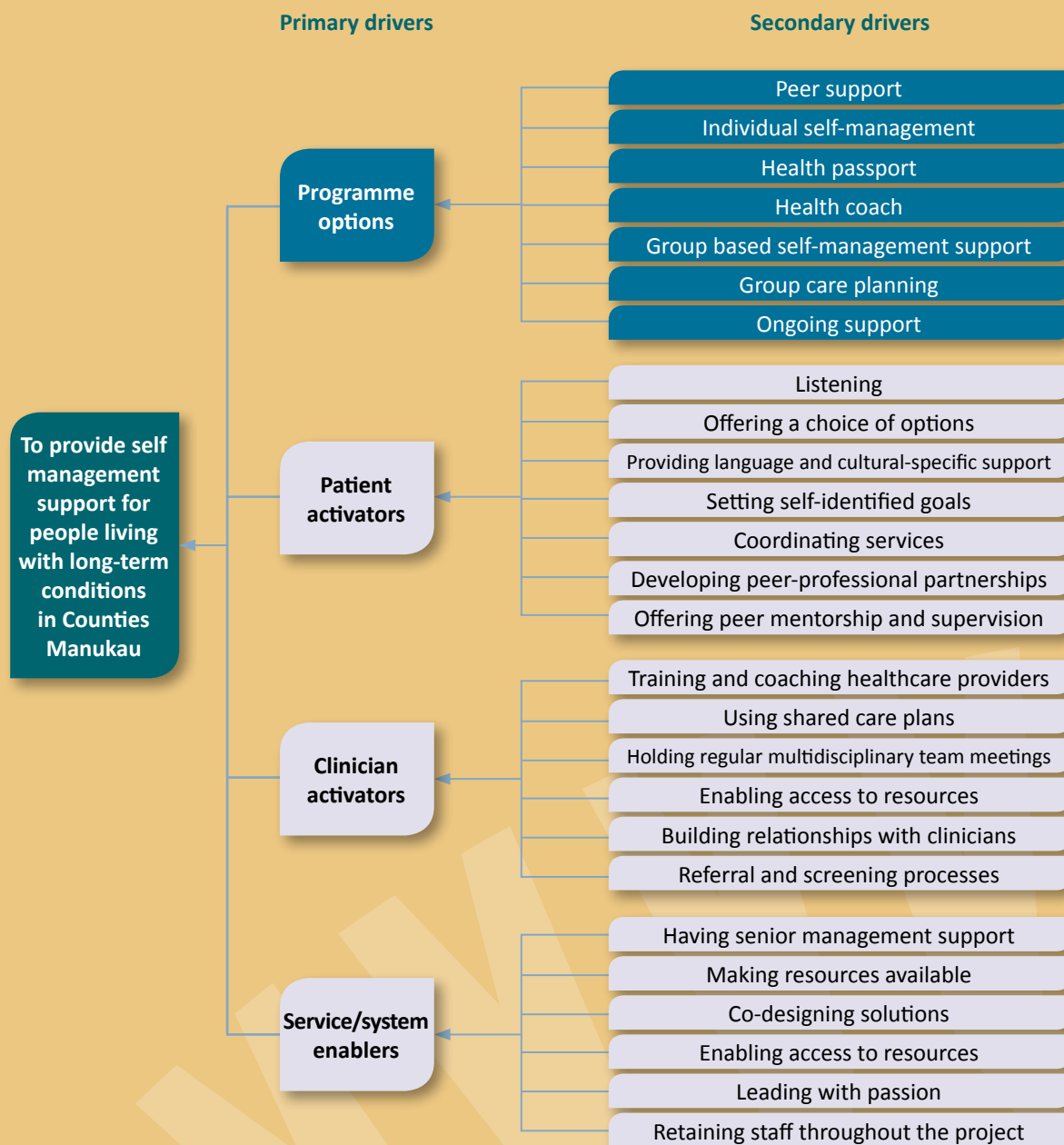
A driver diagram is an improvement tool for building and testing a theory of improvement that sets a measurable goal and identifies the primary factors – or ‘drivers’ – that contribute to reaching that goal. It then breaks those drivers down further into secondary drivers and specific change ideas that contribute to each driver.

The Manaaki Hauora – Supporting Wellness campaign driver diagram identifies four primary drivers: self-management support programme options, patient activators, clinician activators and service or system enablers (Figure 6).

**Figure 6:** Manaaki Hauora – Supporting Wellness campaign driver diagram



# Self-management support options



## Peer support

Using peers to provide self-management support has been shown to improve engagement, decrease depression, and reduce the use of emergency departments and hospitals for patients in mental health services.<sup>8</sup> It can improve self-care and a sense of community belonging, as well as increasing participants' sense of hope, control and ability to effect changes in their lives.<sup>8</sup>

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 helps to forge a bond of understanding, empathy and mutual help.<sup>9</sup>

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 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.<sup>9</sup>

Peer-based behavioural interventions support educational programmes aimed at lifestyle change and help patients to sustain changes.<sup>10</sup> Behavioural strategies may include goal-setting, problem-solving, social support, communication strategies, and exploring feelings.<sup>10</sup>

Peer support can be delivered through face-to-face group peer support programmes, one-to-one support programmes, peer coaches, telephone-based peer support, and web and email peer support programmes.<sup>9,10</sup>

Several collaborative teams in the Manaaki Hauora – Supporting Wellness campaign used peer support to engage patients, including Ola Lelei, Folau I Lagi-Ma, and Manage Better Together: Kia Kaha.

In Ola Lelei, peer supporters facilitate the Wellness Recovery Action Planning (WRAP) programme. WRAP supports self-management among Pacific people with mental health issues, weight gain, and diabetes by helping them to identify the triggers and early warning signs that impact on their mental health and wellbeing. Trained peer supporters who have lived experience of mental health and/or addiction issues plan and deliver the WRAP training with the support of a dietician and a diabetes nurse.

In Folau I Lagi-Ma, a peer supporter makes the first contact with a patient who has been referred to the service. Over the telephone, the peer supporter explains the service, gets consent for future input, and makes an appointment for the initial interview.

A peer supporter is also used to manage DNAs (did not attend) in Folau I Lagi-Ma. In response to difficulties managing patient non-attendance during the implementation of the service, the team instigated a reminder system facilitated by the peer supporter prior to appointments. The difference this made became most apparent during a period in late 2015, when the peer supporter took annual leave. Without the screening call and reminder system, the DNA rate increased markedly.

*"I find this [telephone screening] has been very beneficial in establishing the rapport with the person from the outset."*

Alofa Leilua, Peer Support Specialist, Folau I Lagi-Ma

For Manage Better Together: Kia Kaha, peer support is integral to the team. The Kia Kaha Wheel of Self-Management Support includes seven types of peer-led self-management support which have all demonstrated value for people with long-term conditions (Figure 7).<sup>9</sup> All the options on the Wheel of Self-Management Support are delivered by a clinician-peer-volunteer teamlet in primary care.<sup>11</sup>

**Figure 7: Kia Kaha Wheel of Self-Management Support**





*Manage Better Together: Kia Kaha peer supporters providing telephone support*

## Individual self-management support

Individually delivered interventions can be effective for helping people to manage health-related behaviours, thereby improving health outcomes. For example, a systematic review by Stead and Lancaster found that individually delivered smoking cessation counselling can assist smokers to quit.<sup>12</sup>

In the Manaaki Hauora – Supporting Wellness campaign, an individually delivered, multidisciplinary self-management support intervention was developed by Owning My Gout to help gout patients better manage their condition.

### *Case study: Owning My Gout*

Owning My Gout uses a collaborative model of gout care that includes general practitioners (GPs), nurses and pharmacists. Patients were initially recruited from an East Auckland primary care practice, although the project has now spread to include three practices in South Auckland. Referrals to the Owning My Gout programme are made by GPs for patients with poorly managed gout.

Once a patient is referred, a nurse provides a one-off information and education session using a booklet called *Stop Gout* to help the patient manage their gout better. Patients then begin monthly visits to the pharmacist, who tests their serum urate levels, provides continued education about gout medication, and adjusts their gout prevention medication as appropriate.

The target for all Owning My Gout patients is to bring serum urate levels down to 0.36mmol/L to decrease attacks of gout, and the pharmacist adjusts each patient's medication to reach this target.

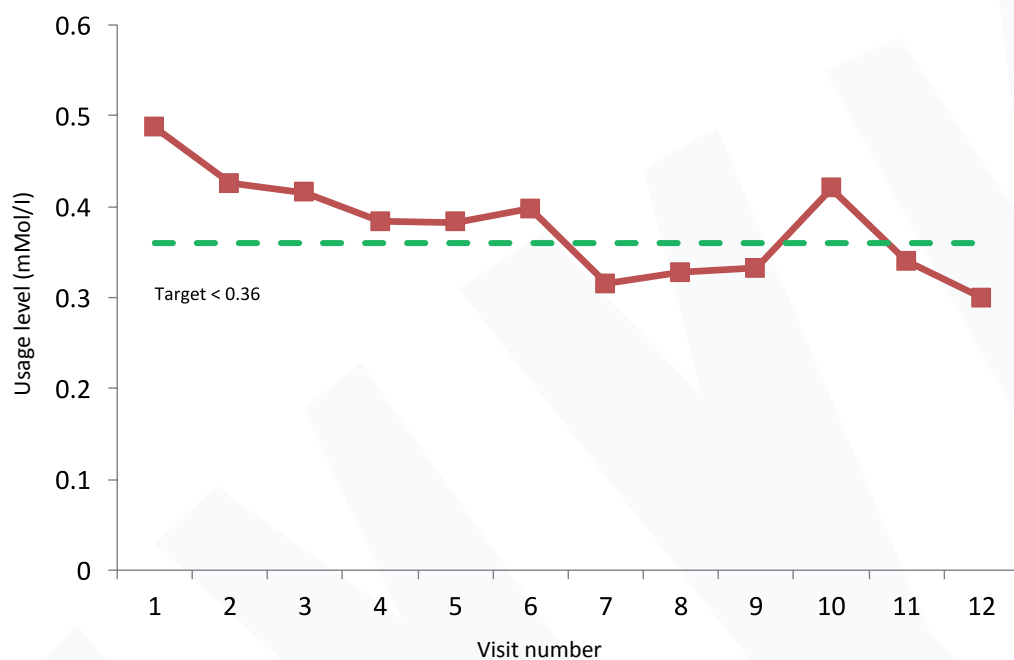


Each patient has a personal graph showing their progress towards achieving the target, which acts as a help and motivator.

Throughout the Owing My Gout programme, the patient remains under the overall care of their GP, who conducts six monthly reviews to monitor the patient's progress. A standing order from the GP allows the pharmacist to adjust the patient's medication. The GP, nurse and pharmacist liaise using an e-shared care record and by being co-located in the same building or a nearby building.

The cohort of patients originally had an elevated serum urate level, with the average being 0.5 mmol/L. As a result of being enrolled in the programme, the average serum urate level has reduced over time, with the target being achieved after six visits on average (Figure 8).

**Figure 8:** Average urate level by visit



*"I have more knowledge about my gout. I've had no bad attacks and I really understand why I am taking my allopurinol and how long it takes to get my dose adjusted to the right level."*

Patient, Owing My Gout

*Point of care testing in Owing My Gout*





## Health passport

Health passports function as a 'road map' to self-management. Patients can use them to set goals and track progress, record personalised health management plans and as a central place to store information resources. Using health passports supports engagement, which helps to improve self-management programme completion rates.<sup>13</sup>

### *Case study: Exercise for Life*

Exercise for Life uses health passports to help patients in the Healthy Hearts and Better Breathing rehabilitation programmes sustain a healthy behaviour change. The idea grew as a way for patients to work towards graduating from the Exercise for Life programme.

Each patient receives a health passport folder when they begin the Exercise for Life programme. An assessment is used to create a personalised summary of their condition, medications and an action plan for the folder (*Table 1*).

**Table 1:** Self-management score assessment

Self-Management Assessment Tool	Knowledge	Engagement
Health Condition	Do you know the name of your condition?  What is your understanding of your condition?	Have you ever looked up information about your condition?
Medications	Do you know the names of your medications and what they do?	Do you take them? Do you ever run out?
Action Plan	How do you know when you are becoming unwell?	What would you do when you are becoming unwell?
Physical Activity	Why is exercise important?	Are you currently doing any exercise/activity?
Lifestyle	What changes do you need to make to become healthier? (Diet, exercise, sleep, smoking, etc.)	What are you doing to make these changes?

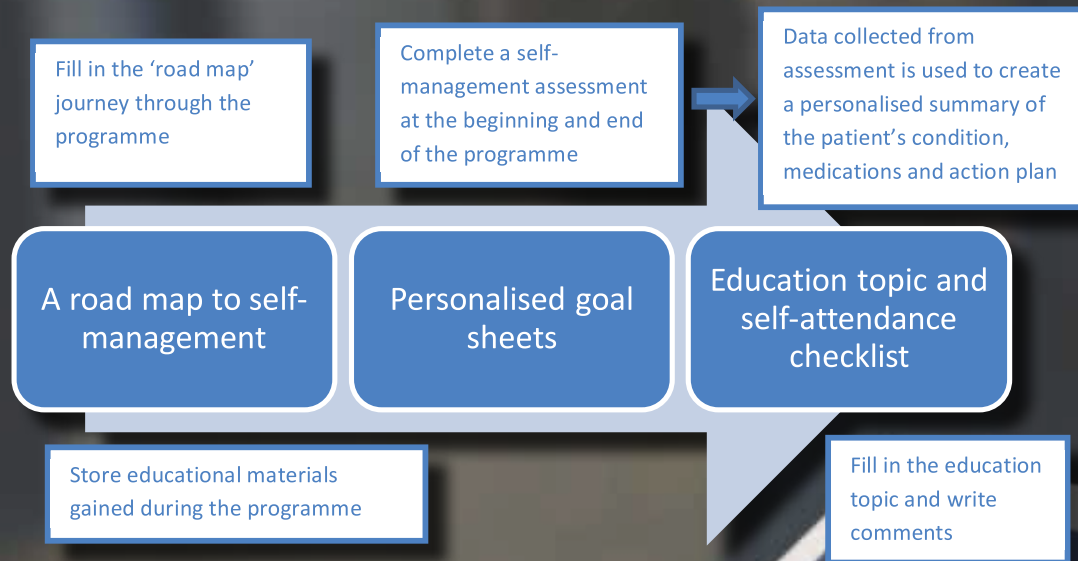
Information from this assessment is used to reach a self-management score for each patient on two scales: knowledge of self-management, and engagement with self-management. Going through this assessment and scoring process requires the clinician to think about where each patient sits with regard to their ability to manage their condition, which in turn enables interventions to be tailored to the needs of the individual patient.

Using information from the assessment as a foundation, the health passport becomes a tailored record of the patient's personal goals and their progress towards them, personal exercise sheet, attendance checklist, road map of their journey through the programme and storage repository for educational materials received during the programme (*Figure 9*).





Figure 9: Earning a passport to health



The health passport brings different ways of learning together into a single resource to allow patients to choose what best suits them.

Patients are encouraged to take the passport home and use it as much as possible. To support this, the passport includes a toolkit to use and share with family. In this way, the passport preserves information beyond the programme and encourages sustainability.

In addition, the passport can be easily transferred between organisations and other community-based programmes, enabling patients to keep using it and information to be shared between services.

Working collaboratively with patients to co-design the passport was the key to developing a user-friendly passport which patients wanted to use. Co-design gave the Exercise for Life team insights into what was and was not helpful for patients, and made it more user-friendly in terms of learning styles and health literacy. Following consultation with patients, more emphasis was put on the value of the activity and education patients received through Exercise for Life, and delivery of information changed to a self-service 'dip in' approach.

The result has been a useful tool for encouraging and facilitating patients through their health journey. All patients using the passport in the programme reported finding it useful, and anecdotally staff reported patients being more engaged and more likely to complete the programme.

*"I just put all my information in my passport and refer to it whenever I need a refresher."*

Patient, Exercise for Life



## Health coach

Health coaching helps patients gain the knowledge, skills, tools and confidence they need to be active participants in care and reach self-identified health goals.<sup>14</sup> It also provides the emotional support and practical assistance needed by many patients with chronic illness, and motivates behaviour change through a structured support partnership.<sup>15,16</sup>

For practices, health coaching has been shown to increase clinician productivity, give good return on investment, and improve patient adherence and documentation compliance.<sup>11,14,17</sup>

The health coaching role can be performed by a member of the healthcare team, such as a registered nurse, health educator or community health worker, or by peers or laypeople who are given appropriate training and support.<sup>14,15</sup> Key competencies are listening and communication, empathy, negotiation skills, and the ability to work in partnership with a patient and healthcare provider. Competency in the culture and language of the patient population is also important. Training and mentoring to develop these competencies and in the tasks the health coach conducts is integral to the success of the health coach role.

A dedicated health coach within a practice supports patients by providing self-management support, acting as a bridge between clinician and patient, giving emotional support, creating continuity and helping to navigate the health system. The tasks a health coach undertakes depend on their scope of practice and the environment in which they work. In primary care, a health coach may:

- create short and long-term goals and action planning with patients
- provide patient education, self-management support and motivational interviewing
- identify patients who do not meet their health goals or are overdue for visits, labs, or referrals
- coordinate patient care
- liaise between clinician and patient and serve as a continuity figure
- undertake medicines reconciliation
- manage a disease register
- enter relevant data into the patient file.

The teamlet model is a successful way to deliver health coaching. In this model, a health coach and a physician work in partnership to extend care beyond the consultation. Pre-consultation, health coaches help with agenda-setting, medication reconciliation, ordering routine services and history-taking. The health coach will then be present during the consultation. Post-consultation, they solicit concerns and help the patient set goals and navigate the system. Between consultations, they provide regular follow-up to assist with action planning, medication adherence and problem-solving.<sup>11</sup>

### *Case study: SMILE*

The teamlet model is used by the SMILE team in the Manaaki Hauora – Supporting Wellness campaign to deliver health coaching for patients of two primary care practices.

Nominated physicians in each practice who are aware of the health coach programme refer suitable patients to the SMILE health coach. Patients may have one or more of a variety of long-term conditions, including diabetes, heart failure, obesity, and smoking.

Once a patient is referred, the health coach makes contact with the patient and arranges a first meeting.

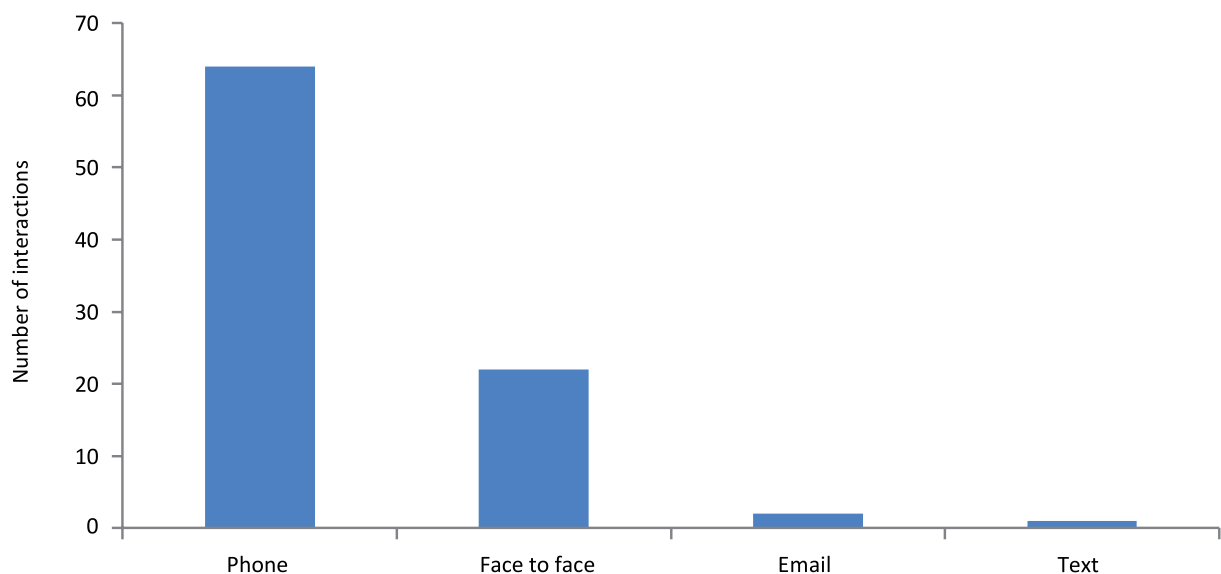




During the first meeting, the health coach and patient set goals based on what is important to the patient and begin building a rapport. After the initial meeting, the health coach offers the patient support options appropriate to their needs and facilitates patient access to community programmes via the GP practice, internet, newspapers and community social services.

Once a plan is in place, the patient and health coach agree on the best way to communicate. Support may be delivered over the phone, by email, or in person (*Figure 10*).

**Figure 10:** Health coach interactions with patients by method





If one-on-one meetings are used, patients can choose to meet where they feel comfortable – at home, at the clinic, or a third ‘neutral’ venue. The frequency of the meetings and the length of the relationship depend on the patient’s needs.

During contact, health coaches provide information and support, help with motivation, set milestone goals and help the patient to monitor progress. Health coaches can also refer patients for specialist support if needed.

The ability to build a relationship and develop trust is a key feature of health coaching. Health coaches can dedicate more time to patients than physicians can, and the dynamic in the relationship is more equal. Health coaches find commonality with patients – usually concepts of the self and the family – as a basis for learning. Thus, the health coach creates an environment where the patient can self-direct healthcare support, and anything can be discussed. The health coach obtains consent from the patient before discussing any of the information shared with the GP.

Another benefit of the health coach model is that getting to know the patient and their home circumstances creates greater understanding of factors in the patient’s lifestyle and physical and socio-economic environment that may influence their health condition or present barriers. As a result, health coaches can tailor self-management support solutions that are the best fit for the individual patient’s circumstances.

*“The health coach helps me to communicate better.”*

Patient, SMILE

### **Case study: Manage Better Together: Kia Kaha**

Manage Better Together: Kia Kaha health coaches work with a GP, nurse and medical assistant team to support a cohort of diabetic patients who have very high HbA1c results (>75).

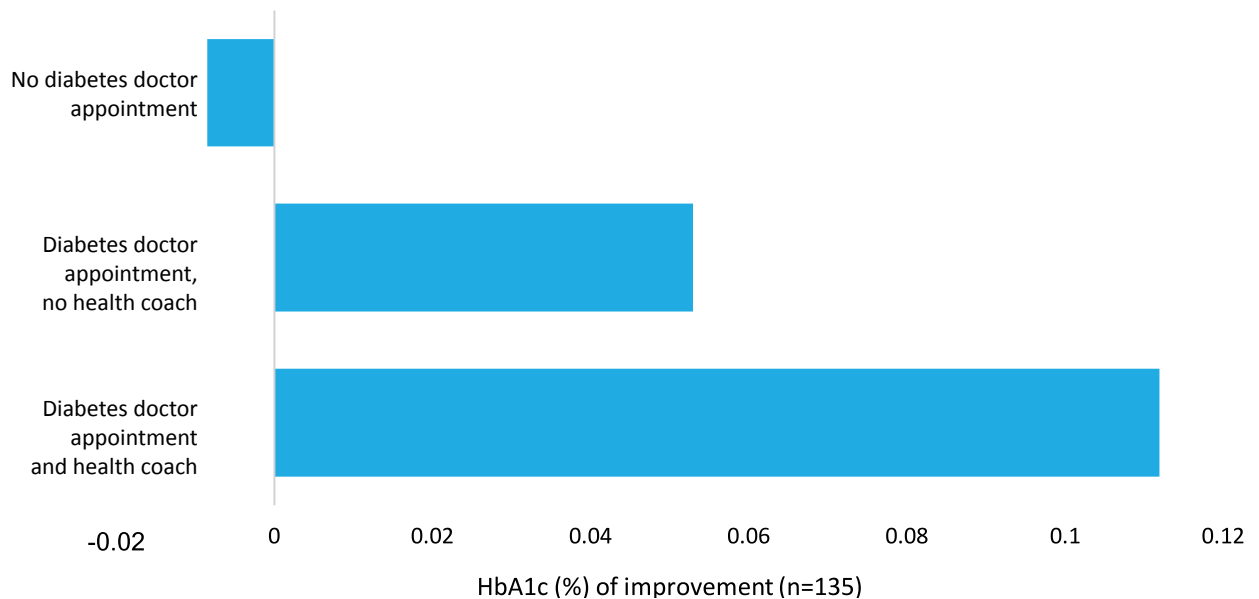
The team uses a health coaching model that has a curriculum for training, as well as an evidence-base when used by peer health coaches.<sup>18</sup> Using this model, health coaches are able to coach in the language of the patient while sticking to the clearly defined processes within the curriculum. This is achieved in a dedicated weekly one-day clinic.

Clinics are delivered by a co-located teamlet focused on diabetes control, which comprises a nurse, a GP, a health coach and a receptionist working together. In the first session, the GP does a special education session about diabetes, the nurse takes measurements and blood tests, and the health coach sets the agenda for the session and explains HbA1c. The patient is also screened for psychological needs. Subsequent sessions can include action planning, medication reconciliation, further disease-specific information with relevant handouts, appointment reminders and continuing support for the patient’s visits with the doctor. The health coach has a clear scope with guidelines and boundaries related to their interactions with patients, and can give a warm hand off to a mental health clinician if required.

Six months after this health coaching model was introduced, the results show that patients supported by a GP and an onsite peer health coach working together to deliver support achieved an approximate reduction in HbA1c of 11.2 per cent. Those supported by a doctor without the help of an onsite health coach achieved an approximate reduction of six per cent. Patients who received care as usual had an approximate one per cent increase in HbA1c (Figure 11).



**Figure 11:** HbA1c improvement from baseline by intervention type



*"Patients' HbA1c are better, they are happier, and they are proud of their achievements."*  
Dr Walter Muller, GP

## Group-based self-management support

Group-based self-management support programmes have been linked with improved patient activation, quality of life, confidence and greater ability to self-manage chronic conditions.<sup>19</sup> In addition, they can increase patients' sense of social connection, coping skills, and physical activity.<sup>20</sup>

### Group-based generic self-management support

Studies of group-based generic self-management support programmes show that participants experience improved health behaviours, fewer visits to the emergency department, increased self-efficacy and better health status.<sup>21,22</sup>

Ola Lelei and Manage Better Together: Kia Kaha both adopted established group-based generic self-management support programmes with proven effectiveness and adapted them for local needs.

### **Case study:** *Ola Lelei – Wellness Recovery Action Planning (WRAP)*

WRAP is a 10-week structured programme designed to develop understanding of recovery and wellbeing concepts. It helps people to decrease and prevent intrusive or troubling feelings and behaviours, increase personal empowerment, improve quality of life, and achieve their own goals.<sup>23</sup>



In the Ola Lelei project, the WRAP programme helps Pacific patients with co-morbid mental and physical health conditions to identify the triggers and early warning signs that impact on their mental health and wellbeing. The standard programme uses lectures, discussions and individual and group exercises, and Ola Lelei adapted it by adding nutritional and exercise components. WRAP provides opportunities for patients to develop strategies and action plans to manage their own wellbeing.

WRAP programmes are facilitated by trained peer supporters, with the support of a dietician and a diabetes nurse, and involve patients and their families. Groups range in size from about 10 to 15 participants.

The programmes run in Counties Manukau Health's Community Mental Health Centres, Māori and Pacific Cultural Mental Health Services and the specialist Early Psychosis Intervention and Intensive Community Teams.

So far, 13 patients have completed the Ola Lelei WRAP course, and feedback has been overwhelmingly positive.

*"The Ola Lelei training provided me with a stepping stone towards achieving my goal. I've learned a lot about how to look after myself – eating well, balancing my food intake and the importance of taking my medication for my wellbeing. The training also gave me the opportunity to meet new people with similar experiences, encouraged me to make new friends and taught me how important it is to work as a team and think positive."*

Patient, Ola Lelei



*Learning to cook healthy desserts in the Ola Lelei WRAP programme*





## Case study: Manage Better Together: Kia Kaha

Manage Better Together: Kia Kaha delivers peer-led self-management education through its Manage Better Course. The Manage Better Courses follow the Stanford Chronic Disease Self-Management Program developed at the Patient Education Center at Stanford University.<sup>24</sup>

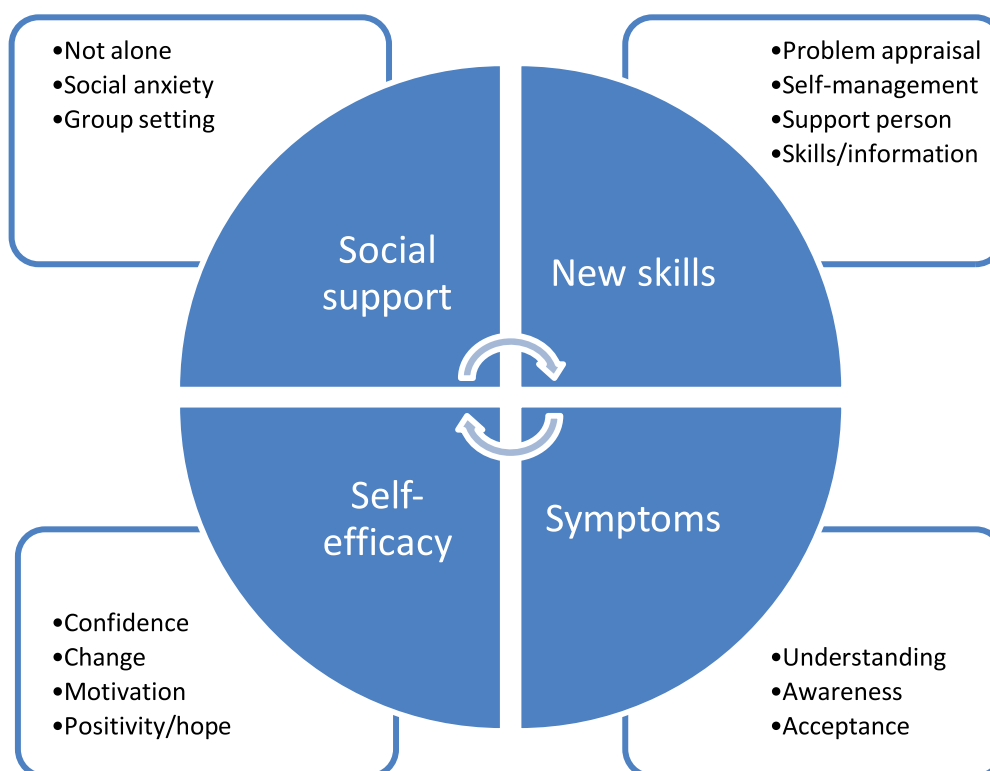
The course is designed to be peer-led, is evidence-based, and is manual-based with an emphasis on programme fidelity. The courses run for six weeks, with a two-and-a-half hour interactive session each week. There is a small group of 12-16 participants per course. Manage Better Together: Kia Kaha provides the courses in several languages, using course materials translated by Stanford or by local Stanford-trained leaders (See: Providing language- and culture-specific support, p.32).

Manage Better Together: Kia Kaha has a team of 21 volunteers, seven employed peers and three health psychologists who are trained in the programme and run the courses regularly. When a health professional leads the programme, they are encouraged to take off their 'professional hat' and lead the course as someone who either has a long-term condition or cares for somebody with one. This is important, as the course supports self-efficacy and is based on the social learning model. This model assumes that people are more likely to do something if they feel they might be successful, and they are more likely to feel that they might be successful if they see someone similar to themselves doing it.<sup>25,26</sup>

The courses are free to the participants and everyone within the general practice and surrounding community is invited to attend. Most referrals come from the medical practitioner or the health coach.

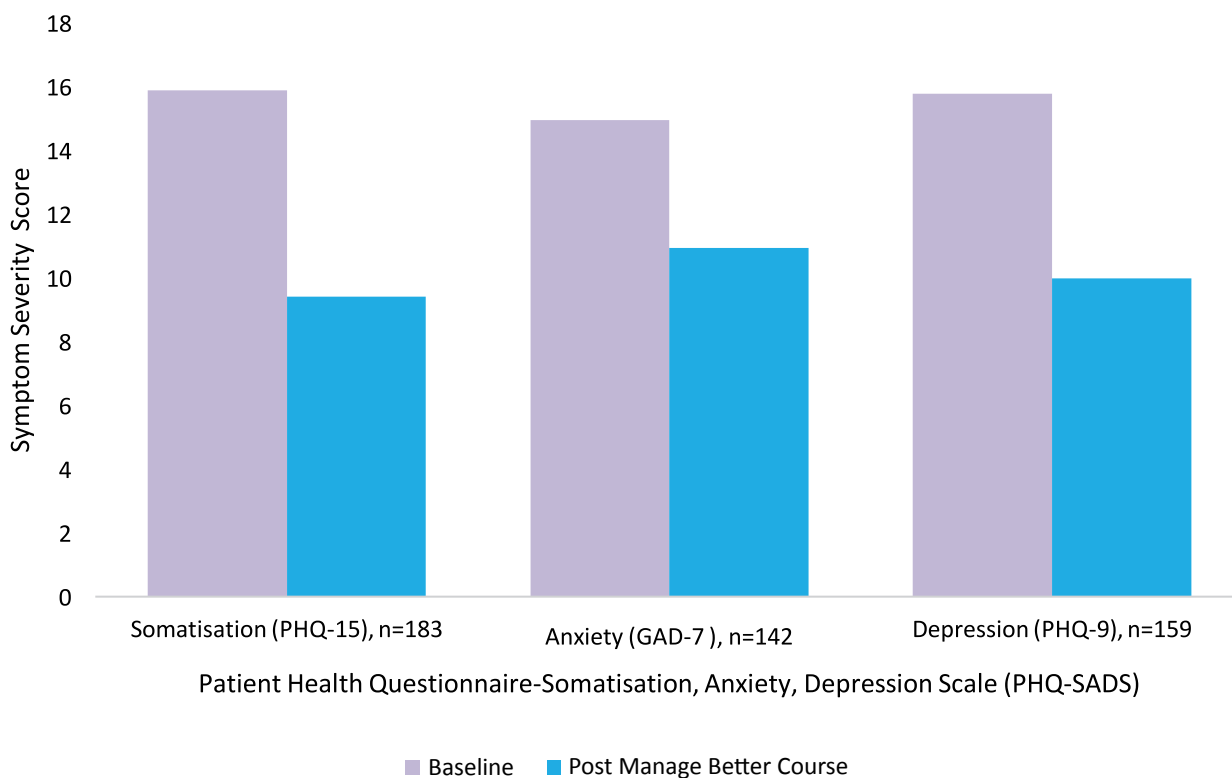
Feedback from course participants has been positive. Participants report acquiring new skills; better social support; improved self-efficacy; and better awareness, understanding and acceptance of their symptoms (*Figure 12*).

**Figure 12:** Thematic analysis of participant comments about the Manage Better Course



Course participants are encouraged to complete the PHQ-SADS (Patient Health Questionnaire – Somatisation, Anxiety, Depression Scale)<sup>27</sup> at first engagement and again when they complete the course. The PHQ-SADS is a measure of psychological distress that comprises scales that measure somatisation, or how much people are bothered by their symptoms (PHQ 15), anxiety (GAD 7) and depression (PHQ 9). People who have high psychological distress scores when they enter the course consistently achieve lower scores at course completion (Figure 13).

**Figure 13:** Self-reported psychological distress in Manage Better Course participants



Participants also consistently improve on eight scales of the Health Education Impact Questionnaire (heiQ),<sup>28</sup> which indicates an increase in skills and attitudes that will help them to manage their health condition better.

Medical outcomes have also improved, with a five per cent reduction in HbA1c among patients with diabetes who have participated in the Manage Better Course.

*"I was hearing words like 'terminal illness' and 'You will just have to learn to live with the pain' from the specialists. However, Kia Kaha helped us to learn about pain management and make a strategic plan as a family.*

*My wife is no longer worried about me dying, my whānau (family) is reconnected and we have a tool box. My goal was to get healthier. I feel I have achieved that. Now I have to maintain it."*

Patient, Manage Better Together: Kia Kaha





*Manage Better Together: Kia Kaha Manage Better Course*

### **Group-based condition-specific self-management support**

Evidence shows that group-based therapy for condition-specific self-management, such as smoking cessation, produces higher success rates than being given self-help materials without face-to-face instruction and group support.<sup>29</sup>

Group-based therapy was a key support option offered by Smokefree Buffet and Exercise for Life.

### ***Case study: Smokefree Buffet***

Smokefree Buffet uses group-based therapy (GBT) as a key self-management support option for smoking cessation. The Smokefree Buffet GBT combines behavioural intervention with weekly tasks and engaging group support.

Behavioural change techniques are used over seven weeks for a one hour session each week. The first two sessions are preparation sessions, and the third week is the quit date. Everybody in the group has the aim of trying to go without a single puff after this third session. By the end of the programme, the patient should have completed four weeks smokefree.

The GBT is delivered by primary care healthcare professionals trained in group-based smoking cessation therapy (See: Training and coaching healthcare providers, p.37). In this way, GBT can be provided to patients by healthcare professionals they have an existing relationship with in the familiar surroundings of their own primary care facility. The smokefree advisor (primary care) assists with recruiting patients and co-facilitating therapy sessions.

Although a cessation practitioner guides these sessions, success often relies on group cohesion. Ideally, about 20 people should be present at the quit date session to generate good group dynamics. However, as is usual for such groups, only about a third of the people who sign on for the programme attend and there is a further drop-off in numbers during the programme, with only about half of those who attend the first session remaining in the group by the quit date session.



Recruiting high enough numbers to keep group dynamics stable after the anticipated drop-off is therefore one of the keys to success. The most successful forms of recruitment have been text outreach, newspaper adverts and broadening the invitation to include member of the community who are not patients at the target practice. The Smokefree Buffet team plans to try using social media as a recruitment tool and, learning from the success of other teams in the Manaaki Hauora – Supporting Wellness campaign, using language-specific GBT.

## **Case study:** *Exercise for Life*

Exercise for Life offers exercise-based rehabilitation programmes with an education and information component to provide patients with self-management skills. The programme aims to create sustainable exercise behaviour for patients by moving from a philosophy of care ‘done to’ the patient to one of care ‘done with’ the patient.

The team used a two-pronged approach to achieve this shift.

The first was developing the skills and confidence of clinicians to deliver self-management support. Through Exercise for Life, clinicians self-assessed their ability and skills in subject areas relevant to self-management support and underwent training as needed (See: Training and coaching healthcare providers, p.37). Clinicians implemented these new skills in the Exercise for Life programme.

The second was the programme itself. Groups of 12-16 patients underwent an eight-week programme. Sessions are held twice a week and include a physical exercise component and an education component. The exercise component is tailored for each individual. Education is interactive, individualised and patient-centric. It includes information on nutrition, medications and action planning. Specialist speakers, such as an occupational therapist, community pharmacist and physiotherapist make regular visits.

Building rapport with patients early on is a key part of the programme’s success. This includes fostering a mutually supportive environment within the group and sensitivity to cultural appropriateness (See: Providing language- and culture-specific support, p.32).

*“I am fitter, thinner, cheekier, and I am looking good, baby!”*

Patient, Exercise for Life



*Exercise for Life group exercise session*





*Exercise for Life group education session*

## Group care planning

Patient-led group care planning has a positive effect on self-management skill, confidence and health-related behaviour.<sup>30</sup>

International evidence confirms that personalised self-management care plans are a best practice approach to self-management support for patients with long-term conditions.<sup>31</sup> Each patient's care plan should be developed collaboratively by the patient, health professionals and others who play a significant role in supporting the patient, such as family members or carers.

The care plan is derived from an assessment of self-management capacity and includes what the patient knows about their conditions, treatment and medication, their behaviours, attitude, how they manage the impact of the condition on their everyday life and the social, emotional, and spiritual aspects of their lives. Furthermore, it incorporates lifestyle risk factors, barriers to self-management and strengths.

A personalised care plan contains patient-defined problems and goals and identifies issues spanning self-management and medical management; family, community and carer support; and psychosocial needs. Mutually agreed interventions and action plans are developed with respective responsibilities, follow-up dates and progress tracking. The aim is to prevent complications and deterioration of long-term conditions and to enhance overall quality of life.<sup>32</sup>

The care plan also includes condition-specific tasks to be carried out by the patient and any condition-specific and generic education (knowledge and skills) as needed by the patient. A balance between holistic and condition-specific approaches and skills is necessary.

The care plan enables the patient to take ownership of and engage in their own care and treatment, enriches the relationship between the patient and their healthcare team, instils a belief in the patient that they can make changes that would enhance their self-management ability and their health outcomes, and enhances the patient's ability to sustain changes once improved self-management and health outcomes have been achieved.



The group psychotherapy approach to formulate a personalised care plan is grounded in cognitive theory,<sup>33</sup> theory related to group processes,<sup>34</sup> aspects of the trans-theoretical model of behaviour change,<sup>35</sup> social learning theory<sup>36</sup> and motivational interviewing.<sup>37</sup> It incorporates recognised self-management support and health coaching strategies.<sup>38,39,40,41</sup>

## Case study: Manage Better Together: Kia Kaha

Manage Better Together: Kia Kaha offers the Manage Better Together Group Care Planning Course, which was adapted from the Flinders Chronic Condition Management Program and the booklet, *My Health Story: Closing the Gap: Tackling Indigenous Chronic Disease*.<sup>42,43</sup> The booklet was adapted to be culturally appropriate for New Zealand. Each patient works with the health psychologist and peer supporter, as well as with family members or carers, to complete it. The booklet enables patients to identify their strengths, needs and concerns, and this becomes their personal care plan. Patients have the opportunity to share their care plan with their doctor, nurse, friends and family. The dynamics of the group environment help patients to feel motivated and share ideas as they work on their care plans.

The Manage Better Together facilitator manual is a resource and guide for facilitators delivering the Group Care Planning Course. The manual provides a framework for helping people with long-term physical and mental health conditions to develop a personalised care plan in a group setting in collaboration with members of a multidisciplinary healthcare team and their family, carer or peers.

The Group Care Planning Course covers two sessions, each with specific objectives (*Table 2*).

**Table 2: Manage Better Together Group Care Planning Course session objectives**

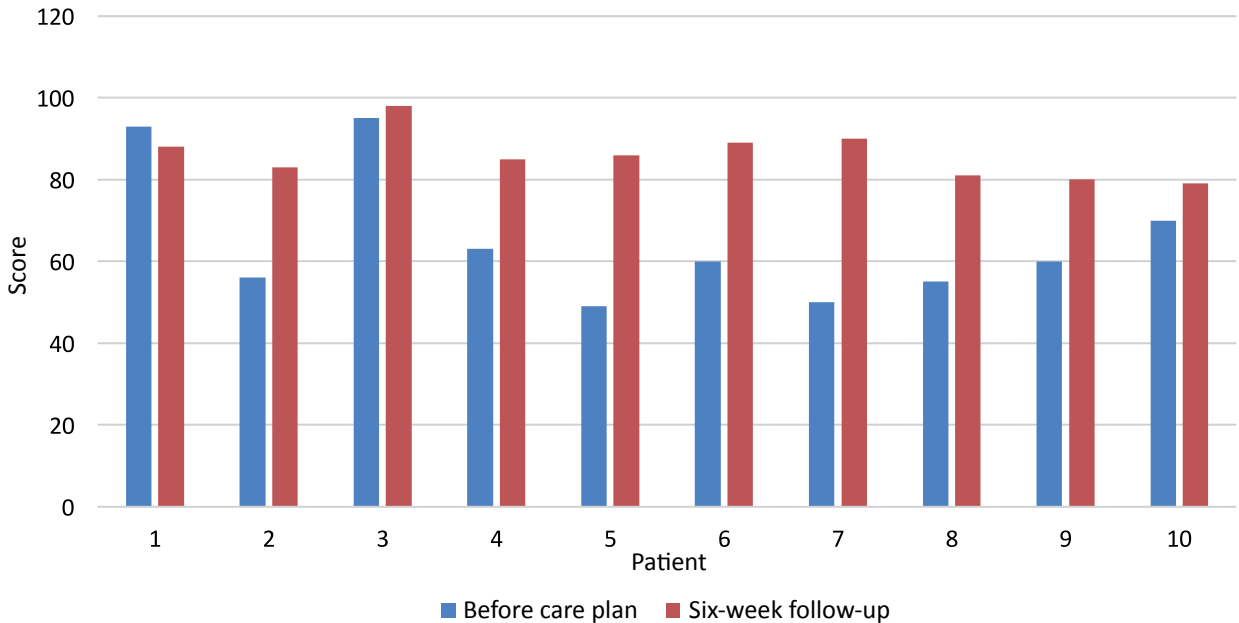
Session 1 objectives	Session 2 objectives
<p>For patients to:</p> <ul style="list-style-type: none"> <li>• have more confidence to modify behaviour to become informed and actively engaged in own health</li> <li>• have an understanding of self-management and self-management support</li> <li>• recognise who is important in their lives to provide support</li> <li>• have an understanding of what makes them strong</li> <li>• determine their self-management capacity</li> <li>• identify their main concern or problem</li> <li>• have a long-term goal</li> <li>• formulate a personalised self-management care plan and health summary</li> <li>• have knowledge of how to work with their providers to address any medical issues</li> <li>• recognise their responsibilities as a self-manager and those of others who provide self-management support.</li> </ul>	<p>For patients to:</p> <ul style="list-style-type: none"> <li>• provide a forum for mutual report</li> <li>• gain understanding of the utility of having a personalised care plan</li> <li>• have an opportunity to 'tweak' their care plan and provide progress on achievements and challenges completing the interventions</li> <li>• gain insight in behaviour change and recognise their own 'readiness' to engage in particular behaviours</li> <li>• understand lapse and relapse and regain momentum to engage in self-management behaviours</li> <li>• build skills to address difficulties or barriers by using a structured problem-solving approach</li> <li>• complete appropriate hospitalisation and self-management tasks before leaving the hospital or care facility</li> <li>• build knowledge of how to monitor early warning signs and symptoms and use a monitoring diary and symptom action plan</li> <li>• discuss other support options for a healthy lifestyle support, including the Wheel of Self-Management Support.</li> </ul>





The Group Care Planning Courses have improved the self-management ability scores of participants, as measured on the Partners in Health scale,<sup>42</sup> by an average of 32 per cent (Figure 14).

**Figure 14:** Partners in Health scores pre-post Group Care Planning Course (n=10)



*“As a result of this course I feel more self-empowered to manage my health goals.”*

Patient, Manage Better Together Group Care Planning Course

## Ongoing support

The nature of long-term conditions means that patients need to be able to sustain self-management practices learned during self-management education interventions on an ongoing basis. Ongoing support helps to maintain patient engagement and connection with the services and resources they need to continue managing their health effectively.

### Case study: BRITE

In the Manaaki Hauora – Supporting Wellness campaign, ongoing support was delivered through a newsletter linked to a web-based information repository and through support groups. The newsletter, *Next Steps*, was developed by the BRITE team. Four issues were distributed to patients of East Health Trust, a primary health organisation, who had completed a six-week diabetes self-management education programme. Each issue of the newsletter reviewed one of the key concepts from the programme and provided a range of information, ideas, tips and links to further resources related to maintaining a healthy lifestyle.

BRITE worked with the team at East Health Trust to consult with programme participants about the development of the newsletter. Based on participants’ feedback, the newsletter was personalised for the target community by adding information about the local pharmacy service and local contacts. Consultation with dietitians resulted in changes to bring the newsletter content into line with advice given in the diabetes self-management education programme.



East Health Trust obtained patient consent to send the newsletter to participants. Initially, the intention was to link the newsletters to joining a Facebook group and provide a package of support for programme graduates that would include the newsletter, Facebook and a website. The initial response rate from participants wishing to receive the resources was poor, and it became apparent that Facebook was a turn-off for many people. When Facebook was removed, almost all participants indicated that they would like to receive the newsletter.

BRITE also developed the Health Navigator website ([www.healthnavigator.org.nz](http://www.healthnavigator.org.nz)) as a comprehensive source of validated health information. Through the website, patients can access accurate, unbiased information that they can understand in the context of their own lived reality; practical tools and guides that help them make lifestyle changes and decisions about their health; and improve their understanding of how to build networks and navigate healthcare services.



## Ongoing support groups

Ongoing support can be delivered through patient-driven support groups.

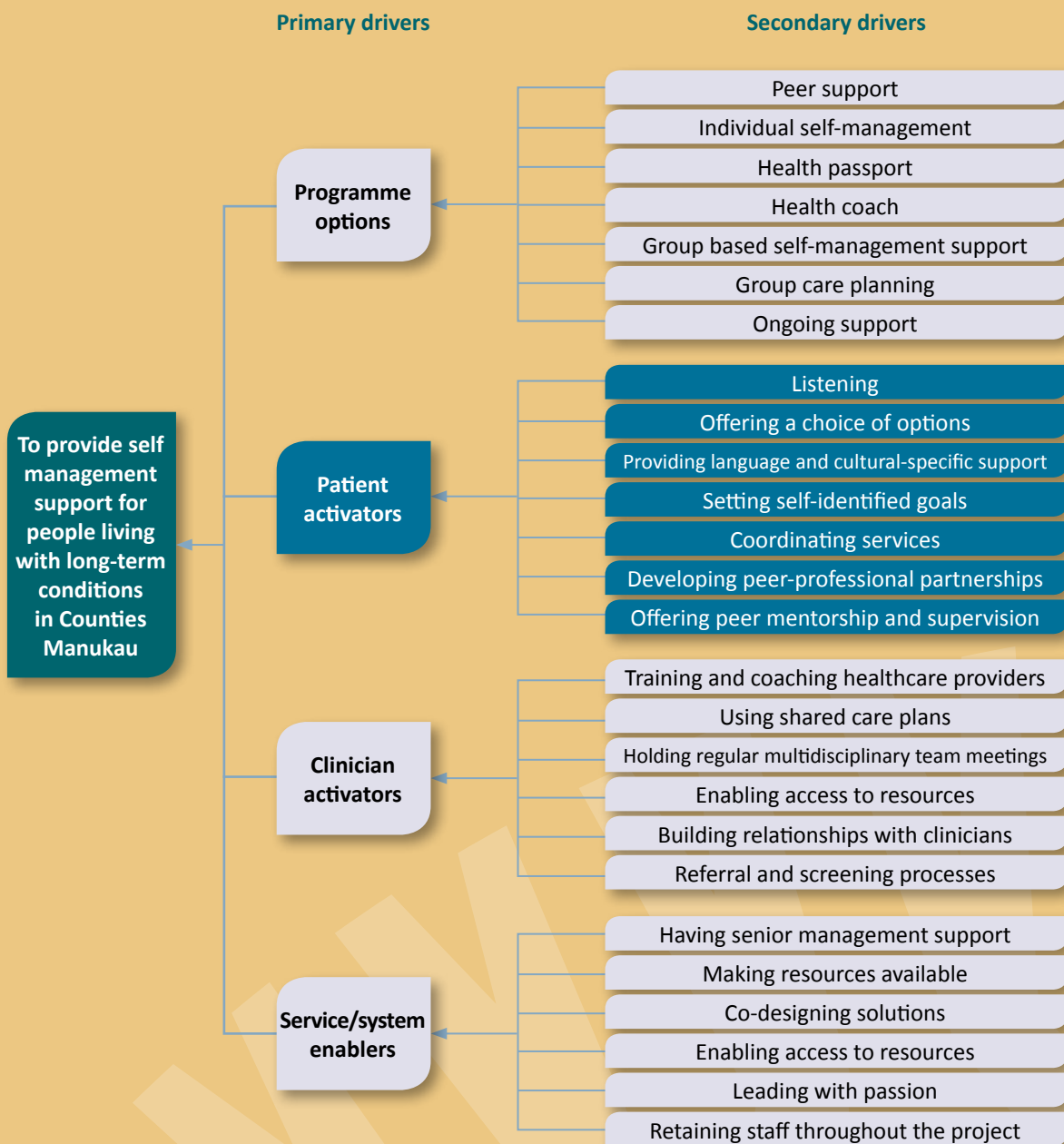
Manage Better Together: Kia Kaha encourages patients to create their own support groups at the end of each of its Manage Better Courses for self-management education. The team does not create the support groups but encourages the participants to decide if they would like to continue to meet and to organise this themselves. Although the healthcare team offers initial support if necessary, most groups do not need it. Course participants then continue meeting regularly to help each other meet their immediate and long-term health goals. In addition to receiving ongoing support through the groups, course graduates are invited to train as volunteers themselves.

*"Everyone spoke of the rapport and trust within the support group, of being heard and listened to, of the presence of aroha [love] and wairua [spirit], and of the opportunity to talk about themselves with no judgements and no attitudes."*

Support Group Coordinator



# Activating patients and whānau (family)



## Listening

It is sometimes difficult for people who are trained in healthcare to hear a patient's story. Healthcare professionals often work with caseloads or appointment systems that do not allow much time for listening. They can also be hindered from actively listening by their 'specialist' perception of what is important for a patient's health, and by a belief that imparting information will change the patient's life. The result of these barriers to listening is that the clinical consultation often becomes a pressured health talk about the patient's condition.

However, patients who need to focus on their health are often not actually interested in having that type of discussion. Their primary concern is often some other troubling aspect of their life or the impact their health condition is having on their life. Until that concern is acknowledged, patients may not be ready to receive new information. A simple process of setting an agenda with the patient may help by offering support for psychological stress and options for the patient to address their concern.



Although listening to a patient's primary concern before discussing health directives may seem counterintuitive to a time-pressured health professional, it is sometimes a time-saving measure.

In Manage Better Together: Kia Kaha, active listening is used to:

- build rapport between the patient and the care team
- understand the patient's primary concern
- enable healthcare professionals to better understand factors in the patient's lifestyle that influence their health, the motivation behind their behaviour, and the self-management support options that fit best with the patient's life
- make it easier to solve problems to overcome any barriers to engaging with self-management support options.



## Offering a choice of options

Involving patients as equal partners in the process of identifying knowledge and engagement gaps and choosing how to address them is an important activator. Offering patients tailored treatment options, chosen by the individual, increases engagement and improves outcomes.<sup>44</sup>

The role of the healthcare professional when a range of self-management support options are available is to ensure patients understand the options so they can make an informed choice about what best suits their needs and lifestyle. Healthcare professionals must be able to confidently advise patients on self-management support options and refer them according to their choice.

For example, Smokefree Buffet tested a variety of change ideas to provide patients with access to the fullest possible range of evidence-based smoking cessation support options. Patients were able to choose from: drop-in clinics; group-based therapy; smoking cessation aids such as Quickmist, Cooldrops, prescription medication, and nicotine patches, gum or lozenges; text, phone or social media-based support; home visits; Quit Card; Quit Bus and Quit Line. A smokefree menu was developed to inform patients of the options available.

Tailored treatment options helped to double the number of patients who remained smokefree at four weeks post quit date during this collaborative project.<sup>44</sup>

*“My doc’s nurse called me and offered me a group programme or one-on-one support at different time slots. The drop-ins were ideal for me because of my working hours.”*

Patient, Smokefree Buffet



*A 'buffet' of smoking cessation options*

The principle of offering patients choice was also applied by the Folau I Lagi-Ma team. To ensure patients received self-management support in an environment where they felt comfortable, they were offered a choice of venues, including the GP clinic, their home, or a neutral third location, such as a local café. The choice was offered by a peer supporter during initial telephone screening to explain the Folau I Lagi Ma service and encourage attendance. Patients were better able to engage in an environment where they felt relaxed. In addition, visits that occurred in the home offered the opportunity to understand a patient in their own context, particularly from an occupational therapy perspective.

In Manage Better Together: Kia Kaha, all interactions between the patient and the healthcare team are based on the 'Patient Choice, Patient Voice' approach. This approach focuses on understanding the patient's self-identified primary concern and on offering a choice of options to address that concern in a way that fits with the patient's lifestyle and preferences. The peer supporters in the Manage Better Together: Kia Kaha team are trained to offer patients options from the Wheel of Self-Management Support (See: Figure 7, p.11) and to know which indicators or requests need further referral or support from a clinician. If the team cannot respond directly to a patient's primary concern, the goal is to connect the patient with a clinician or service that meets their needs.





The flexibility of the Patient Choice, Patient Voice approach allows the patient to choose a support option which suits them. For example, a patient who wants to manage their health better but works two jobs and cannot make appointments or attend a course may be offered the choice of support with making an action plan and having follow-up phone calls. Online information on websites such as Health Navigator<sup>45</sup> may also be offered. The peer supporter who offers the support options also asks permission to call again or send further information.

## Providing language- and culture-specific support

Counties Manukau Health organisational values provide the foundation for language- and culture-specific information in the Manaaki Hauora – Supporting Wellness campaign. The values are:

- **Valuing everyone** – Make sure everyone feels welcome and valued.
- **Kind** – Care for other people's wellbeing.
- **Together** – Include everyone as part of the team.
- **Excellent** – Safe, professional, always improving.

With a diverse population which includes significant Māori, Pacific and Asian minority groups, language and cultural appropriateness is an essential part of activating patients in Counties Manukau to engage with healthcare and learn to manage their own health better.

The Exercise for Life programme operates in Mangere and Otara, two areas with a high proportion of Māori and Pacific people. The programme is designed to be appropriate for these cultures. For example, an exploration of whakapapa (ancestry) is integrated into the warm-up for each session: participants introduce themselves, talk about their background and, at the same time, reinforce learning by reviewing key lessons from the previous session.

In addition, the group-based nature of Exercise for Life allows clinicians to capitalise on group dynamics to identify and work with natural leaders within the group. These natural leaders can be encouraged to take a role in liaison between clinicians and patients, rapport building and strengthening the group's identity and cohesion. One of the benefits of this approach is that it creates leaders who are cultural peers for most of the patients.

Manage Better Together: Kia Kaha also recognises that even world-class support may not reach the people who need it if it is not appropriate to their language and culture. Manage Better Together: Kia Kaha Manage Better Courses for self-management education and individual self-management support are offered in English, Tongan, Hindi, Samoan and Mandarin. Translated course materials are provided by Stanford to ensure programme fidelity. The team also provides a kaupapa (Māori culture) version of the course led by Stanford-trained leaders who are conversant in Te Reo (Māori language). The course is in English but includes Māori elements, such as karakia (prayers), mihi (greetings), pipiha (introductions), waiata (songs) and korero (conversation).

In addition to translated course materials, the Tongan programme was run in the Tongan language by a Tongan peer in a predominantly Tongan suburb of Auckland. The Tongan programme proved extremely popular, with the first group starting with 20 patients and growing to 25, which was its maximum capacity. This is a contrast to the typical trend for the Stanford programme, which the Manage Better Course is based on; the programme often loses participants over its six-week duration. The success of the Tongan course led to the use of further translations of the Stanford Chronic Disease Self-Management Program, such as the Hindi, Samoan and Mandarin versions.

Similarly, Owning My Gout adapted its education resource, *Stop Gout*, to be appropriate for the language and culture of the patient groups they work with. The resource was originally available in English and





*Manage Better Together courses are offered in English, Tongan (pictured), Hindi, Samoan, Mandarin and kaupapa Māori*

Māori, but was translated into Mandarin to fit the needs of the large Chinese community at the East Auckland practice where the project was piloted. Later, as the project spread into the predominantly Pacific South Auckland suburbs of Mangere and Otara, *Stop Gout* was translated into Samoan and Tongan. These translated versions have been shared for use by other services.

## Setting self-identified goals

Goal setting has proven benefits as part of self-management support. It is associated with shorter stays in hospital, reduced readmissions, and improved self-care knowledge and behaviours. Regular and proactive follow-up is crucial to maximise the benefits of goal setting.<sup>2</sup>

Self-identified health or occupational goals increase the likelihood of engagement by offering interventions that are meaningful to the patient. Goals need to reflect an individual's self-defined 'well life'.

In *Folau I Lagi-Ma*, patients are at the centre of goal setting. During the project, supporting patients to work towards goals that are important to them in the context of their daily lives increased overall patient quality of life and energy levels. Patient satisfaction with health, personal relationships, self, ability to perform activities of daily living, and conditions at home also improved.<sup>46</sup>

In *SMILE*, the health coach works with patients to set personalised goals and monitor progress towards achieving them. A health coach can dedicate more time than a GP can to building a rapport and understanding a patient's circumstances and priorities. The health coach is therefore well-placed to help patients set goals that are meaningful to them.

In *Manage Better Together: Kia Kaha*, the team end as many conversations with patients as possible with questions that encourage patients to think about setting goals and how to achieve them. For example, they may ask:

- We have talked about a few things today that might help in managing your health and wellbeing. Which one would you like to work on first?



- Would you like to make an action plan?
- Can I follow up with you in a week by phone?

A goal or plan is never made *for* a patient, but always *with* a patient. It need not necessarily be a health-centred goal or plan; what matters to the patient is the most important consideration. Most patients choose to work on a healthy diet, being more active, taking medications regularly or managing stress.

## Coordinating services

When services work together they can develop a better understanding of patients' barriers to accessing self-management support services and better coordinate available resources to mitigate those barriers.

The Ola Lelei team used better service coordination to identify and overcome a problem with patient attendance at their self-management support programme, Wellness Recovery Action Plan (WRAP). Although WRAP received plenty of referrals, a significantly smaller number of patients would actually attend, and attendance numbers dropped off dramatically over the 10-week course of the programme.

To understand why, Ola Lelei met with the patients' keyworkers from the Faleola Service (Pacific Mental Health Service) to brainstorm barriers that prevented patients from regularly attending the course and possible solutions. This was an effective way not only to problem-solve, but also to engage the keyworkers and encourage their investment in the Ola Lelei programme.

It became clear that reliable transport was an issue for many patients. The Ola Lelei team targeted that barrier by developing a transport plan for each patient referred to WRAP. The plans leveraged service coordination with Faleola Service keyworkers. Each patient had a keyworker, and this keyworker coordinated with the community support worker or community liaison worker involved in the patients' care to provide transport to and from the WRAP course.

To sustain the success of the transport intervention, Ola Lelei maintain a presence at the weekly Faleola Service team meetings, where they highlight any patients who have not attended WRAP the previous week to find out why. This has increased the accountability of keyworkers in ensuring that patients who require transport receive it consistently.

Since the transport plan was put in place, attendance at the WRAP courses has doubled.

## Cross-sectorial service coordination

People's basic needs have to be addressed before they can begin to focus on their health or engage in meaningful occupation. Because the determinants of health include factors such as housing, which are beyond the scope of services provided by most healthcare organisations, cross-sectorial coordination with social services may be required to activate some patients to engage with self-management support.

For example, Folau I Lagi-Ma liaised with Housing NZ to arrange housing and housing modifications, such as installing ramp access and wet room showers, for patients who needed it.





## Developing peer-professional partnerships

Delivering self-management support options that use peer support and engagement depends upon developing successful partnerships between peer supporters and healthcare professionals. This includes building relationships, creating buy-in to the partnership, clarity about ways of working together and communicating so that patients receive a consistent and coordinated message, and how to deal with any problems the peer supporter may encounter that are beyond the scope of their role.

Peer health coaches play a key role in SMILE. Because the health coach role is designed to extend the services of a general practice, a close working relationship with the GP is essential.

The GP and health coach manage referrals in two ways: face-to-face and through a referral book for the health coach with the patient's name, National Health Index (NHI) number and a brief description of the reason for referral.

The health coach has access to the MedTech patient management system, which serves as a platform for dialogue between the practice and the health coach. Access to MedTech enables the health coach to log follow-up and feedback directly into the patient's notes about the patient's progress, ask questions, and set tasks. MedTech documentation acts as a trigger for liaison between the health coach and practice staff, and clarifies patient care and support.

Regular communication between the health coach and practice staff is also maintained in other ways. The health coach is invited into the practice each week, which helps to build the relationship between the health coach and practice staff. Attendance at team meetings and informal 'corridor conversations' are an invaluable source of information for the health coach and serve to remind practice staff about the health coach role.



## Offering peer mentorship and supervision

Peer support interventions can be an effective and economical way of delivering self-management support to people with long-term conditions. However, volunteers or staff members who are not trained healthcare professionals need appropriate mentorship and supervision from qualified healthcare professionals to ensure they are adequately trained, guided and supported to deliver high quality self-management support interventions with fidelity and that they have access to help dealing with problems beyond their scope of practice.

The Manage Better Courses offered by Manage Better Together: Kia Kaha are largely available due to course graduates training to become facilitators of the programme themselves. Since the courses are designed to be peer-led, these graduate volunteers make excellent facilitators and for many it becomes a pathway back into confidence and the community.

To support this volunteer workforce, the Manage Better Together: Kia Kaha team have weekly mentoring meetings where facilitators who are staff, volunteers and trainers discuss the courses and troubleshoot problems. This ensures the fidelity of the courses and the wellbeing of the facilitators.

By training a team using an evidence-based curriculum that has clear guidelines and processes, such as the Stanford Chronic Disease Self-Management Program used by Manage Better Together: Kia Kaha, it is possible to ensure safety for both the provider of care and the supervisor. The clarity of guidelines and scope make effective supervision and quality control achievable. Doing this well is an ongoing process. It is important to allocate time and resources to the crucial role of mentoring and supervision. Team meetings, huddles and written feedback are essential to create and maintain a high-functioning team.

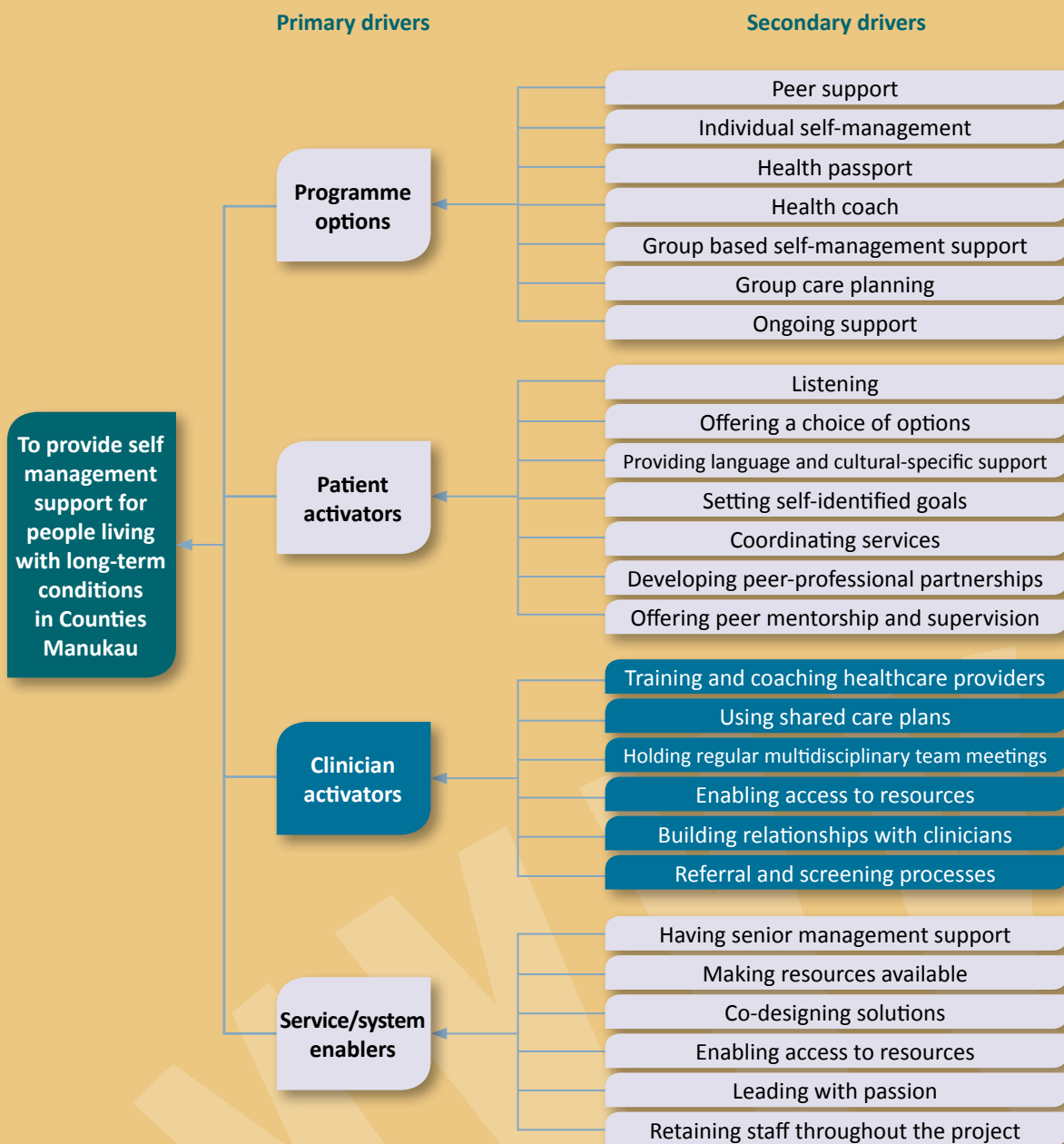
*“Doing this course myself and knowing how it helped me through the hard times in my life makes me go that extra mile to bring positive changes in the lives of others.”*

Volunteer facilitator, Manage Better Together: Kia Kaha





# Activating clinicians and teams



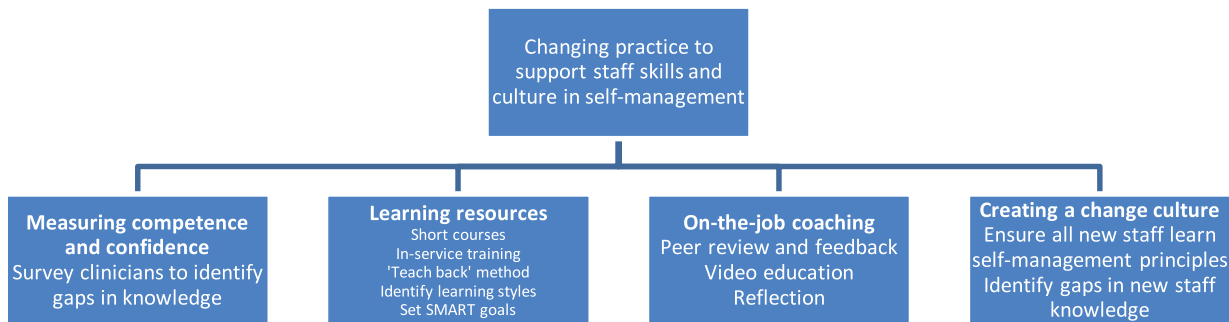
## Training and coaching healthcare providers

Improving clinicians' confidence and competence in self-management correlates with improved patient knowledge and engagement in self-management.<sup>47</sup>

Strategies to support staff skills in self-management principles and develop a self-management culture include:

- measuring clinician competence and confidence in self-management principles
- providing learning resources
- on-the-job coaching
- creating a change culture (Figure 15).

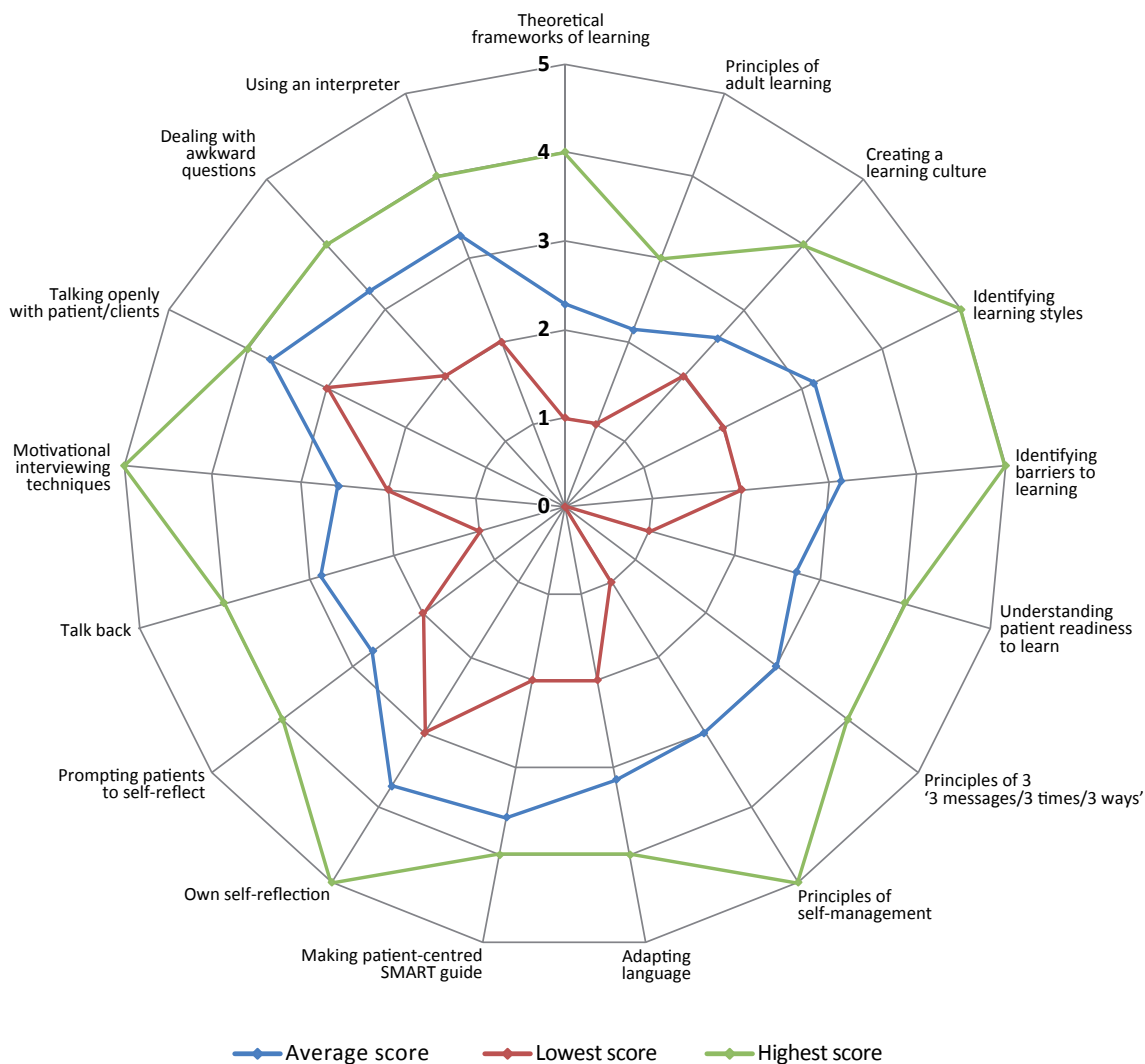
**Figure 15: Changing practice to support staff skills and culture in self-management**



Clinicians’ perceived levels of confidence and competence in self-management principles can be measured using a survey. The survey should cover the key skills and knowledge which enable clinicians to support their patients to learn. These include motivational interviewing techniques, the ‘Teach back’ method, understanding patient readiness to learn, principles of adult learning, theoretical frameworks of learning, and creating a learning culture.

In Exercise for Life, a survey of physiotherapists highlighted areas where staff confidence and competence in self-management support needed to be improved, which provided a basis for tailored training (Figure 16).

**Figure 16: Physiotherapists’ self-reported confidence and competence in self-management support skills**



Training was then delivered according to need by using simple, easy-to-access learning resources and on-the-job coaching tools (*Figure 15*).

To perpetuate culture change, healthcare organisations should survey new staff to identify gaps in their knowledge of self-management principles and provide training as appropriate.



*Mentorship in Exercise for Life*

### **Cross-training staff in the same model**

All healthcare professionals who will be involved in delivering self-management support need to be trained and supported appropriately to deliver the model of care. Cross-training staff together helps to deliver a coordinated approach.

Upskilling everyone on the team to provide appropriate evidence-based self-management programmes is a key focus of Manage Better Together: Kia Kaha. All team members are trained in three evidence-based self-management support models: The Flinders Program; the Stanford suite of chronic disease self-management programmes; and the health coaching curriculum from the Center for Excellence in Primary Care. This enables the team to both train and practice using a common skill base which includes a common language, practice and boundaries.

In Smokefree Buffet, the team provided training for GPs and practice nurses in primary care to deliver group-based therapy. A single person conducted the training to ensure a consistent approach. This support was instrumental in enabling primary care practices to organise and run group-based therapy for their own patients. Building capability for primary care practitioners to provide group-based therapy themselves enabled patients to participate in sessions at their regular primary care practice, where a relationship of trust had already been established.



In Owning My Gout, the lead project pharmacist trained GPs, nurses and pharmacists at the East Auckland primary care pilot site together in the principles and processes involved in the Owning My Gout model of care to ensure a shared understanding of how the model operated and the roles and responsibilities of each member of the care team. In addition, a rheumatologist provided a professional development session on gout management to improve participating clinicians' knowledge of the target condition. The rheumatologist provided ongoing support by answering questions and assisting with patient management as required. Following the professional development session, there was a sudden surge in referrals.

## Using shared care plans

Interdisciplinary teamwork helps to put patients at the centre of care and promote a more holistic view of the patient among clinicians. This strengthens the patient-clinician therapeutic alliance, which is vital for developing an effective self-management package.<sup>48</sup> Communication across disciplines also improves with an interdisciplinary approach, enabling clinicians to build on each other's expertise, which breaks down silos and fosters a sense of increased competence among clinicians.<sup>48</sup>

Interdisciplinary teamwork is distinct from multidisciplinary teamwork. Multidisciplinary teamwork draws on knowledge from different disciplines, but disciplines stay within their boundaries. Interdisciplinary teamwork creates and harmonises links between disciplines into a coordinated and coherent whole.<sup>49</sup> Collaborative care plans can be achieved only with an interdisciplinary approach.

Save Your Breath developed an interdisciplinary assessment form for chronic obstructive pulmonary disease to facilitate interdisciplinary teamwork. The team developed the form in response to frustrations voiced by patients and clinicians about communication in the acute respiratory ward at Counties Manukau Health. Patients were dissatisfied about having to repeat the same information over and over again to different healthcare professionals, and clinicians reported a lack of systems to support interdisciplinary teamwork, resulting in duplication.<sup>48</sup>

Save Your Breath developed the assessment form by breaking down the core skills of each allied health profession and identifying which components were discipline-specific and which could be generalised and assessed by all allied health and nursing staff without compromising patient safety. For example, with prompting from the assessment form, all team members could assess the patient's home and social environment and highlight any need for further investigation. Disciplines involved were occupational therapy, physiotherapy, social work, needs assessment, dieticians and nursing. Implementation of the interdisciplinary assessment form was supported by a cross-disciplinary training programme.

*"It's good because I only have to answer the same questions once! What you need when you're sick is to rest, but that's hard to do in hospital with people coming and going all the time."*

Patient, Save Your Breath





In Owing My Gout, a GP, pharmacist and nurse worked together in a collaborative model of care. To share information, they used an e-shared care record that all members of the team could access. As the pharmacist took a greater role in managing the patient's condition than is usual in gout care, including adjusting medication dosages and tracking patient urate levels, the e-shared care record was important to ensure that information about dosage adjustments and test results was visible to the GP.

## Holding regular multidisciplinary team meetings

Successful interventions for patients with complex long-term conditions often involve input from a multidisciplinary team.<sup>50</sup> Regular multidisciplinary team meetings are an integral part of multidisciplinary care, and they have positive outcomes both for patients and for healthcare providers. They offer health professionals with expertise in a range of specialities the opportunity to discuss options for patient care. Some of the benefits of regular multidisciplinary team meetings are better treatment planning, better service coordination, greater continuity of care, clear communication, and more efficient use of time and resources.<sup>51</sup>

For Folau I Lagi-Ma, holding regular multidisciplinary team (MDT) 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.

*"Service provision is more integrated."*

Dr Tim Hou, GP, Mangere Health Centre; Harriet Pauga, Nurse Manager, Mangere Health Centre





In Manukau Locality – Diabetes, multidisciplinary team ‘virtual review’ meetings bring together GPs and nurses at primary care practices with a visiting senior medical officer (SMO) and locality nurse. A social worker and a diabetes nurse specialist also attend on an as-needed basis.

The MDT meetings have four functions:

- to give staff of the primary care practice the opportunity to discuss challenging patient cases with a specialist as an alternative to referring patients to a specialist clinic
- to act as a link to secondary care services for patients who did need a referral to secondary care
- to increase GPs’ awareness of programmes and services that were available for their diabetic patients
- to increase the capability of the practice to manage diabetic patients, as learning from the reviews about how to manage one patient can also be applied to others. GPs also learn from specialist advice provided about medications and dose titration.

Meetings are held for an hour at lunchtime to ensure as many staff as possible are free to attend, and between five and fifteen patients are typically discussed. To date, twelve practices have participated in the meetings, with the frequency of the meetings guided by the needs of each practice.

Relationship building and preparation by the SMO and locality nurse are important to gain access to practices and make the MDT meetings work. When the project began, the SMO contacted GPs at target practices by telephone to discuss the proposal to hold MDT virtual reviews. Prior to each meeting, the locality nurse advises the SMO of the patients who will be discussed. During the meeting, the locality nurse records notes of what needs to be done for each patient.

A feedback survey on the MDT virtual reviews showed that, of 13 respondents at five practices, all found the meetings useful or extremely useful, all have increased their knowledge of diabetes care and all but one have greater confidence in diabetes care. The majority of respondents indicated an interest in including a dietician, health psychologist, podiatrist and patients in the meeting.

## Enabling access to resources

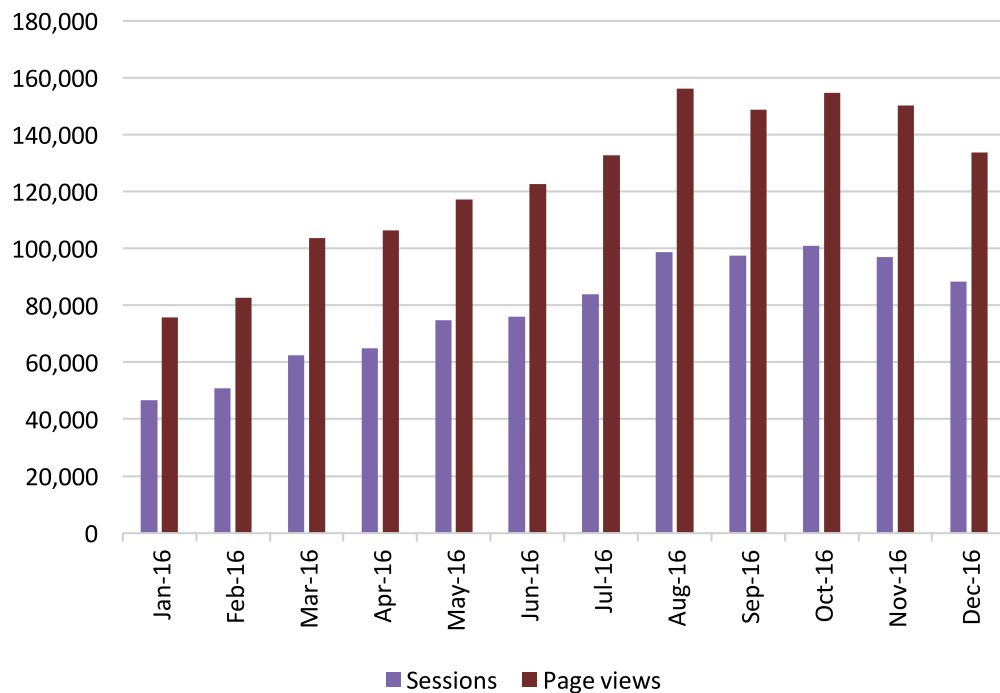
Healthcare providers and patients alike need better access to reliable and effective resources that help people to take charge of their health, build patient-provider relationships, share decision-making and improve patient wellbeing and health outcomes.

The BRITE team uses a number of resources to improve the capacity and capability of healthcare providers to provide self-management support.

- The Health Navigator website enables primary care and specialist teams to help patients and whānau to access reliable health and self-care resources. The website is New Zealand’s only source of validated health information. It brings together information on health conditions, medications, services and support, and tips for healthy living and self-management. For clinicians, there are easy-to-use tools and strategies to understand and use self-management support practices without system change. Health Navigator offers a bi-monthly newsletter, *The Long Term Conditions Bulletin*, which keeps healthcare providers up-to-date with news and research related to long-term condition management. Use of the website has increased steadily (Figure 17).



**Figure 17: Health Navigator website statistics - monthly visits for 2016**



- The Manaaki Hauora Network (<http://manaakihauora.ning.com>) is a web-based community of practice that provides project teams in the campaign with a platform to share tools, resources and learning. The network has 58 active members.
- A toolkit and programme for home-based self-management support, *Taking Charge*, which is being tested for use as a resource that primary care providers can prescribe for people with long-term conditions who are unable or unwilling to attend a self-management education group.

## Building relationships with clinicians

The Smokefree Buffet team worked across secondary care, primary care, mental health and maternity care, so building the Living Smokefree Service's relationship with clinicians in each of these areas was crucial to encourage referrals and build the ability of each participating service to provide sustainable in-house support. Each area had a dedicated smokefree advisor, who built relationships with key stakeholders and supported each participating service to trial different interventions for attracting high needs patients who smoke into smoking cessation support options. The Smokefree Buffet team found face-to-face interaction with clinicians to be the most effective way of building relationships.



Enhanced partnerships between the Living Smokefree Service and other healthcare services enabled seamless support to be offered to clients, which contributed to a doubling in the number of patients who remained smoke-free four weeks after quitting.<sup>44</sup>

*“Passion and commitment are infectious and, when aligned with reliability and ingenuity, build a very successful Smokefree team. Referrals are promptly dealt with, and women and whānau, along with stakeholders, appreciate all the support given.*

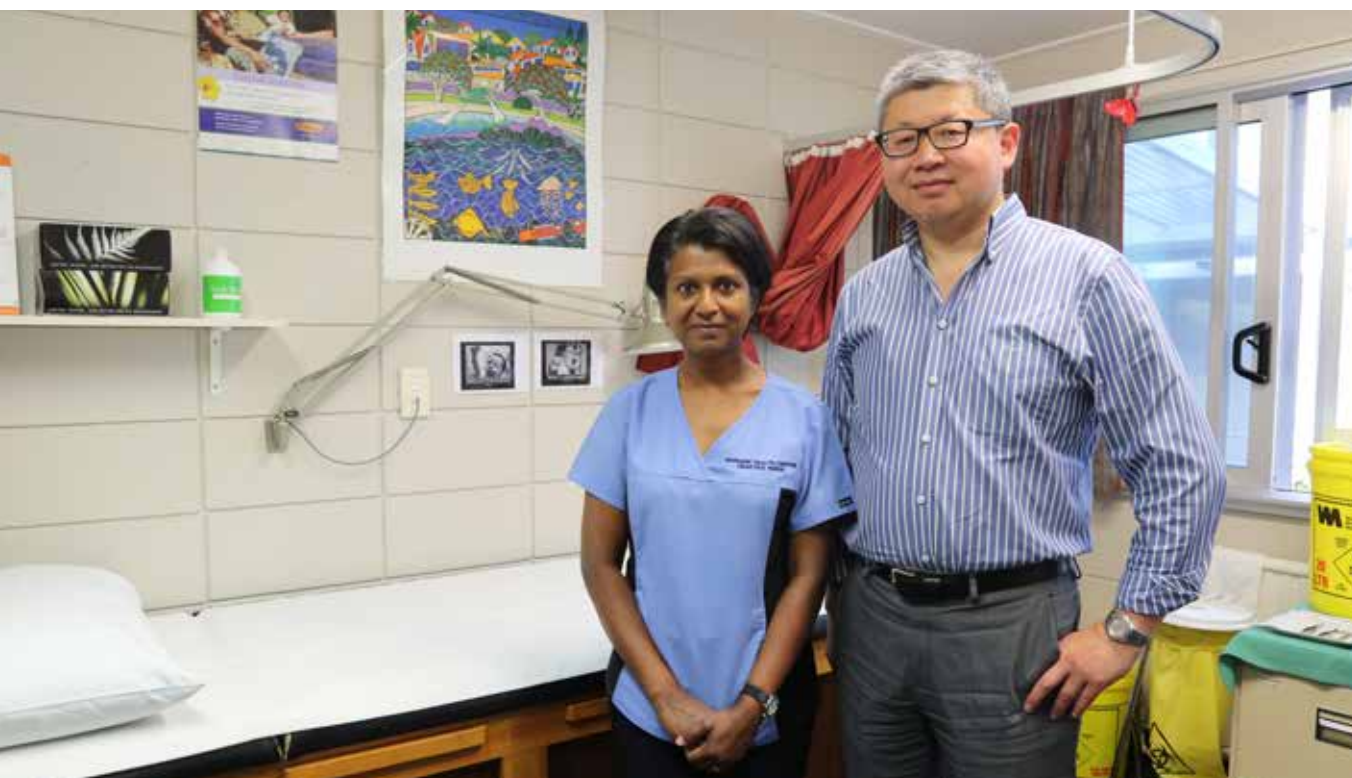
*Excellent communication keeps everyone informed. Keep up the great job!”*

Maternity Quality & Safety Coordinator

The Folau I Lagi-Ma team also 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 supporter 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.

*“We have seen results and things getting done.”*

Dr Tim Hou, GP, Mangere Health Centre; Harriet Pauga, Nurse Manager, Mangere Health Centre



*Practice nurse, Mala Beermathy (left) and GP Dr Tim Hou of Mangere Health Centre*

For the Ola Lelei team, building relationships with healthcare professionals across several services was the key to understanding and mitigating the barriers to patient attendance at their WRAP course. Because Ola Lelei targets Pacific patients with co-morbid mental and physical health issues, working with the Faleola Service (Pacific Mental Health Service) keyworkers was essential.

Initially, there was an issue with the lack of engagement from the Faleola staff. The Ola Lelei team put together a presentation for the keyworkers and included them in brainstorming the barriers for patients attending the course and possible solutions. They also began attending the weekly Faleola Service meetings and maintained a fixed item on the agenda to promote the Ola Lelei WRAP programme and sustain buy-in. As well as directly addressing the problem, this engaged the keyworkers and encouraged them to take ownership of the problem. Following this, the keyworkers were more engaged and actively promoted Ola Lelei WRAP to increase referrals.

They have used a similar approach to engage successfully with Community Support Workers (CSW) and Community Living Service (CLS) staff. The team gave a presentation about the programme and demonstrated the difficulties they experienced in maintaining consistent attendance numbers. The CSW/CLS group shared ideas and feedback, and now participate in maintaining attendance at WRAP by providing patients with transport to and from the programme.

## Referral and screening processes

Effective processes for screening and referral help to maximise the value of self-management support services to patients and healthcare providers alike by ensuring that the patients who are most likely to benefit are the ones who receive the service.

Communication is important. GPs need to know what self-management support services are available, which patients will benefit, and where and how to get help.

Good screening and referral processes play a role in activating clinicians. GPs want to help their patients. If a self-management support programme becomes swamped with unsuitable referrals and has to turn patients away, it can be de-motivating for GPs.

Smokefree Buffet used a proactive process for screening and referral to the Counties Manukau Pregnancy Incentives Programme (CMPPI), which provides ongoing behavioural support for smoking cessation, access to quitting medications and the opportunity to earn vouchers for every week a pregnant smoker stays smokefree. The process simultaneously ensured that the right patients were referred to the programme and picked up any patients with potential to benefit from it who had been missed.

The existing referral process needed to be improved because many women in Counties Manukau do not access maternity care early in pregnancy, instead choosing to confirm their pregnancy with their regular primary care provider. Although primary care health professionals work hard to ensure patients are offered the ABC smoking cessation intervention (**A**sk about smoking status, provide **B**rief advice and offer **C**essation support), some people are missed. For pregnant women, it is particularly important to access smoking cessation support as soon as possible.

The Smokefree Buffet team worked with the primary health organisation (PHO) to find pregnant smokers and refer them to the CMPPI. To find the women, they used PHO dashboard tools to identify missed interventions and apply filters to target pregnant women who were currently smoking. PHO tools further filtered these women by residence, weeks of pregnancy, ethnicity and quintile.

Using these tools, the PHO compiled a list of 400 women for the Smokefree Buffet team to contact. After removing duplicates and out-of-area patients, the Smokefree Buffet team contacted 83 women by telephone. Of these, 50 were ineligible for the programme because they had already stopped smoking, were no longer pregnant or had already enrolled in support. Of the 33 eligible women, 17 (52 per cent) accepted support. This compares favourably with the two referrals and one acceptance of support the CMPPI was receiving previously from the PHO each month.





Of the 17 women who accepted CMPIP support, eight set a quit date and five stopped smoking within four weeks. Smokefree Buffet's strategy of carefully identifying and reaching out to eligible patients worked with 17 women who would not otherwise have accepted support.

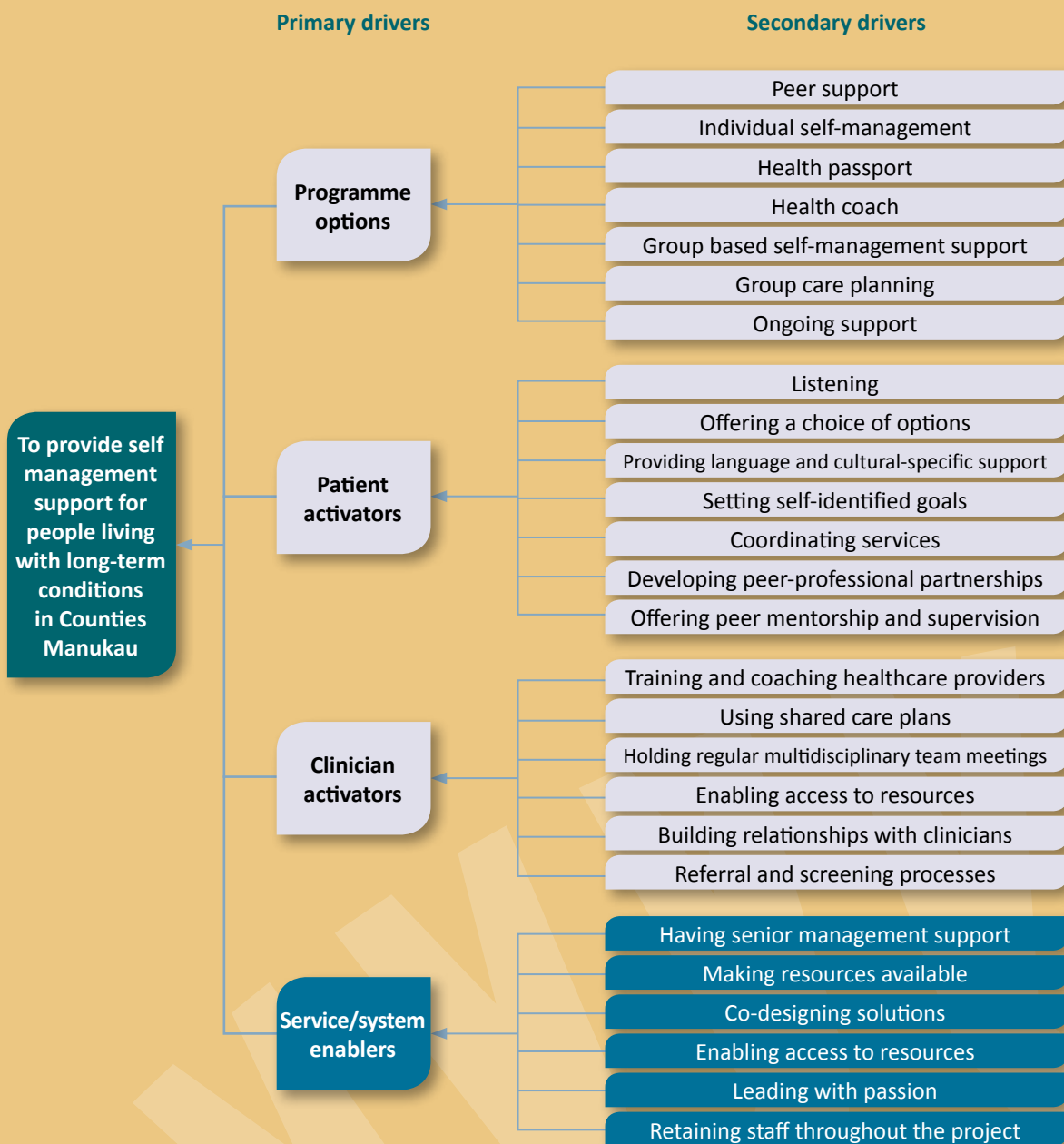


Folau I Lagi-Ma initially faced a challenge obtaining referrals and consent. There was limited understanding of the role of occupational therapy and peer support. In addition, many different initiatives and projects were underway at the Mangere Health Centre, resulting in change fatigue among practice staff. It was therefore important to create an easy referral pathway, build relationships and increase understanding of the Folau I Lagi-Ma service.

A referral form was created and circulated to Mangere Health Centre for feedback before being finalised. The form includes 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. It was incorporated into the Mangere Health Centre information system for easy access by clinicians.



# Service- and system-level enablers

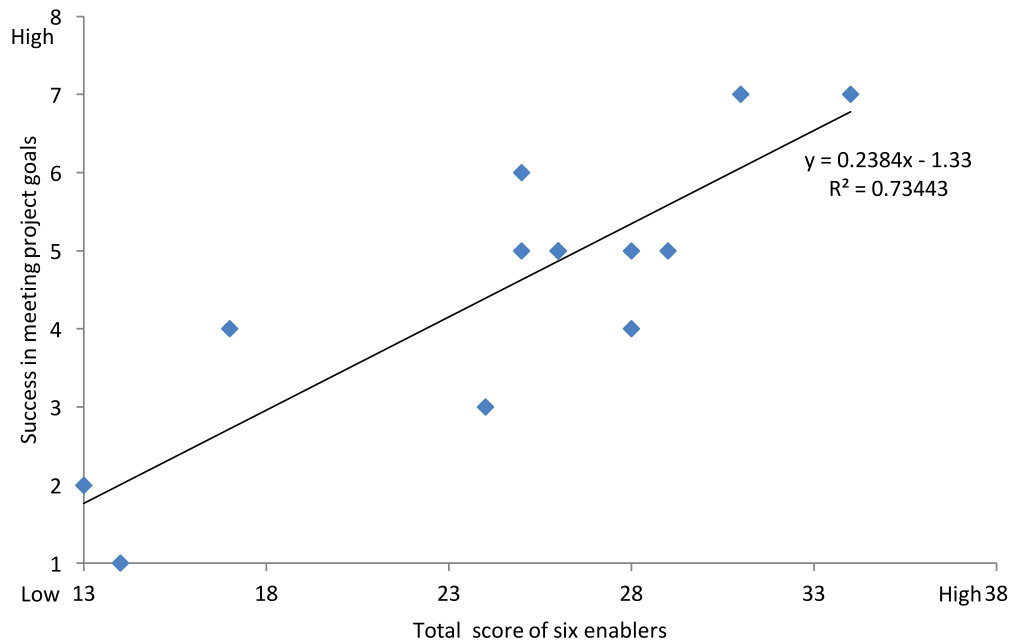


Patient and whānau activators and clinician and team activators cannot operate in isolation. They must be complemented and supported by activated services and systems.

The Manaaki Hauora – Supporting Wellness campaign identified six key service- and system-level enablers for establishing self-management support services. The six enablers were identified by the campaign leadership team through consultation with project teams. This anecdotal evidence was then tested by improvement advisors using Likert scales to assess the correlation between the presence of the enablers and team progress. Project teams that had more enablers in place made greater progress towards their goals (*Figure 18*).



**Figure 18:** Success in meeting project goals vs. Total of six enablers

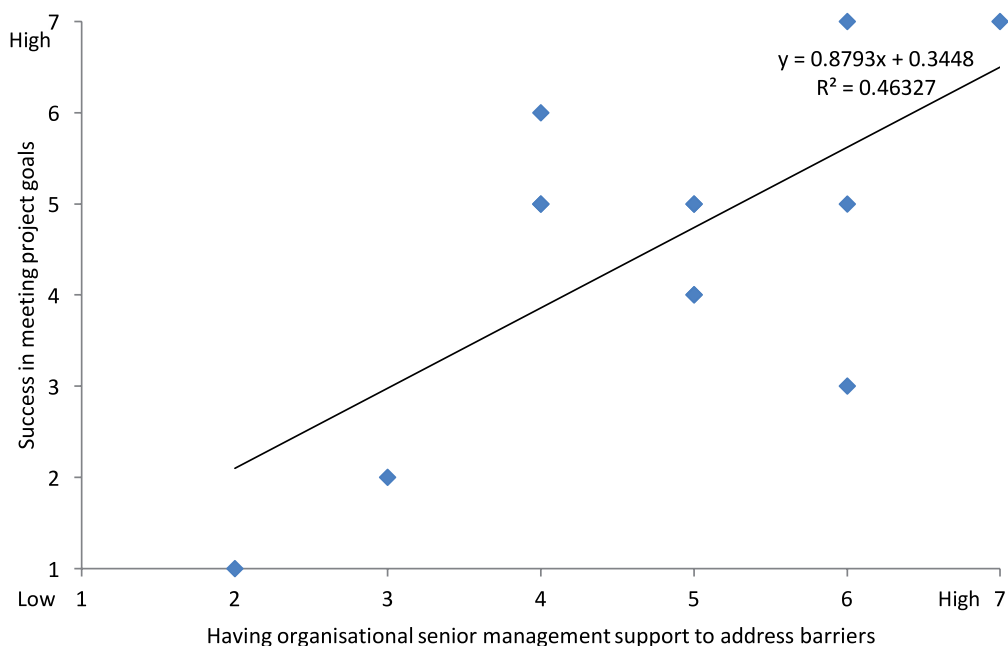


## Having organisational senior management support to address barriers

The support of senior organisational management to mitigate barriers is an acknowledged determinant of success for improvement projects. This was one of the factors most strongly associated with project teams achieving their goals. The support of senior management is critical to success because embedding self-management support in practice requires changes to systems of care.

Senior managers can show their support by taking a visible interest in the project, for example attending learning sessions; by providing valuable insight and advice for teams preparing business cases for their projects; and by facilitating and expediting operational and administrative needs, such as obtaining non-standard equipment or resources or back fill of full-time equivalent staff.

**Figure 19:** Success in meeting project goals vs. Having organisational senior management support to address barriers



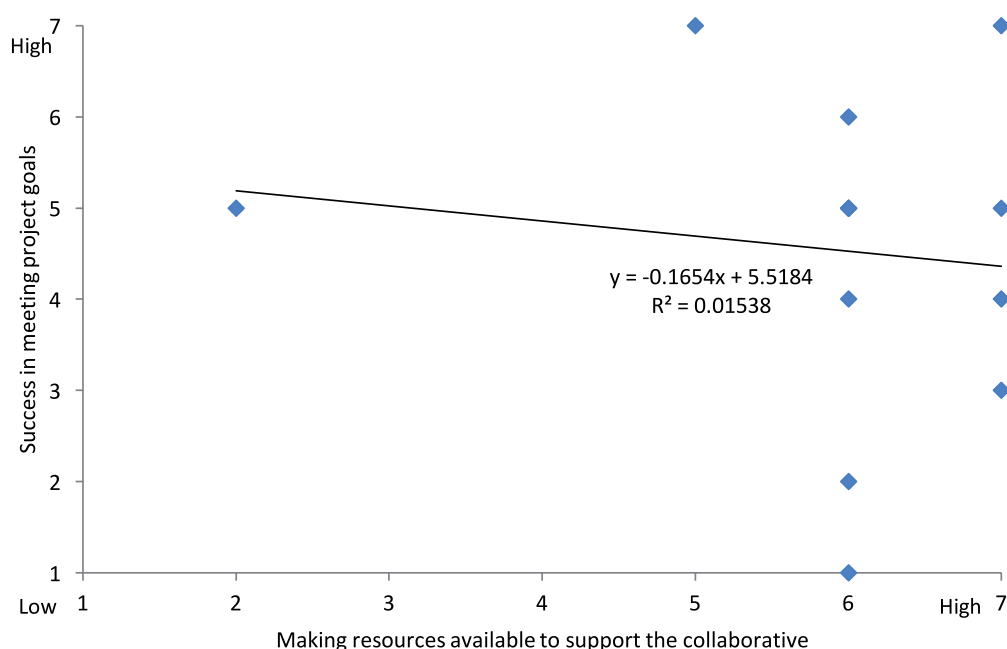
## Making resources available to support the collaborative

Appropriate resources need to be made available to support a collaborative project. There are two key resources that projects need to make progress: staff time and budget.

Much of the staff time resource required relates to releasing staff to attend learning sessions and weekly project team meetings. Attending learning sessions is important because it enables staff to develop skills in quality improvement methodology, and weekly team meetings keep the project on track. Time does not normally need to be allocated for running PDSA cycles. These should be small and frequent enough to fit into the everyday workload.

Teams also need an appropriate budget. Funding for quality improvement collaboratives should be flexible, because the evolving nature of the methodology means that the team will not know what the final change package will be at the beginning of the project. Teams therefore need budgetary flexibility as they adopt, adapt and abandon change ideas. Having flexibility to trial new kinds of support, and to continue to fund and grow them if they work, is therefore key to success.

**Figure 20:** Success in meeting project goals vs. Making resources available to support the collaborative



## Co-designing solutions

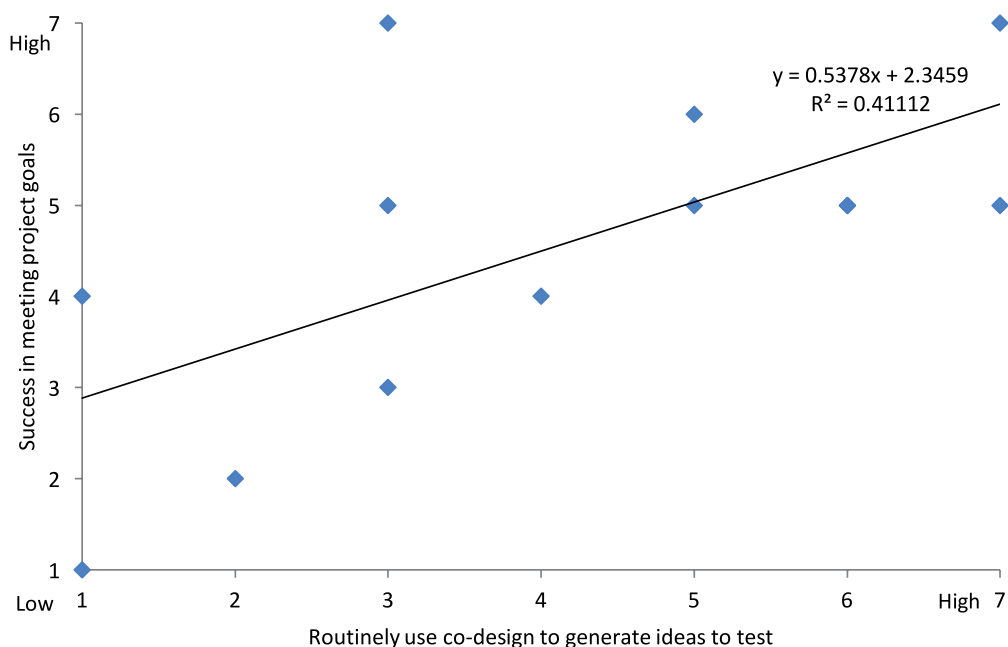
Co-design with patients is increasingly recognised as an essential element of any initiative that seeks to improve healthcare services. Patient input was critical to the success of the self-management support projects because engaging patients in self-management means understanding their needs, wants and preferences, as well as the barriers they face to managing their health. Co-design avoids the pitfalls of clinicians assuming they know what matters to patients, which can result in time and resources wasted on interventions that are not meaningful and appropriate for the target population. Co-design is thus key to generating the ideas to test using the collaborative methodology.

Co-design approaches should not be token; they must involve a genuine process of engaging a group of patients in helping teams to come up with solutions. Ideally, co-design should involve a group of patients and family members, reflecting the cultures of the community served to ensure input is representative. Teams must remember that patients are individuals, and one patient's perspective may differ markedly from another's – thus a richness of ideas can be generated to test.



Teams in the Manaaki Hauora – Supporting Wellness campaign incorporated patient input into their projects by including patient representatives in the project team or gathering feedback from patients on PDSA cycles. The most successful collaboratives also had large groups of patients and family who met regularly and were involved in shaping the improvement programme. These collaboratives all found that some of their most successful change ideas were generated from the process of co-design.

**Figure 21:** Success in meeting project goals vs. Routinely using co-design to generate ideas to test



*Listening to the patient perspective in a co-design group*

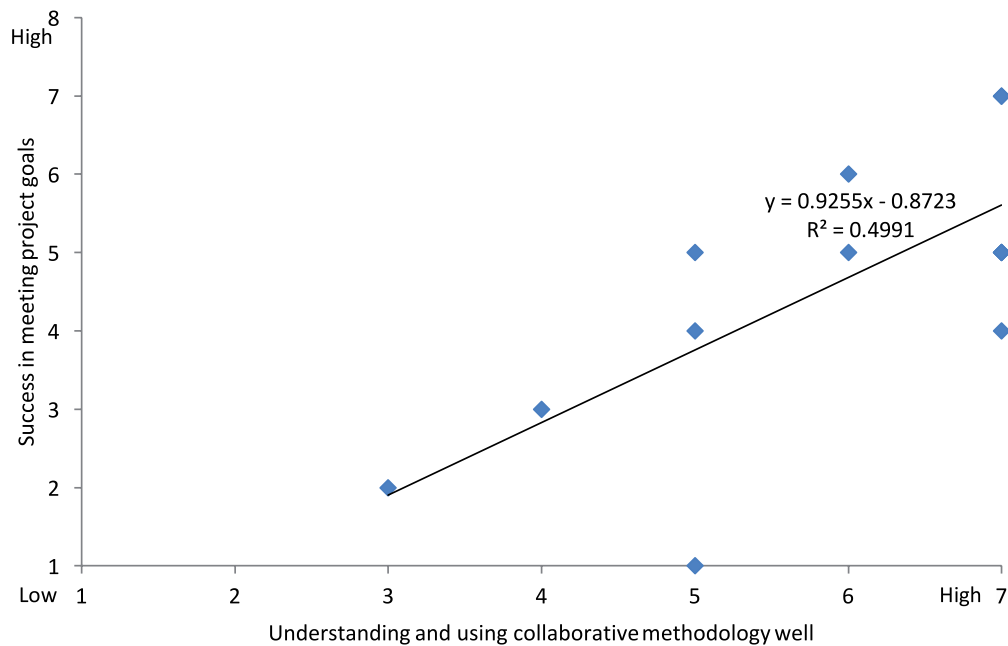
## Using collaborative methodology

Collaborative quality improvement methodology provides teams with a disciplined framework for putting improvement into practice. The Breakthrough Series Collaborative Model for Achieving Breakthrough Improvement comprises learning sessions interspersed with action periods. The learning sessions



provide project teams with the knowledge and skills to do improvement, and give teams access to improvement experts for coaching and support. Action periods allow teams to develop and test ideas for change. This approach ensures that the change packages which teams develop are proven effective through the use of measures. This replaces change driven by opinion with change driven by evidence. The beauty of this process is that ‘there is no wrong idea’. Rather than arguing about what is best or right to do, ideas are simply subject to testing via PDSA cycles – starting with small scale, low risk/disruption tests. If initial testing suggests the idea has resulted in improvement then larger scale tests are run, leading ultimately to implementing the idea as ‘practice as usual’ if it proves successful.

**Figure 22:** Success in meeting project goals vs. Understanding and using collaborative methodology well



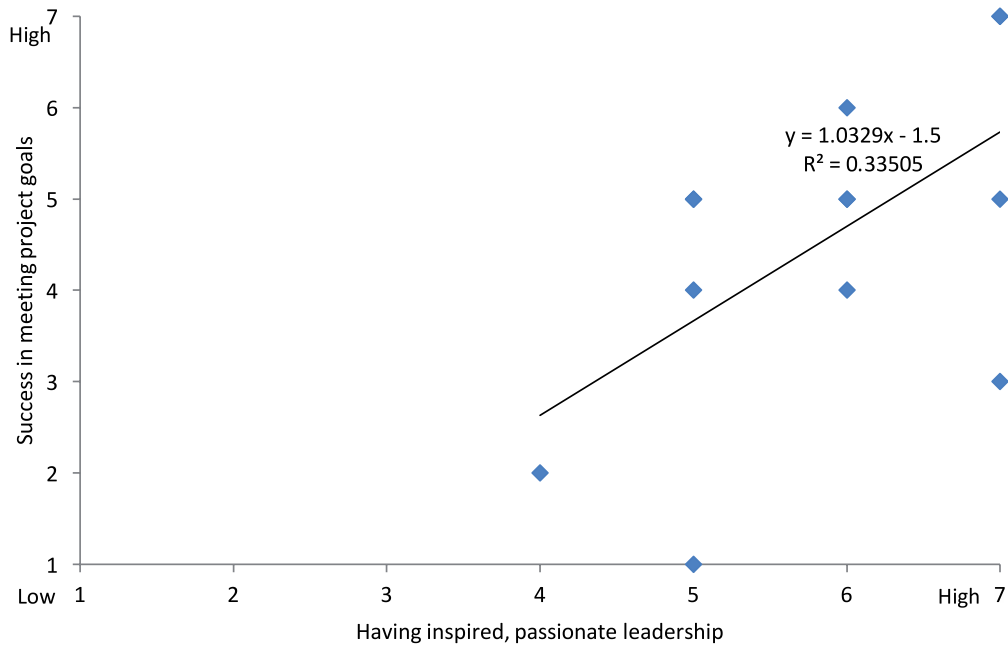
*Members of the Save Your Breath team at a campaign learning session*



## Leading with passion

Project teams need passionate leadership within the team, as well as support from organisational management. The project leader is a key influencer of team performance. Passionate leaders believe in what they are trying to do, and their commitment in turn motivates and inspires other team members. This gives the team drive and direction, and maintains progress. Leaders need to be someone respected by other members of the team, who will embrace the methodology and lead by example.

**Figure 23:** Success in meeting project goals vs. Having inspired, passionate leadership



## Retaining staff throughout the project

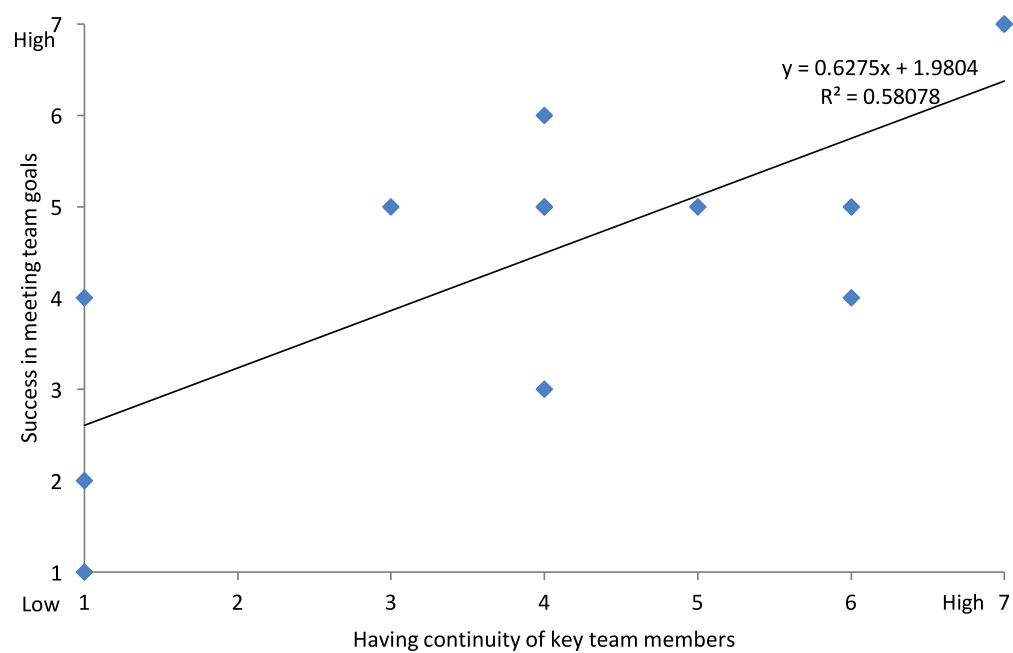
High turnover among staff involved with the project can result in unstable leadership, a fluctuating number of team members, or over-reliance on a single champion. These factors can disrupt project progress. In addition, new staff members who are brought on board may lack buy-in to the project and understanding of the methodology.

As staff turnover can sometimes be unavoidable, it is important that teams undertake succession planning to mitigate potential disruption. Succession planning ensures there is someone to take over leadership roles if necessary, and plans for how new team members will be brought up to speed and engaged with the project.

Having an appropriate number of team members makes succession planning easier. Project teams of only two or three people are more vulnerable to disruption if a member leaves. They also lack the critical mass to spark ideas and share the workload. While the ideal number of people per team depends on the nature of the project, having six to eight allows for easier succession planning and spreading the workload.



Figure 24: Success in meeting project goals vs. Having continuity of key team members



The Folau I Lagi-Ma team





# Conclusion

Self-management support enables people with long-term physical or mental health conditions to manage their health effectively. It empowers people to become more confident about managing their health conditions and to recognise and maintain their responsibility to be actively engaged in their own care. It benefits people's attitudes, behaviours and quality of life.

Self-management support options that demonstrated reach and impact in the Manaaki Hauora – Supporting Wellness campaign include the use of peers to engage with and support patients, personalised self-management support, health passports, the use of health coaches, generic and condition-specific group-based self-management support, group care planning, and ongoing support.

These options work well when the patient, the clinician and the healthcare system are activated.

The Manaaki Hauora – Supporting Wellness campaign identified effective patient and family activators as listening, offering patients a choice of options to fit with their preference and lifestyle, providing language- and culture-specific information and programmes, setting self-identified goals, service coordination, and developing peer-professional partnerships with appropriate mentorship and supervision from healthcare professionals.

Activating clinicians and healthcare teams means providing the training and coaching needed to practice self-management support, enabling multidisciplinary teamwork by using shared care plans and holding regular MDT meetings, providing access to resources, building relationships with clinicians, and establishing effective referral and screening processes.

The campaign identified six system-level enablers which must exist in complement with factors that activate patients and clinicians to establish and deliver self-management support services that work well and make a difference for people with long-term conditions. The support of senior managers to address barriers is important, as is making resources available. The use of co-design and collaborative methodology provides quality improvement teams with a framework for ensuring that services and resources meet the needs of patients and their families and putting improvement initiatives into practice. Quality improvement project teams also need passionate leadership, and they are more likely to succeed if staff turnover is low during the project period or succession planning is undertaken to ensure disruption to project progress is minimised.



certificate

AWARDED TO:  
Smokefree Buffet  
for successfully participating in the  
Manaaki Hauora - Supporting Wellness  
campaign

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WELLNESS

WELLNESS



# References

1. Institute of Medicine (US) Committee on the Crossing the Quality Chasm: Next Steps Toward a New Health Care System. Patient self-management support. In: Adams K, Greiner AC, Corrigan JM (Eds). The 1<sup>st</sup> Annual Crossing the Quality Chasm Summit: A Focus on Communities. Washington, DC: National Academies Press; 2004: p.57.
2. De Silva D. Evidence: Helping people help themselves. London: The Health Foundation; 2011.
3. Burd H, Hallsworth M. Supporting self-management: A guide to enabling behaviour change for health and wellbeing using person- and community-centred approaches. Realising the Value; 2016.
4. 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; 2012.
5. Institute for Healthcare Improvement. The Breakthrough Series: IHI's Collaborative Model for Achieving Breakthrough Improvement. Boston: IHI; 2003.
6. Langley GL, Moen R, Nolan KM, et al. The improvement guide: A practical approach to enhancing organizational performance. San Francisco: Jossey-Bass; 2009.
7. Coleman K, Austin BT, Brach C, Wagner EH. Evidence on the Chronic Care Model in the new millennium. Health Affairs (Millwood). 2009 Jan-Feb; 28(1): 75-85.
8. Davidson L, Bellamy C, Guy K, et al. Peer support among persons with severe mental illness: a review of evidence and experience. World Psychiatry. 2012; 11: 123-8.
9. Heisler C, Building peer support programs to manage chronic disease: seven models for success. Oakland, CA: California HealthCare Foundation; 2006. Available from: <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20B/PDF%20BuildingPeerSupportPrograms.pdf>
10. Funnell, MM. Peer-based behavioural strategies to improve chronic disease self-management and clinical outcomes: evidence, logistics, evaluation considerations, and needs for future research. Family Practice. 2010; 27: i17-i22.
11. Bodenheimer T, Laing BY. The teamlet model of primary care. Annals of Family Medicine. 2007 Sep-Oct; 5(5): 457-461.
12. Lancaster T, Stead LF. Individual behavioural counselling for smoking cessation. Cochrane Database of Systematic Reviews 2005, Issue 2. Art. No.: CD001292. DOI: 10.1002/14651858.CD001292.pub2.
13. Stewart J, Candy S, Foster E, et al. Earn your passport to health: how to engage patients to sustain a healthy behaviour change. Poster presentation. APAC Forum 2016, 12-14 September, Sydney. Available from: <http://koawatea.co.nz/?s=earn+your+passport>
14. Bennett HD, Coleman EA, Parry C, et al. Health coaching for patients with chronic illness. Family Practice Management. Sept/Oct 2010; 24-29.
15. Lanese BS, Dev A, Srivastava P, et al. Introducing the health coach at a primary care practice: impact on quality and cost (Part 1). Hospital Topics. 2011 Jan-Mar; 89(1): 16-22.
16. Huffman M. Health coaching: a new and exciting technique to enhance patient self-management and improve outcomes. Home Healthcare Nurse. 2007 Apr; 25(4): 271-274.



17. Leahey TM, Wing RR. A randomized controlled pilot study testing three types of health coaches for obesity treatment: professional, peer, and mentor. *Obesity*. 2013 May; 21(5): 928-934.
18. Health coaching. In: Center for Excellence in Primary Care [Internet]. San Francisco: University of California San Francisco; c2013. Available from: <https://cepc.ucsf.edu/>
19. Kosmala-Anderson JP, Wallace LM, Turner A, et al. Self-reported effects of attending the Health Foundation's Co-Creating Health self-management programme for patients with type 2 diabetes mellitus in London, England. *Archives of Medical Science*. 2014; 10(4): 773-781.
20. Johnston S, Irving H, Mill K, et al. The patient's voice: an explanatory study of the impact of a group self-management support program. *BMC Family Practice*. 2012; 13: 65.
21. Lorig KR, Sobel DS, Stewart AL, et al. Evidence suggesting that a chronic disease self-management programme can improve health status while reducing hospitalization. A randomized trial. *Medical Care*. 1999; 37: 5-14.
22. Lorig KR, Sobel DS, Ritter PL, et al. Effect of a self-management program on patients with chronic disease. *Effective Clinical Practice*. 2001; 4: 256-262.
23. What is WRAP? In: Copeland Center for Wellness and Recovery [Website]. Available from: <https://copelandcenter.com/wellness-recovery-action-plan-wrap>. Accessed December 2016.
24. Stanford Patient Education Research Center. Chronic Disease Self-Management Program (Better Choice, Better Health Workshop). [Internet]. Stanford School of Medicine; 2017 [cited 2017 Feb 9]. Available from: <http://patienteducation.stanford.edu/programs/cdsmp.html>
25. Bandura A. Social learning theory. Oxford, England: Prentice Hall; 1977.
26. Bandura A. Self-efficacy. In: VS Ramachaudran, editor. *Encyclopedia of human behavior*, vol. 4, p.71-81. New York: Academic Press; 1994. Reprinted in: H. Friedman, editor. *Encyclopedia of mental health*. San Diego: Academic Press; 1998.
27. Patient health questionnaire including PHQ, PHQ 9, PHQ-Brief and PHQ-SADS. *Psychiatric Times*. UBM Medica; c1996-2017 [cited 2013 March 11]. Available from : <http://www.psychiatrictimes.com/clinical-scales-patient-health-questionnaire>
28. 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.
29. Stead LF, Lancaster T. Group behaviour therapy programmes for smoking cessation. *Cochrane Database of Systematic Reviews* 2005, Issue 2. Art. No.: CD001007. DOI: 10.1002/14651858.CD001007.pub2.
30. Harvey PW, Petkov JN, Misan G, et al. Self-management support and training for patients with chronic and complex conditions improves health-related behaviour and health outcomes. *Australian Health Review*. 2008 May; 32(2): 330-8.
31. Coulter, AR. Delivering better services for people with long-term conditions. London: The King's Fund; 2013.
32. Battersby M, Harvey P, Mills PD, Kalucy E, Pols RG, Frith PA, McDonald P. SA HealthPlus: A controlled trial of a statewide application of a generic model of chronic illness care. *The Millbank Quarterly*. 2007; 85(1): 37-67.
33. Beck J. Cognitive behavior therapy. New York: The Guilford Press; 2011.



34. Yalom I, Leszcz M. The theory and practice of group psychotherapy. 5th ed. New York: Basic Books; 2005.
35. DiClemente JO, Prochaska CC. Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy*. 1982; 19: 276-288.
36. Bandura, A. Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*. 1977; 2: 191-215.
37. Miller WR, Rollnick S. (2013). *Motivational interviewing: Helping people change*. 3<sup>rd</sup> ed. New York: The Guilford Press; 2013.
38. Wagner E, Austin B, Von Korff M. Improving outcomes in chronic illness. *Managed Care Quarterly*. 1996; 4: 12-25.
39. Lorig KR, Holman HR. (2003). Self-management education: History, definition, outcomes and mechanisms. *Annals of Behavioural Medicine*. 2003; 26(1): 1-7.
40. Battersby M, Von Korff M, Schaefer J, Davis C, Ludman E, Greene, et al. Twelve evidence-based principles for implementing self-management support in primary care. *The Joint Commission Journal in Quality and Patient Safety*. 2008; 36(12): 561-580.
41. Bodenheimer T, Ghorob A. Health coaching. *Health Coaching UCSF Center for Excellence in Primary Care*. California: University of California; 2014.
42. Battersby M, Ask A, Reece MM, Collins JP. The Partners in Health Scale: The development and psychometric properties of a generic assessment scale for chronic condition self-management. *Australian Journal of Primary Health*. 2003; 9(4): 41-52.
43. The Flinders Program [Internet]. Flinders Human Behaviour & Health Research Unit, Flinders University; c2016 [cited 2017 Feb 22]. Available from: <http://flindersprogram.com/>
44. McKenzie G, Fernandes B, Lee M, et al. Smokefree Buffet selection – What’s your preference? Poster presentation. APAC Forum 2016, 12-14 September, Sydney. Available from: <http://koawatea.co.nz/smokefree-selection-whats-your-preference-offering-freedom-of-choice-for-patients-as-they-embark-on-their-smokefree-journey-a-collaborative-initiative-between-patients-healthcare-professionals/#>
45. Health Navigator New Zealand [Internet]. Health Navigator; c2017 [updated 2017 Feb 13; cited 2017 Feb 21]. Available from: <http://www.healthnavigator.org.nz/>
46. Forrest R, McCabe L, Sutherland F, et al. Folau I Lagi-Ma – Journey to wellness: Supporting people to paddle their own waka to wellness. Poster presentation. APAC Forum 2016, 12-14 September, Sydney. Available from: <http://koawatea.co.nz/folau-i-lagima-journey-to-wellness-supporting-people-to-paddle-their-own-waka-to-wellness/>
47. MacKenzie N. Turning knowledge into engagement: How do clinicians engage more effectively to improve self-management? Poster presentation. APAC Forum 2016, 12-14 September, Sydney. Available from: <http://koawatea.co.nz/turning-knowledge-into-engagement-how-do-clinicians-engage-more-effectively-to-improve-self-management/>
48. Cavit L, Dekker L, Donald L, et al. “There’s no point hearing from someone who doesn’t live with it, otherwise it’s just their point of view!” Save Your Breath: Partnering with COPD patients to help them live well in the community. Poster presentation. APAC Forum 2016, 12-14 September, Sydney. Available from: <http://koawatea.co.nz/no-point-hearing-from-someone-who-doesnt-live-with-it-otherwise-its-just-their-point-of-view-save-your-breath-partnering-with-copd-patients-to-help-them-live-well-in-the-community/>



49. Choi BC, Pak AW. Multidisciplinarity, interdisciplinarity and transdisciplinarity in health research, services, education and policy: 1. Definitions, objectives and evidence of effectiveness. Clin Invest Med. 2006 Dec; 29(6): 351-64.
50. Wagner EH, The role of patient care teams in chronic disease management. BMJ. 2000 Feb 26; 320(7234): 569-572.
51. Ministry of Health. Guidance for implementing high-quality multidisciplinary meetings: Achieving best practice cancer care. Wellington: Ministry of Health; 2012. Available from: <http://www.health.govt.nz/publication/guidance-implementing-high-quality-multidisciplinary-meetings>





# Further information

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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**KO AWATEA**  
APPLIED HEALTHCARE INNOVATION



COUNTIES  
MANUKAU  
HEALTH





# Appendix A: The collaboratives

The Manaaki Hauora – Supporting Wellness campaign covered 16 collaborative teams. Ten are featured in this guide.

## Exercise for Life

Counties Manukau Health runs two eight-week rehabilitation programmes, Healthy Hearts and Better Breathing, to support the long-term management of people with heart failure and chronic obstructive pulmonary disease, respectively. To sustain the gains achieved during rehabilitation, participants in these programmes need to embed exercise into their lifestyles. This includes overcoming barriers, prioritising exercise, and understanding the positive role of exercise in their cardio-respiratory health.

Exercise for Life aimed to develop a change package that would support 100 participants in Healthy Hearts and Better Breathing to increase their self-management survey results by December 2016.

The team also developed programmes to train staff to deliver self-management support.

## Folau I Lagi-Ma

The vision of Folau I Lagi-Ma is to support people with chronic conditions to understand their health and how their lifestyle can positively impact on their conditions; make behavioural changes to integrate health information into practice in their daily activities; and understand that engaging in meaningful activities can promote health and wellbeing.

The aim of the project was to support 45 people from Mangere Health Centre with long-term conditions to improve their overall EUROHIS Quality of Life scale score by four points by December 2016.

Folau I Lagi-Ma integrates an occupational therapy and peer support service into a primary care practice in Counties Manukau to deliver better care for people living with chronic conditions.

## Manage Better Together: Kia Kaha

Manage Better Together: Kia Kaha is a team-based approach to self-management support developed and tested in a large urban primary health organisation that serves an area with multiple ethnicities, financial deprivation and health inequities.

The aim of Manage Better Together: Kia Kaha was to offer self-management support to 5,000 people with long-term conditions in the Otara locality by December 2016, through:

- activating patients via engagement with one or more of a menu of evidence-based self-management support options
- connecting to local health and social services required to meet needs
- engaging with care providers through training and mentoring in self-management support models.

Manage Better Together: Kia Kaha provides self-management support that is appropriate for either physical or mental long-term conditions. Support and training is delivered by a team comprising volunteer and employed peer supporters and health psychologists, who work closely with the locality primary care teams, to provide the 'Wheel of Self-Management Support' options available in the local community to consumers and their family or support people.



As of December 2016, Manage Better Together: Kia Kaha has enabled 5,000 consumers to access self-management support, by providing support options to patients referred, as well as training primary care staff in relevant self-management support models.

### **Smokefree Buffet**

The vision for Smokefree Buffet is to ensure that users of secondary care, primary care, mental health and maternity care services with long-term conditions have the best possible access to the full range of evidence-based smoking cessation support options and engage with stop smoking service provision.

The aim of the project was to increase the number of people engaged and supported to be smokefree with the Living Smokefree Service by 50 per cent by June 2016, and double the number of people smokefree at four weeks post quit date by strengthening the cessation component of the Smokefree ABC (Ask, Brief Advice, Cessation) and providing a self-management toolkit with a range of smoking cessation options.

### **SMILE (Self-Management is Life Enhancing)**

The vision for SMILE is to normalise self-management support in ProCare-affiliated general practices in the Manukau locality.

The aim of the project was to trial a reliable and sustainable general practice model of self-management for people with long-term conditions at 10 practices by December 2016.

The project builds from the relationships, skills and resources in general practice to implement a relatively low cost, highly accessible, evidence-based self-management training course for each practice's 'community of interest'. It uses health coaches to help patients gain the knowledge, skills, tools and confidence to become active participants in their own care.

### **Ola Lelei – WRAP (Wellness Recovery Action Planning)**

The aim of Ola Lelei – WRAP was for 33 Pacific people seeking wellness in Counties Manukau to have participated in the WRAP programme by December 2016.

Ola Lelei – WRAP provides a peer-led holistic self-management programme for people who access specialist mental health services.

### **BRITE (Building Responsiveness Into Teams' Efforts)**

The aim of BRITE was to improve health provider self-management support capacity and capability and to improve patient engagement and self-care skills by reaching at least 500 people via BRITE projects by December 2016.

BRITE uses a website, an online community of practice, a toolkit for home-based self-management, a newsletter and social media channels to provide better access to reliable and effective self-help resources that enable people to take charge of their health.

### **Save Your Breath**

Save Your Breath is a project based in the acute respiratory ward at Counties Manukau Health. The aim of Save Your Breath was to reduce readmissions (any repeat admission within 12 months) by 40 per cent for patients with chronic obstructive pulmonary disease discharged from the acute respiratory ward by December 2016.





## **Owning My Gout / Advancing Better Care**

The aim of Owning My Gout / Advancing Better Care was to provide a multidisciplinary (general practitioner, nurse and community pharmacy) gout self-management process to all eligible and consented patients at The Doctors Ti Rakau by 1 July 2016, and to spread the learning and process to support all eligible patients at a further two practices by 1 December 2016.

Two main focuses of the project are to optimise prescribed gout treatments and to provide a support package to enable gout patients to self-manage their condition and improve quality of life.

## **Manukau Locality – Diabetes**

The aim of Manukau Locality – Diabetes was to reduce HbA1c levels by at least 10 per cent for 50 per cent of patients with poorly controlled diabetes who are identified by primary healthcare practices and who are willing to participate in supported self-management activities by December 2016.



