Self-Management Support Campaign

Self-Management Support for 50,000 people living with long term conditions

Vision:

Whaanau inspired, enabled, resourced to be in control of their health.

Kia whai kaha
Whai mana painga
Ki nga Kahanga
Oranga ki tua o rangi

Key Principles:
Inspired – Information/ knowledge / communication / role models / champions
Enabled – Self-management support/ engagement/ techniques & tools
Resourced – co-ordination of services/ people/ partnership / peer support
Resulting in People being in control of their health-empowerment / motivation / activation

Six questions to be asked of every Change Programme:

1. **Aim** - *Is there an agreed aim that is understood by everyone in the system?*

   To provide self-management support for 50,000 people living with long term conditions across Counties Manukau (Localities, Primary Health Organisations, Outpatient clinics, Middlemore Hospital, communities) by 1 December 2016.

2. **Correct changes** - *Are we using full knowledge to identify the right changes and prioritising those that have the biggest impact on our aim?*

   Self-Management Support (SMS) is a collaborative between people living with Long Term Conditions (LTC), their whaanau and health professionals. It includes a range of interventions required for good management of LTCs.

   There is growing evidence for integration of SMS into routine health care practice[1]. There is strong evidence to show that self-management improves:

   - Emotional well-being
   - Depression and anxiety
   - Diet, exercise
   - Communication with the care team
   - Social support

[1] Battersby M et al. Twelve evidence-based principles for implementing Self-Management Support in primary care. Jt Comm J Qual Patient saf 2010 Dec;36 [12]:156-70

Active participation of those with LTCs leads to better health outcomes and lower health service utilization, including reduced readmissions in the 30 day post discharge period[2].

Winnard et al identified a cohort of 54,290 Counties Manukau Health (CMH) adult residents with one or more LTCs in 2011[3].

- 33,140 with Diabetes
- 15,690 with Gout
- 11,780 with Cardiovascular Disease (CVD)
- 5,620 with Chronic Obstructive Pulmonary Disease (COPD)
- 4,490 with Coronary Heart Failure (CHF)

In that year this group had a total of:

- 31,770 hospital admissions accounting for 119,840 bed days
- 223,090 outpatients visits with a 6% DNA rate

Whilst comprising 14% of the CMH adult population, the group had a disproportionate share of service utilisation:

- One third of all discharges and Emergency Care (EC) visits
- Half of ASH admissions and outpatient visits.

Recommended actions on health literacy in CMH are to integrate with other organisational priorities such as Campaigns, At Risk Individuals (ARI) programme and Localities[4].

Winnard D, Watson P et al[5] identified that consistent with international studies, people who received care for Mental Health (MH) disorders in Counties Manukau in 2011 had a higher prevalence of having LTC. In 2011 the numbers of people with long term health conditions and receiving care for mental health conditions are as follows:

- MH & Diabetes 4,000
- MH & CVD 2,000
- MH & COPD 1,200
- MH & CHF 800

Research indicates that 12-18% of individuals with long term medical conditions are likely to have a severe mental health and/or addiction (MH&A) condition. This same

[2] Mitchell SE et al. Patient activation and 30-day post-discharge hospital utilization. J Gen Intern Med 2014 Feb;29 [2]:349-55

[3] Winnard D et al. People identified with diabetes, CVD, COPD, Gout and/or CHF in CMDHB in 2011. Report for CMDHB Jan 2013

[4] Health literacy in Counties Manukau: A discussion paper for CM Health Executive Leadership team (2014)

[5] Winnard D,Watson P et al, Populations who have received care for mental health disorders. Counties Manukau Health. An overview. Auckland: Counties Manukau Health.

research also demonstrates that the presence of such a MH&A condition significantly affects the ability of individuals to self-manage their condition, and results in worse health outcomes and increased service utilisation. The presence of psychosocial complexity (including language and cultural barriers) contributes to poorer outcomes for such individuals in the current health system. Research has demonstrated that identifying and meeting this MH&A need, and addressing psychosocial and cultural issues, results in greatly improved outcomes and significantly reduced health service utilisation in secondary and tertiary settings.

The Kia Kaha, Manage Better, Feel Stronger Collaborative in the Beyond 20,000 Days Campaign is an example of self-management support targeting individuals with LTCs and co-morbid mental health or addiction conditions. The project has tested and developed a change package that includes an assessment which is clinician led and peer supported, care co-ordination, peer led self-management programme, wellness care plan and connection to Primary Care team. Early results from their work show a 25% reduction in Emergency Care presentations.

East Health Trust provides seven different self-management education groups – Diabetes self-management education, Diabetes (Stanford model), Generic self-management (Stanford), Weight reduction, smoking cessation, pain (Stanford), Healthy Eating Activity Lifestyles (HEALs).

In the three years up to May 2014, East Health Trust provided 29 self-management groups, with 352 participants. The two East Health Trust Master Trainers have trained over 35 people as SME Leaders including many clinical psychologists and community leaders, plus three staff from Ti Rawhiti who are very active leaders for our Ti Rawhiti programmes.

Assessment using the HeiQ questionnaire showed improvement in the means for in all domains:

- Health-directed behaviour
- Positive and active engagement in life
- Emotional well-being
- Self-monitoring and insight
- Constructive attitudes and approaches
- Skill and technique acquisition
- Social integration and support
- Health service navigation.

Although less active than the Eastern Locality, other PHOs still generate a lot of activity by in the self-management arena. There are also local (DHB) networks for those providing and promoting Self-Management Education in primary care, and a strong regional network that meets regularly.

Being cognisant that self-management support is not only about group education, the ARI programme includes the concepts of self-management through the requirement of goal setting and care planning. The PHO's are embedding the

philosophy of the self-management approach through ARI training, particularly with Janine Bycroft. In the Eastern Locality the Master Trainers will also be utilised to instil the self-management philosophy for all health care providers so that every contact with a provider will encompass the same approach i.e. it is the responsibility of all of us to empower people to self-manage. This is also a community up approach encouraged by Health Promotion activities.

Dr Richard Cooper, Self-Management Educator leads the Tu Whatukura – Men to Stand Tall, Self-Management Education for Maori Men programme across Counties Manukau. The vision is whanau supporting each other in prevention and self-managing their diabetes and other long term conditions. The key objectives are:

- To educate whanau on the seriousness of Diabetes and other long term conditions
- Encourage whanau on being more active
- Encourage whanau on making better choices in buying, cooking and eating food
- To increase self-management.

This Campaign is aligned and builds on the Very High intensity Users (VHIU) and ARI programmes within the Localities and priority programmes for CMH.

3. **Clear Change Method** – *Does everyone know and understand the method we will use to improve?*

The same Break-Through Series (BTS) Collaborative methodology will be used as in the following campaigns and programmes: 20,000 Days and Beyond 20,000 Days Campaigns (CMH), CLAB Campaign (National Collaborative), Safety in Practice (Auckland Region Primary Care), First Do No Harm (Auckland Region) and ERAS (National Collaborative).

The Collaborative approach is based on a philosophy of "all teach, all learn". A Collaborative includes: pre-work, team coaching, face-to-face and virtual meetings in which teams learn from both expert faculty and each other; monthly reporting and assessments; and on-going support from experts and peers during Action Periods, where the teams apply learning and implement iterative tests of change.

Locality based Collaboratives teams will be established to test and adapt change packages to implement self-management support for people with LTCs across the Counties Manukau community. The Model for Improvement[6] will be used to test improvement at the local level, can turn ideas into action and connect action to learning so that the right changes can be developed and scaled up to maximise improvement.

[6] Langley Gerald J, et al. The Improvement Guide, 2nd Edition 2009

4. **Measurement** – *Can we measure and report progress on our improvement aim?*

   We will measure and evaluate the success of the Campaign with a suite of outcome and process measures that will be developed. Some measures could be:

   - Number of individuals provided Self-Management Support
   - Number of referrals to SMS
   - Number of people completed Self-Management Education (SME) courses / programmes
   - Number provided Peer Support
   - Number of services activated
   - Number of care plans completed/achieved
   - Reduction in unplanned GP visits and EC presentations for those with LTCs
   - Number of care co-ordination completed
   - Increase in outcome measures PHQ-SADS, ED-5D-3L
   - Improved HeiQ results
   - Increased self- assessed rating on informed choice, control and capability for self-management (PREMs & PROMs, Partners in Health)
   - Qualitative feedback from team members and those with LTCs.
   - Reduction in readmission for those with LTCs
   - Improved health literacy for those with LTCs
   - Leadership engagement – number of walk arounds

5. **Capacity** and **Capability** - *Are people and other resources deployed and being developed in the best way to enable improvement?*

   - Leaders and teams to be engaged and trained in the BTS and Model for Improvement methodology
   - Establishment of SMS teams in Locality community MDT teams
   - Develop Peer Support Specialist workforce
   - Identify existing community workforce – community support workers, Health navigators, co-ordinators to support the programme
   - Provide training for health professionals, community support workers, peer support leaders to support people in Self-Management
   - Evaluation of Campaign
   - Ko Awatea to provide Improvement Advisors, Collaborative Project Leads/ Managers and Campaign management resources.
   - Existing Collaborative teams that have self-management component for people with LTCs to align with the SMS package:

     - Better Breathing
     - Healthy Hearts - fit to exercise
     - Supporting Life After Stroke
     - SMOOTH - Safer Medication Outcomes on Transfer to Home
     - VHIU – Very High Intensity Users
     - Feet for Life
     - Inpatient Diabetes Care pathway

- SMART – Safer Medical Admission Review Team
- Well Managed Pain

6. Spread Plan - *Have we set out our plan for testing, implementing and sharing new learning to spread improvement everywhere it is needed?*

The scale up and spread plan is to provide the SMS packages consistently and reliably across CMH based PHOs, 105 General Practices, Middlemore Hospital and Outpatient Clinics for all people with long term conditions.

The second phase to this work will be would take place from January 2016 to December 2016. It would involve multiple tactics to achieve performance improvement at scale across counties Manukau.

Funding
- SME contracts with PHOs co-ordinated and aligned to SMS
- Existing resources reshaped as testing and implementation progresses

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