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Self-Management Support Toolkit

Health Navigator



Acknowledgements

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Editors

Dr Janine J Bycroft and Mary-Anne Boyd. Updated by Pat Flanagan July 2014

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Version 2.0 July 2014: This continues to be a work in progress. Please contact us with suggestions for improvement to this toolkit and notification of changes to programmes, eligibility and contact details. Updates will be posted on the Health Navigator NZ website as they become available.

Visit www.healthnavigator.org.nz for additional links and an electronic copy of this toolkit.

Regions: This toolkit was funded for the Auckland central area and subsequently Counties. Therefore some of the content is specific to these regions. If you are interested to expand or localise this toolkit for your region, contact the editors to discuss.



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Foreword

The health needs of our communities are changing and consequently the capacity and capability of healthcare teams also needs to change. One of the key components for improving health is the concept of self-management, particularly for the prevention and optimal management of long-term conditions. While well developed in some pockets or organisations across the country, overall knowledge, understanding and uptake of self-management programmes by both service users and health care practitioners remains low with minimal adoption across the broader health system.

Development of the toolkit

One of the recurring requests from participants at a series of regional Self-Management Master Classes in June 2009 sponsored by New Zealand's Ministry of Health, and workshops since is for a self-management toolkit. Health practitioners want a practical guide and resource to help them apply self-management principles within their clinical work.

The Auckland District Health Board sponsored this project and worked with Health Navigator NZ to develop a toolkit. While some of the programmes listed will only be available for the local Auckland population, we hope most of the resources and toolkit will be applicable to health providers and teams throughout New Zealand.

The methodology included:

- A limited literature review to identify key themes from the literature with regard to implementing self-management within primary care
- Identifying relevant toolkits from other countries, regions and disciplines
- Establishment of a review group to guide project planning, toolkit development and content
- An environmental scan to identify existing self-care programmes, tools and resources within local communities, regionally and nationally. Contacting organisations and services to supply programme information
- Reviewing and analysing identified programmes for their quality, self-management basis, accessibility and appropriateness for high needs populations
- Consultation with a range of stakeholders and experts
- Wide sector input through design and analysis of an online survey to over one hundred clinicians across the country – including some people who are competent self-managers of long term conditions.
- On-going review and revision of serial drafts

This toolkit provides practical tools, resources, programme information and examples to help teams apply evidence and knowledge-based approaches to self-management support. Over time, it is hoped this toolkit can be localised for different regions of the country as well as updated, revised and refined to become an essential guide to self-management support for healthcare teams throughout New Zealand.

This is a work in progress and we welcome your comments and suggestions for continued improvement and refinement of this toolkit. Through resources and training such as this, the Health Navigator Charitable Trust hopes to contribute to **Shared knowledge - shared responsibility - shared care.**

Dr Janine Bycroft

Clinical Director
Health Navigator NZ

Outline

Foreword & Introduction

Key Principles

1 Key principles & concepts

Resources & Programmes

2 Generic self-management programmes

3 Condition-specific self-management resources

4 Issue-specific resources for patients and whanau

Tools

5 Improve communication & support behaviour change

6 Implementing self-management in your clinical practice

Appendices

7 Extra tools & resources

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Abbreviations

DHB – District Health Board

DSME – Diabetes self-management education

PHO – Primary Health Organisation

PMS – Practice Management System

SME – self-management education

SMS – self-management support

Icons

To help with navigation through this toolkit, the following icons have been used.



Highly recommended resource



Download resource at this link



Book



Report



Links to a Video resource

Introduction

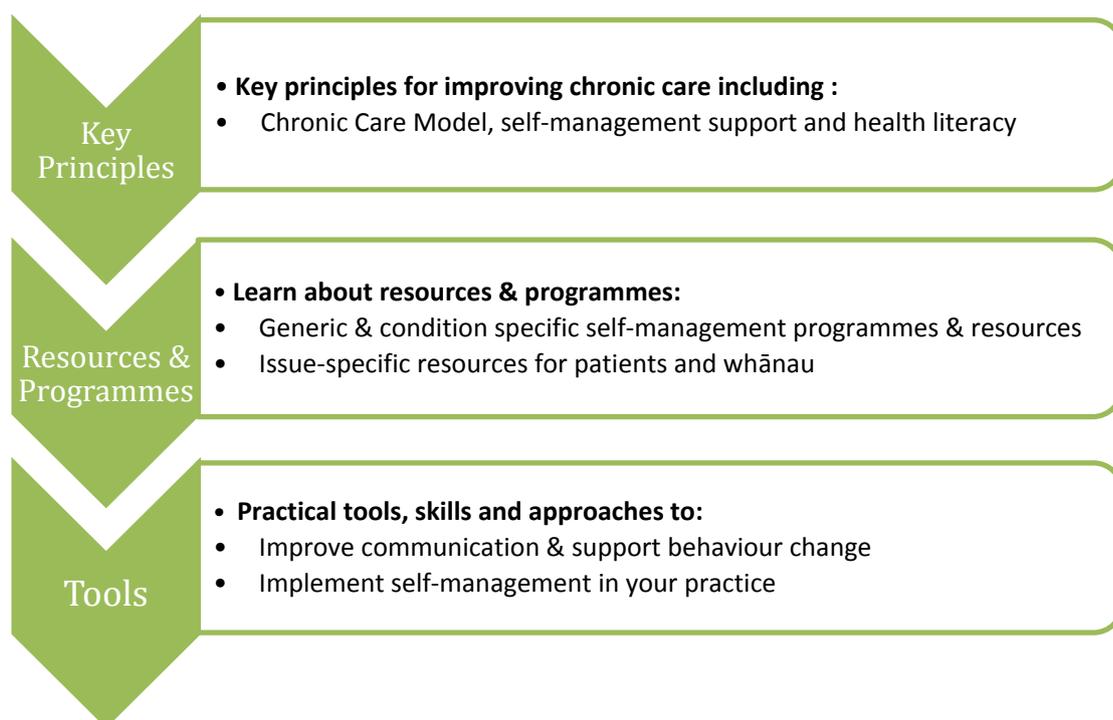
This toolkit will assist you to work collaboratively with patients and clients to manage their long-term health conditions more effectively. It provides practical tools, resources and programme information to help you apply evidence-based approaches around self-management support.

This toolkit will help you:

- Learn about self-management approaches within a New Zealand environment
- Choose the most appropriate self-management resources to assist your patients
- Implement self-management support approaches within your clinic, practice or organisation
- Develop your skills as a health professional
- Learn about some simple quality improvement tools to use in your day-to-day work

Toolkit structure

The toolkit has been developed for easy reading and reference. Most of the images link directly to the corresponding website or resource. Hyperlinks within the document allow quick transitions to additional sections and templates. There are 3 key sections plus appendices and the toolkit has the following structure.



Who is this toolkit for?

This toolkit is for frontline practitioners in general practice, community and specialist services looking for new ways of working to improve health with your communities, patients or clients.

SECTION 1:

KEY PRINCIPLES

Chapter 1: Background – Context, Key Principles and Concepts

A brief guide to drivers for health system reform, and key principles and concepts for self-management and self-management support

-
- 1 Background
 - 2 The Chronic Care Model
 - 3 Person centred care and self-management
 - 4 Self-management support
 - 5 Health literacy
 - 6 Shared decision making
 - 7 Cultural competence
-

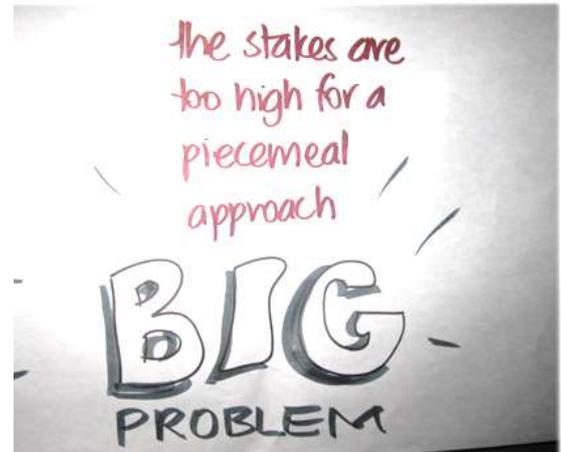


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1.1: Background

Health challenge of the 21st century

Accordingly to the World Health Organisation, epidemiological evidence has overwhelmingly identified long-term conditions as the health challenge of the 21st century. Within New Zealand, long-term conditions such as cardiovascular



disease, diabetes, respiratory conditions, cancer, arthritis and mental health conditions are a major contributor to persisting health disparities with Māori and Pacific peoples experiencing significant premature morbidity and mortality for all these conditions.

Long-term conditions¹ account for:

- **91% of all deaths in New Zealand¹** (Table below)
- **70-78% of all healthcare spending.**

New Zealand

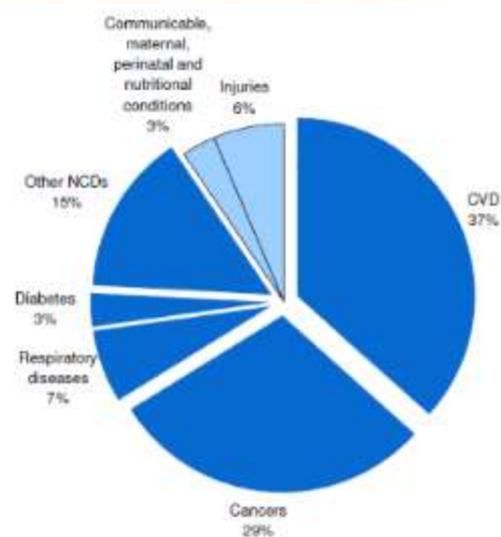
2010 total population: 4 368 136
Income group: High

NCD mortality			
<i>2008 estimates</i>			
Total NCD deaths (000s)	males	females	
	13.1	12.8	
NCD deaths under age 60 (percent of all NCD deaths)	14.1	11.1	
<i>Age-standardized death rate per 100 000</i>			
All NCDs	410.7	285.1	
Cancers	149.1	110.8	
Chronic respiratory diseases	30.1	20.5	
Cardiovascular diseases and diabetes	171.2	106.1	

Behavioural risk factors			
<i>2008 estimated prevalence (%)</i>			
Current daily tobacco smoking	males	females	total
	21.4	20.1	20.7
Physical inactivity	45.9	50.2	48.1

Metabolic risk factors			
<i>2008 estimated prevalence (%)</i>			
Raised blood pressure	males	females	total
	40.8	33.0	36.8
Raised blood glucose
Overweight	69.2	62.6	65.8
Obesity	27.3	29.3	28.3
Raised cholesterol	57.5	57.9	57.7

Proportional mortality (% of total deaths, all ages)



NCDs are estimated to account for 91% of all deaths.

Global Call to Action

Such is the challenge of long-term conditions (also known as **non-communicable diseases** or chronic disease) that the United Nations held a health summit in September 2011. This is only the 2nd United Nations summit in history to focus on global health (the first was on HIV/AIDs). Dr. Margaret Chan, Director-General of WHO, said *medical professionals had long been aware of the “ominous” trend of non-communicable diseases that encircled the globe. “We plead for lifestyle changes and strict tobacco legislations,” she said. Calling non-communicable diseases “a slow-motion disaster,” she declared: “These are the diseases that break the bank”.*

“These are the diseases that break the bank”.

Dr Margaret Chan, Director-General of World Health Organisation

The impact of long-term conditions is now of major global significance and there is an urgent need for cost-effective and evidence-based prevention, self-management and treatment strategies.

The alarming picture of pervasive unhealthy lifestyle changes of whole populations is of great concern because of the predictable adverse impact on the health of communities and countries. This was highlighted by the World Health Organisation in their 2002 World Health Report: *Reducing Risks, Promoting Healthy Life*, but like most countries, health promotion and public health advertising performs poorly and has low expenditure compared to the food, beverage and entertainment industries.

Growing Burden of Long-Term Conditions

- **Over 6 out of 10 adults (66%) and 1 in 3 children** having or having had a long-term condition diagnosed by a doctor as expected to last 6 months or more.¹
- Diabetes is estimated to cause between 1200 – 1600 deaths per year, many of these premature especially in Māori and Pacific peoples.
- Many of these conditions have common risk factors including reliance on processed foods with excessive salt, fat and sugar, **physical inactivity, smoking and excessive alcohol intake.**
- The proportion of the population aged 65 years or over is expected to double within the next 50 years and the elderly have high rates of comorbidity and disability.
- The rates of disability within our community are high at
 - 25% of 45-64 year olds, and
 - more than 50% of people aged 65 years and over.

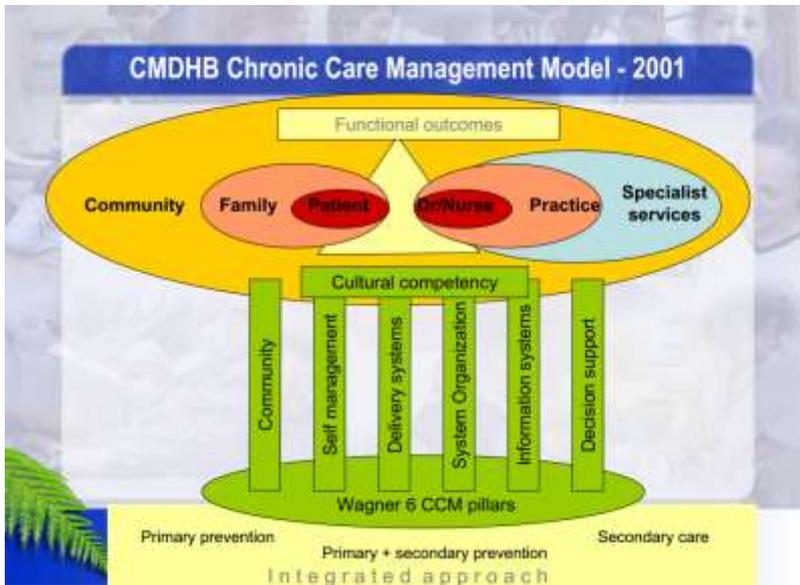
Four Common Risk Factors:

1. *Unhealthy diet*
2. *Physical inactivity*
3. *Smoking*
4. *Excessive alcohol*

¹ Ministry of Health. 2008. [A Portrait of Health. Key Results of the 2006/7 New Zealand Health Survey](#). Wellington.

1.2 The Chronic Care Model

To help address these elements, multiple models and frameworks for improving chronic care have arisen. One useful and evidence-based model is the Chronic Care Model developed by Wagner and colleagues in the 1990s. This model identifies the essential elements of a health care system that encourage high-quality chronic disease care.



These elements or pillars are:

1. the community,
2. the health system,
3. self-management support,
4. delivery system design,
5. decision support and
6. clinical information systems.

Under each pillar, a range of evidence-based change concepts can be chosen to guide quality improvement work. Over time, organisations effectively addressing the elements of this model have been able to move from reactive, episodic care to prepared, proactive teams working in partnership with

informed activated patients/families and communities with significant improvements in health. The Counties Manukau District Health Board (CMDHB) model shown above has the original 6 pillars of the Wagner model but has added cultural competency and a more expanded perspective to align more closely with the New Zealand Health system.

Of the six pillars, Professor Ed Wagner has commented that self-management support is the most important, yet is frequently overlooked or underdeveloped. Self-management support was also identified by the Institute of Medicine as one of three important strategies for improving quality of care. It is also a key part of the paradigm shift the WHO has called for from clinician centred-care to truly patient-centred care. For more information about implementing self-management and working with the chronic care model go to the chapter 'Implementing self-management' in this toolkit.

What we've learned...

*"What's most important is at the bottom of the model...
Patient needs are related to specific roles that effective practice teams have mastered"*

Ed Wagner, New Zealand 2011



Key Resources

	<p>Improving Chronic Illness Care</p> <p>The McColl Institute is a non-profit organisation focused on quality improvement and research for chronic care.</p> <p>Their website, Improving Chronic Illness Care includes an extensive array of information, tools and resources to support organisations and practice teams.</p> <p>Visit the website at: www.improvingchroniccare.org</p>
	<p>Institute for Healthcare Improvement (IHI)</p> <p>The IHI is another key organisation known internationally for being an excellent source of resources, tools and programmes to support chronic care & transformational change.</p> <p>One IHI programme adopted by a number of NZ organisations is The Triple Aim. The NZ version as stated by the Quality & Safety Commission is:</p> <ol style="list-style-type: none">1. Improve the health of the population;2. Enhance the patient experience of care (including quality, access, and reliability); and3. Reduce, or at least control, the per capita cost of care <p>Visit the website at www.ihl.org</p>

References

- Ministry of Health. 2004. *Population Ageing and Health Expenditure: New Zealand 2002–2051*. Wellington: Ministry of Health.
- Ministry of Health. 2008. *A Portrait of Health. Key Results of the 2006/7 New Zealand Health Survey*. Wellington: Ministry of Health.
- Morgan, G. Simmons, G. 2009. *Health Cheque*. Phantom House Publishing.
- World Health Organization. 2002. *Innovative Care for Chronic Conditions Framework*. Geneva:
- New Zealand Guidelines Group. *Management of Type 2 Diabetes*. Wellington: New Zealand 2003.
- Epping-Jordan JE, Pruitt SD, Bengoa R, Wagner EH. *Improving the quality of health care for chronic conditions*. Quality and Safety in Health Care 2004;13:299-305.
- Davis RM, Wagner EH, Groves T. *Managing chronic disease*. BMJ 1999;318:1090-91.
- World Health Organization. *The World Health Report 2002: Reducing Risks, Promoting Healthy Life*. Geneva
- Von Korff M, Gruman J, Schaefer J, Curry SJ, Wagner EH. *Collaborative management of chronic illness*. Annals of Internal Medicine 1997;127(12):1097-102.
- Lewis R, Dixon J. *Rethinking management of chronic diseases*. BMJ 2001;328:220-2.

Person Centred Care and Self-Management

Self-management support along with collaborative care planning, health literacy improvement and shared decision making are all activities that deliver person centred care. This section provides a high level description of these constructs.

Self-Management

Self-management refers to the tasks that someone with a long-term condition and their whānau or social network undertakes to live well. It includes:

- Having and using knowledge and improving understanding of the condition and/or its management
- Actively sharing in decision-making with health professionals, significant others and/or carers and other supporters
- Monitoring and managing signs and symptoms of the condition(s)
- Managing the impact of the condition on physical, emotional, occupational and social functioning
- Living healthier day to day by taking action to address risk factors and promote health by focusing on prevention and early intervention
- Adopting a self-management care plan agreed and negotiated in partnership with health professionals, significant others and/or carers and other supporters
- Having access to, and confidence in, the ability to use support services.

(Based on Flinders Human Behaviour & Health Research Unit: Principles of Self-Management)



Self-Management Support (SMS)

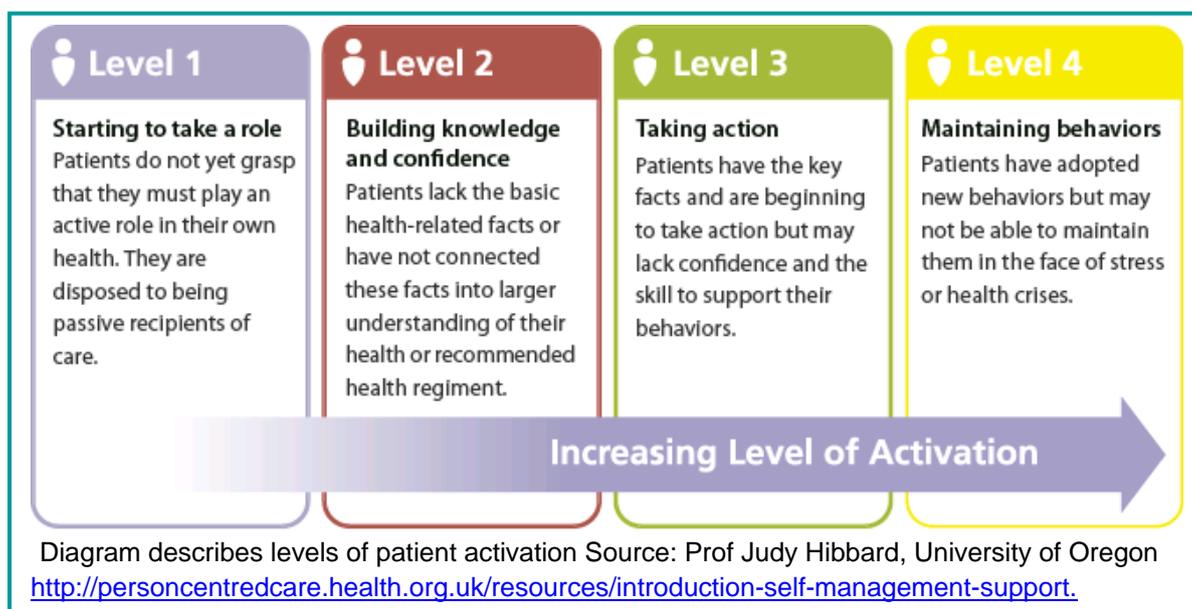
Self-management support is the assistance caregivers or health professionals give patients with chronic disease in order to encourage daily decisions that improve health-related behaviours and clinical outcomes. Self-management support can be viewed in two ways: as a portfolio of techniques and tools that help patients choose healthy behaviours; and a fundamental transformation of the patient–caregiver relationship into a collaborative partnership.²

Effective self-management support is about attitudes and action.

Support for people managing a disease or long-term condition includes:

- Improving Health Literacy by-
 - giving patients information in a way they can understand;
 - patients giving practitioners information and asking questions
- shared decision-making
- teaching and learning generic and/or disease-specific skills
- setting goals – based on the patient’s preferences and priorities
- negotiating & supporting healthy behaviour change
- training and learning problem-solving skills
- assisting with the emotional impact of having a chronic condition or living with someone who has a long-term condition
- Support navigation of community services and other resources
- providing care that is coordinated, planned, proactive and flexible to fit with a person/whanau’s other commitments and pressures
- healing relationships with a healthcare team that enables regular and sustained follow-up

Active Support works best



Providing information is helpful, but it is not sufficient: without the confidence and skills to use information. Information alone will not lead to better health outcomes. Methods that improve people’s activation and self-efficacy are the most effective ways of improving self-management and supporting healthy behaviour change.

² De Silva, D. (2011) Evidence: Helping people help themselves. The Health Foundation 2011

In the provision of self-management support the patient is no longer be the passive recipient of care but an activated self-manager of their condition.

AND....

The clinician is no longer simply an expert who tells the patient what to do, but a professional skilled in enabling people living with a long-term condition to change their behaviour.

Characteristics of Successful Self-Management Support

Von Korff et al in 1997 and Battersby and Lawn 2009 identified five key evidence-based elements for collaborative self-management support and conclude with the important observation that “*these elements make up a common core of services for chronic illness care that need not be reinvented for each disease.*”

Five key elements



Evidence for self-management

Self-management is a key component for improving health outcomes, particularly for the prevention and optimal management of long-term conditions.

From a range of reviews, there is good evidence that increased self-management support can:

- Improve adherence to treatment regimes
- Improve shared decision-making
- Improve communication and coordination
- Reduce hospitalisations and after hours visits
- Improve health outcomes and quality of life
- Reduce health disparities when targeted to high needs populations
- Leads to patients feeling more in control
- Result in increased confidence and self-efficacy
- Lead to improved wellbeing and reduced depression and anxiety.

*Most healthcare reform focuses on **supply**. Self-management support initiatives are important because they are some of the few approaches have the potential to reduce the **demand** side of the equation.*

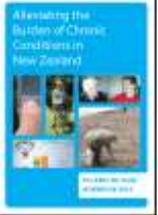
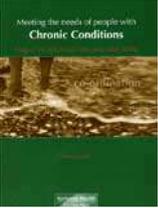
A recent review by the Health Foundation in the UK (Helping People Help Themselves) has set out to answer questions such as, why should our role change to support self-management? What is the evidence that self-management support works.

....The attitudes and skills of healthcare providers can have a significant effect on the extent to which people feel engaged and supported and this is an area in need of further exploration."

“From this review, the general components that have been found to work well to support self-management include:

- *involving people in decision making*
- *emphasising problem solving*
- *developing care plans as a partnership between service users and professionals*
- *setting goals and following up on the extent to which these are achieved over time*
- *promoting healthy lifestyles and educating people about their conditions and how to self-manage*
- *motivating people to self-manage using targeted approaches and structured information and support*
- *helping people to monitor their symptoms and know when to take appropriate action*
- *helping people to manage the social, emotional and physical impacts of their conditions*
- *proactive follow up and*
- *providing opportunities to share and learn from other service users.”*

Recommended Resources

	<p>Health Navigator NZ</p> <p>For a list of systematic reviews, reports and literature about self-management, visit www.healthnavigator.org.nz/library/bibliography</p>
	<p>Alleviating the Burden of Chronic Conditions in NZ</p> <p>Literature review and reports looking at long-term conditions and related services within District Health Boards. The Workbook identifies 10 key approaches for improving outcomes and self-management is one of these.</p> <p>http://dhbrf.hrc.govt.nz/index.php/current_projects#ABCC_NZ_Study</p>
	<p>Meeting the Needs of people with chronic conditions</p> <p>National Health Committee on Health and Disability, 2007 Recommends ways in which government agencies, health providers and community groups can contribute to improving the management of chronic conditions</p> <p>www.health.govt.nz/publication/meeting-needs-people-chronic-conditions</p>

References

Helping People Help Themselves – Evidence Pack

http://www.health.org.uk/media_manager/public/75/publications_pdfs/Helping%20people%20help%20themselves.pdf

What is self-management and the 6 principles of self-management?

www.flinders.edu.au/medicine/sites/fhbhru/self-management.cfm#sixPrinciples

Bycroft, JJ. Tracey, J. **Self-management support: A win-win solution for the 21st century.** NZFP Vol 33, No.4, 2006

Department of Health & Ageing. (2005) **National Sharing Health Care Initiative- Evaluation Report**

www.health.gov.au/internet/main/publishing.nsf/Content/chronicdisease-nateval

Zwar.N, Harris M, Griffiths R, et al. **A systematic review of chronic disease management.**

Australian Primary Healthcare Research Institute, University of New South Wales School of Public Health & Community Medicine, 2007

Ratima, M.– **Literature review on self-management.** Tamaki Primary Health Organisation , 2009

Department of Health, UK – Range of reports and documents -

www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/Browsable/DH_4890904

Bodenheimer T, Lorig K, Holman H, Grumbach M. **Patient Self-management of Chronic Disease in Primary Care.**

JAMA 2002;288(19):2469-2475.

Lawn, S. & Battersby, M. (2009) **Skills for person-centred care: Health professionals supporting chronic condition prevention and self-management.** IN D'CRUZ, H. M., JACOBS, S. W. & SCHOO, A. (Eds.)

Knowledge-in-practice in the caring professions: Multi-disciplinary perspectives

Von Korff M, Gruman J, Schaefer J, Curry SJ, Wagner EH. **Collaborative management of chronic illness.** Ann Intern Med. 1997 Dec 15;127(12):1097-102.

Health Literacy

“Health literacy is defined as the ability to obtain, process, and understand basic health information and services in order to make informed and appropriate health decisions.” – Ministry of Health

Why is it important?

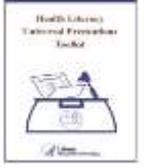
- **High prevalence** – **Over 50% of the adult NZ population** are likely to have some difficulties with health literacy. Recent results from the 2010 Korero Marama: Health Literacy and Maori report confirm that,
 - on average, New Zealanders have poor health literacy skills;
 - up to 80% of Maori men and 75% of Maori women had poor health literacy skills and are at risk of adverse outcomes
- **Premature morbidity and mortality** – Low health literacy has been shown to be an independent risk factor for poorer health, increased complications and hospitalisations and dying younger than one’s peers. (American Medical Association)
- difficulties with health literacy can result in **difficulty accessing health care, following instructions** from a clinician, and **medication errors**. (Safeer, 2005)
- **Safety issues** - A study showed only 35% of people with basic or below basic health literacy could correctly demonstrate how they would take their medications when asked, “*Show me how many pills you would take in one day.*” The instructions on the bottle said “Take two tablets by mouth twice daily.” (Davis 2006).
- **Low health literacy is an independent risk factor for premature mortality** (American Medical Association)
- **Costs:** Low health literacy cost countries billions of dollars per year. In the US, this is estimated to be between \$106 billion to \$238 billion each year. This represents between 7% and 17% of all personal health care expenditures. (George Washington University Medical Center School of Public Health and Health Services)
- **Hidden problem** - Shame and embarrassment are very common responses for people with limited health literacy and people regularly report going to extraordinary efforts to hide and cover up any reading or comprehension difficulties. While reading ability is related, there are many other factors that contribute to health literacy so you cannot assume based on education or occupation.
-

It is estimated that nearly half of our adult population are likely to have some difficulties with health literacy:

- This may translate to practical difficulties such as understanding appointment letters, forms, educational resources and medication instructions.
- It also has major implications for informed consent, health inequalities, patient safety and quality of care.

[Click here](#) for practical resources to assist with communication and health literacy.

Recommended Resources

	<p>Health Literacy NZ </p> <p>Developed by Workbase NZ, this website provides free information and resources about health literacy and for groups working in the health sector and adult literacy. Visit at: www.healthliteracy.co.nz</p>
	<p>Health Navigator NZ</p> <p>Health literacy section and resources. www.healthnavigator.org.nz/centre-for-clinical-excellence/health-literacy</p>
	<p>Health Literacy and Patient Safety </p> <p>A video from American Medical Association www.ama-assn.org/ama/pub/about-ama/ama-foundation/our-programs/public-health/health-literacy-program/health-literacy-video.page "Health literacy and patient safety: Help patients understand" (YouTube)</p>
	<p>Health Literacy Universal Precautions Toolkit </p> <p>(Prepared by North Carolina Network Consortium, The University of North Carolina for Agency for Healthcare Research and Quality. April 2010).</p> <ul style="list-style-type: none"> • Excellent toolkit, links, tools and info sheets. • http://nchealthliteracy.org/toolkit/
	<p>Online Health Literacy Training of Public Health Professionals</p> <p>Free online health literacy training tutorial provided by the U.S. Centers for Disease Control and Prevention. http://www.cdc.gov/healthliteracy/training/index.html</p>
	<p>Kōrero Mārama: Health Literacy and Māori</p> <p>NZ specific results from the 2006 Adult Literacy and Life Skills Survey, 2010 http://www.health.govt.nz/publication/korero-marama-health-literacy-and-maori-results-2006-adult-literacy-and-life-skills-survey</p>

References

Safeer RS, Keenan J. **Health literacy: the gap between physicians and patients.** Am Fam Physician. 2005 Aug 1;72(3):463-8.

Davis TC, Wolf MS, et al. **Literacy and misunderstanding prescription drug labels.** Ann Intern Med. 2006 Dec 19;145(12):887-94

Powers BJ, Trinh JV, Bosworth HB. **Can this patient read and understand written health information?.** JAMA. 2010 Jul 7;304(1):76-84.

Morris, N.S; Charles D MacLean, C D. Chew, L D; et al. **The Single Item Literacy Screener:** Evaluation of a brief instrument to identify limited reading ability. BMC Family Practice 2006.

Agency for Healthcare Research & Quality (2011). **Health Literacy Interventions and Outcomes: An Updated Systematic Review.** March 2011. US Department of Health & Human Services. Available at: <http://www.ahrq.gov/clinic/tp/lituptp.htm>

Board on Neuroscience and Behavioral Health (2004). **Health Literacy: A Prescription to End Confusion.** Institute of Medicine

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2010). **National Action Plan to Improve Health Literacy.** Washington, DC

Shared Decision Making

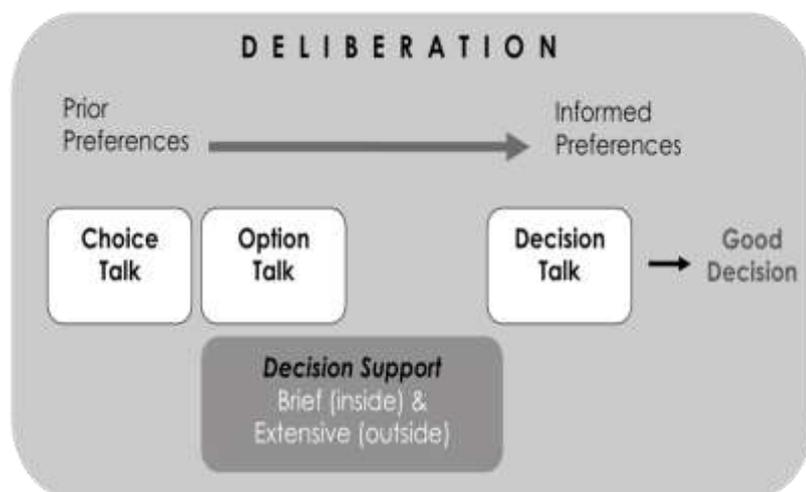
What is shared decision making?

Shared decision making is at the core of person-centred care; where people are supported to make informed decisions about and effectively manage their own health and care, and where their individual needs, values, preferences, abilities and goals are respected. It has a slightly different purpose than self-management support in that it is an activity that supports patients to make a specific decision, for example, whether or not to take a particular medication whereas self-management support supports patients to confidently make daily informed decisions and take actions about their health and healthcare.

Shared decision making involves a “*health professional and person working together to consider evidence-based clinical information about tests, treatment options, likely benefits and outcomes, and potential risks and then choosing, in collaboration, the course of treatment, management or support that best fits the person’s informed preferences.*” It recognises and brings together the clinical knowledge, skills and experience of the health professional, and the person’s own knowledge, health related experience, values and preferences.

Shared Decision Making

Person learns about their options
Health professional learns about person’s values and preferences
Together they deliberate and figure out the best option.



What are the benefits of shared decision making?

Evidence suggests that shared decision making improves health professionals’ communication with people. It also improves people’s overall experience of care, including improving knowledge about their condition and treatment options, involvement in care and self-confidence in their own knowledge and self-care skills

However, there is mixed evidence around whether it improves concordance with treatment unless a behaviour modification component and robust follow-up is included.

Decision Aids

Decision aids are handouts, audio tapes, videos or online resources that are designed to help patients understand the advantages and disadvantages of various treatment or decision options. There is good evidence that they can be helpful as it is very difficult to remember all the key points to discuss with every patient/client about every important treatment decision.

[Click here](#) for practical resources to assist with communication and shared decision making.

Recommended Resources

	<p>Ottawa Personal Decision Guide (OPDG) Ottawa Hospital Research Institute Learn more about OPDG here: http://decisionaid.ohri.ca/decguide.html</p>
	<p>Health Foundation Person Centred Care Resource Centre http://personcentredcare.health.org.uk/person-centred-care/shared-decision-making</p>
	<p>Testing for prostate cancer: a consultation resource New Zealand Guidelines Group Download the pdf here: www.nzgg.org.nz/guidelines/0153/Prostate_Practitioner_Show_Card.pdf</p>
	<p>Your Heart Forecast (Interactive tool) Heart Foundation How healthy is your heart?. Try out the tool here: www.heartfoundation.org.nz/programmes-resources/health-professionals/your-heart-forecast/Your-Heart-Forecast-Online-Tool/</p>
	<p>Cochrane Systematic Review of Decision Aids Ottawa Hospital Research Institute Download the full review or summary document here: http://decisionaid.ohri.ca/cochsystem.html</p>
	<p>Mayo Clinic Shared Decision Making National Resource Center</p> <ul style="list-style-type: none"> • Decision Aids: http://shareddecisions.mayoclinic.org/decision-aids-for-diabetes/ • Resources http://shareddecisions.mayoclinic.org/resources-tools/ • Videos www.youtube.com/watch?v=a8KnOg83cdg <p>NOTE: American website so some differences with NZ.</p>

References

- Salzburg Global Seminar. **Salzburg Statement on Shared Decision Making**. BMJ 2011; 342:d1745 Online at <http://www.bmj.com/content/342/bmj.d1745.full>
- 2009 Update: O'Connor AM, Bennett CL, Stacey D, et al. **Decision aids for people facing health treatment or screening decisions**. Cochrane Database of Systematic Reviews 2009, Issue 2.
- Shared Decision Making Presentation – Dartmouth Medical School. More information and references are available at: www.healthnavigator.org.nz/self-management/share-in-decision-making
- Newcastle Magic Team**. Overview of Shared Decision Making V1.3 19.4.12– based on material from The Health Foundation MAGIC resource centre.
- The Health Foundation**. *Helping people share decision making*. The Health Foundation, 2012.
- The Diabetes Mellitus Medication Choice Decision Aid*. **Mullans, R. et al**. 2009, Archives of Internal Medicine/vol 169, p. no. 17.
- King, E. et al**. *The MAGIC programme Evaluation*. London : The Health Foundation, 2013.
- McManus, A** *Health Promotion Innovation in Primary Health Care.*, Australasian Medical Journal, pp. 6,1, 15-18. 2013
- Politi, M. et al**. *Implementing Clinical Practice Guidelines about Health Promotion and Disease Prevention through Shared Decision Making*. Journal General Internal Medicine, 2013.
- Royal College of Physicians**. *Shared Decision Making; a Summary of Learning from the Event*. London : Royal College of Physicians, 2011.
- King, E. et al**. *The MAGIC programme Evaluation*. London: The Health Foundation, 2013.

Cultural Competence

“Cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds.” – New Zealand Medical Council

With growing ethnic diversity in the New Zealand population, it is increasingly important for health providers and practitioners to provide services that are responsive to the diverse cultural, linguistic and religious groups that they serve. Cultural competence is now also required under the **Health Practitioners Competence Assurance Act 2003**, with each professional regulatory body setting standards of cultural competence for their members. Providing cultural competent care is also fundamental to the successful implementation of a self-management approach, as care must start with respect and acknowledgement of the person’s values, beliefs and preferences.

Right 1 of the HPCAA is the right to be treated with respect:

- (1) Every consumer has the right to be treated with respect.
- (2) Every consumer has the right to have his or her privacy respected.
- (3) Every consumer has the right to be provided with services that take into account the needs, values and beliefs of different cultural, religious, social and ethnic groups, including the needs, values and beliefs of Māori.”

Cultural competence includes the right to be treated with respect with regard to:

- Ethnicity, gender, spiritual beliefs,
- sexual orientation, lifestyle, age
- social status or perceived economic worth.

Elements of cultural competence for Maori Health

The four key elements to cultural competence when treating a Māori patient and their whānau³ are:

1. Attitudes

A culturally competent health professional should be open to trying to engage and learn; be prepared to ask patients about their preferences and follow their lead; and will attempt to enter into, and understand, the patient’s world.

2. Awareness

A culturally competent health professional should also be aware of potential judgements and prejudices based on skin colour and appearance; be aware of Māori cultural expectations around consultations and personal interaction; and be aware of the importance of pronunciation (and when in doubt, ask the patient for help).

3. Knowledge

A culturally competent health professional will be aware of Māori history, have some knowledge and a respect of Māori culture.

4. Skills

The skills that a culturally competent health professional should have include; the ability to ask about the patient’s background and heritage; the ability to involve whānau; the ability to ensure that the patient understands what is being planned; and the ability to seek advice and the capacity to develop the connections through which this can happen.

³ BPAC Article August 2011 - Building cultural competence: the Medical Council’s direction. Modified doctor to health professional.
http://www.bpac.org.nz/magazine/2011/august/cultural_comp.asp

Recommended Resources

	<p>Cultural Competency Guidelines The Royal New Zealand College of General Practitioners</p> <p>Download the guidelines here: www.rnzcgp.org.nz/assets/documents/Publications/College-Resources/Cultural-Competence.pdf</p>
	<p>Developing cultural competency in accordance with the Health Practitioners Competence Assurance Act Mauri Ora Associates</p> <p>Download from: http://www.rnzcgp.org.nz/assets/documents/Publications/Archive-NZFP/Oct-2006-NZFP-Vol-33-No-5/BacalOct06.pdf</p>
	<p>Pacific Cultural Competences Useful document providing an overview of the literature on Pacific cultural competence including definitions, rationale, benefits, competence measures and mechanisms, and role of Pacific cultural competence in service quality and recommendations for the New Zealand health and disability sector. (Ministry of Health, 2008)</p> <p>http://www.health.govt.nz/publication/pacific-cultural-competencies-literature-review</p>
<h2>Culturally and Linguistically Diverse Resources</h2>	
	<p>Culturally and Linguistically Diverse Resources & Training (CALD) </p> <p>An excellent online training programme in cultural competence and Culturally and Linguistically Diverse (CALD) topics is available for all health practitioners working within the Waitemata, Auckland and Counties Manukau DHB region.</p> <p>Visit www.caldresources.org.nz to sign up for FREE training and resources</p>
	<p>Toolkit For Staff Working In A Culturally And Linguistically Diverse Health Environment</p> <p>Both downloadable and online e-toolkit available for anyone to view at: www.asianhealthservices.co.nz/cr/Cross-Cultural%20Resources/Cross-Cultural%20Resources.htm</p>
	<p>Additional Resources</p> <ul style="list-style-type: none"> • Asian, Migrant and Refugee Health Publications www.asianhealthservices.co.nz/cr/Publications/Asian,%20Migrant%20and%20Refugee%20Health%20Publications.htm • Health Information in Multiple Languages • Asian, Migrant and Refugee Culture-Specific Services, Programmes Initiatives • Aotearoa NZ Refugee Research Directory – health and wellbeing section http://nzrefugeereseach.wikispaces.com/Health+and+wellbeing
	<p>Refugee Health Wide range of resources and useful links</p> <p>http://www.refugeehealth.govt.nz/links.asp</p>
	<p>Refugee Health Collaborative – Auckland DHB and PHOs Website outlining some of the activities and resources collated as part of a refugee health collaborative, focusing on improving services and care for refugees within Auckland.</p> <p>https://sites.google.com/site/refugeecollaborative/</p>

Whanau Ora Programme

Whanau Ora is a key cross-government work programme jointly implemented by the Ministry of Health, Te Puni Kōkiri and the Ministry of Social Development.

It is an approach that places families/whānau at the centre of service delivery, requiring the integration of health, education and social services and is improving outcomes and results for New Zealand families/whānau.

Introduced in 2010, Whānau Ora is driven by a focus on outcomes: that whānau will be self-managing, living healthy lifestyles, participating fully in society, economically secure, successfully involved in wealth creation, cohesive, resilient and nurturing.

In order to achieve this, services providers and agencies are required to work differently to centre their focus on whānau. In 2010 Twenty-five provider collectives were selected to develop Programmes of Action to deliver Whānau Ora services. These collectives represented more than 150 individual organisations across New Zealand.

Whānau Ora has now been in the DHB Annual Plans for two years and continues to be a government priority in 2014/15. DHBs are expected to continue support the local Te Puni Kōkiri-led Whānau Ora provider collectives and take steps towards improving service delivery within these providers, and supporting the building of mature providers.

(Ministry of Health 2014)

- For more information about your local Whanau Ora Collective contact your PHO.

Collaborative Care Planning

Care planning is the process of proactively developing a structured, comprehensive plan by the patient and their significant others, carers & health professionals(s). It defines problems, goals, actions, timeframes & accountability of all involved to prevent complications & deterioration of long-term health conditions. (Battersby 2007)

Fundamental to care planning is the principle of patient-centred care which places the patient as the focus of any healthcare provision. The focus is on the needs, concerns, beliefs and goals of the patient rather than the needs of the systems or professionals. The patient feels understood, valued and involved in the management of their condition. Patients are empowered by learning skills and abilities to gain effective control over their lives versus responsibility resting with others. (Michie, Miles & Weinman, 2003)

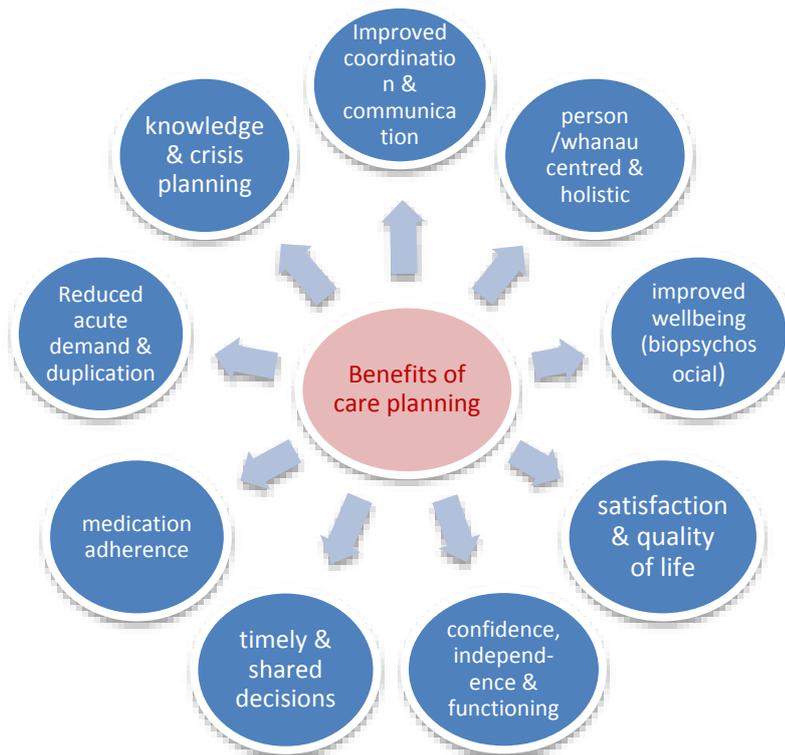
A care plan typically includes:

- Mutually agreed list of problems
- Patient defined goals
- Medical management, including medications
- Prioritised action plan/interventions/steps/tasks - based on SM needs of patient and their carer
- Crisis or contingency planning with written information re early warning signs/red flags & action to take
- Who is responsible for what with sharing of responsibility
- Key action plan in person's preferred language
- Time for review & follow up

Key principles of personalised care planning

- Continuous process resulting in an **overarching care plan that is regularly reviewed**
- A **holistic, systematic approach** based upon the person/whanau's strengths, values and aspirations and puts their goals, choices and lifestyle wishes in the centre of the process
- Is a **dynamic process** of discussion, negotiation, decision making and review that takes place between the individual and the professional – who have an equal partnership
- Is **planned, proactive and anticipatory** with regular follow up and **emergency planning** for crisis episodes
- The person should be encouraged to have an active role in their care, be provided with information or **signposting** to enable informed choices and supported to make their own decisions within a guidance of managed risk
- Assessment and care planning views the person 'as a whole' supporting them in all their needs and individual diverse roles, including family, parenting, relationships, housing, employment, leisure and education.
- Information about support networks, including peer support, carers and family support groups is included
- Results in an overarching, **single care plan that is owned by the person** but can be accessed by those providing direct care.

Figure 1: Potential benefits of personalised care planning



The figure above outlines some of the key benefits of personalised care planning. Care planning can range from very simple and brief for someone with mild disease or risk factors through to comprehensive, multidisciplinary care planning for someone with severe disease or a life limiting condition.

[Click here](#) for practical resources to assist with Collaborative Care Planning.

Individually and collectively we need to consider what we do at every encounter with the health system to assist clients to develop their knowledge, personal skills, self-efficacy (confidence), motivation and resources to manage their health as optimally as possible.



Sharing knowledge – sharing responsibility for health – shared care

SECTION 2: RESOURCES & PROGRAMMES

Use the information in Chapters 2 & 3 to develop your knowledge and skills in self-management support, to practice in ways that support self-management and to learn about a range of community and other self-management programmes. Add your own resources in too.

Chapter 2: Generic self-management skills, resources & programmes

Self-management skills can be learnt and will increase a person and whānau's ability to proactively manage their health conditions. This can improve quality of life, sense of control, confidence levels, and health outcomes.

1	<u>Generic Self-management skills for patients/clients</u>
2	<u>The Self Care Toolkit</u>
3	<u>Stanford Model – Self Management Programmes</u>



“Attending the self-management programme was one of the best things I’ve done. It has made such a difference and my health has been so much better.”

(Stanford Self-Management Programme
Course participant)

Stanford leaders enjoying a group activity

2.1: Self-management skills for patients

Evidence has shown that what we do as health professionals can strongly influence (positively or negatively) a patient's ability to self-manage their health. This section includes tools, skills and resources we can start using to help our patients/clients have more confidence, knowledge and specific skills to improve their health and wellbeing. There are five main areas of self-care and self-management support.

Five areas of self-care – some ideas to get started

1.	Information	<ul style="list-style-type: none"> Needs to be trustworthy, accurate, culturally and linguistically appropriate, relevant to New Zealand Try to individualise and tailor to a person's situation Find useful information, tools, self-help books, online media and videos at www.healthnavigator.org.nz Use existing skills in a team working practice including nurse coordinator, health psychologist, occupational therapist, physiotherapist, podiatrist and pharmacist.
2.	Skills and knowledge training	<ul style="list-style-type: none"> Refer patients to self-management courses (see page 33) Education one-on-one, in groups, with whānau Consider people's learning style – visual, auditory or kinesthetic Use structured problem solving (template in appendices) e-therapy – broad range of online programmes
3.	Tools and self-monitoring devices	<ul style="list-style-type: none"> Scales, blood pressure monitors SMART Phones – texting support programmes, health and goal setting apps Pedometers + goal setting can be useful Peak flow meters & Blood glucose monitoring – when appropriate Tele-monitoring – wide range of options developing
4.	Healthy lifestyle choices	<ul style="list-style-type: none"> Referral to Green Prescription Learn about local nutrition programmes HVAZ – Healthy Village Action Zone – Programme in Pacific churches across Auckland DHB region Community Gardens Smoking Advisors Sports clubs Tai chi in parks
5.	Support networks	<ul style="list-style-type: none"> Social support is essential – encourage people to build and strengthen their own support networks among neighbours, friends, family and interest groups. Support groups and helplines can be very helpful – visit www.healthnavigator.org.nz/self-management/support-networks

One of the areas we have the greatest challenge with in long-term condition management is supporting patients to make positive behaviour change and healthier lifestyle choices. This includes aspects of

medication adherence and health literacy, lifestyle factors and is impacted by financial, social, environmental, psychological, cultural and educational factors.

The traditional medical approaches of advising or telling people what to do doesn't work as well anymore. Attitudes have changed, expectations are different, cultural and social pressures are different. Likewise giving people lots of information, using fear tactics or our traditional style of patient education rarely changes behaviour. ([View Thomas Goetz TedMed talk](#))

What is more effective is sharing the decision-making, teaching people self-management skills (such as communication skills, problem solving, goal setting, action planning) and focusing on approaches that improve engagement, activation, motivation and self-efficacy. Fortunately these skills can be effectively taught by allied health providers and peer leaders. Therefore build a team with broader roles, skills and stronger connections with community groups and local resources.

Self-management skills

There are a number of self-management skills patients or clients can learn. These can be taught in the clinic, by peers (through peer support or buddy schemes), through self-help books, phone support, via online programmes or by referring patients to self-management programmes.

Self-management skills that can be learnt include:

- Decision-making and sharing in decision-making
- Problem solving
- Goal setting
- Action planning
- Improving communication with health professionals
- Utilising resources within one's community such as walking groups, local swimming pools
- Fatigue and pain management
- Interpersonal skills
- Scheduling & pacing
- Relaxation
- Managing voices
- Adoption of healthier lifestyle behaviours such as healthier nutrition and increased physical activity
- Growing vegetables
- Tips for remembering medications
- Positive affirmations
- Peer support

Many of these skills are valuable life skills. People that have learned self-management skills have improved their communication skills and relationships, returned to work and improved their social wellbeing.



© Reflection Graphics 3

2.2: The Self Care Toolkit and the Pain Toolkit

“...for people with persistent health conditions” Pete Moore, patient & author

This is a great resource to share with your patients or clients. It was developed by Pete Moore, a patient living with chronic pain, asthma and osteoarthritis in the UK with support from health professionals and has proven so popular; there is now an accompanying website and 1 day workshops. The purpose of the booklets and website are to support patients to become proactive in managing their own health. It is particularly useful for patients who do not wish to participate in ‘formal’ classes or programmes.

	<p>The Pain Toolkit</p> <p>The pain toolkit and self-care toolkit have proved popular tools in the UK. The website has some useful resources and suggestions for people living with chronic pain.</p> <p>Website – www.pain toolkit.org</p>
	<p>Self-Care Toolkit – Booklet</p> <p>In association with the Pain Society of NZ and Health Navigator NZ, printable versions of these great little booklets have been adapted for NZ audiences.</p> <p>Two Booklets:</p> <ol style="list-style-type: none"> 1. The Self Care Toolkit (any condition) 2. The Pain Toolkit <p>NZ versions of the booklets, visit: www.healthnavigator.org.nz/self-management/care-plans-action-plans</p>

The Self Care Toolkit’s 12 tools

The toolkits introduce 12 tools that can help people develop healthier self-management skills and strategies for managing pain, tiredness, motivation and wellbeing. Worth having a look and see what you think.

1.	1. Accept that you have a persistent health condition and then begin to move on
2.	Get involved – build a support team
3.	Pacing
4.	Learn to prioritise and plan out your days
5.	Setting goals/action plans
6.	Being patient with yourself
7.	Learn relaxation skills
8.	Stretch and exercise
9.	Keep a diary and track your progress
10.	Have a plan for set backs
11.	Team work
12.	Keep practicing and using 1-11 daily

2.3: Stanford Model – Community-Based Self-Management Programme

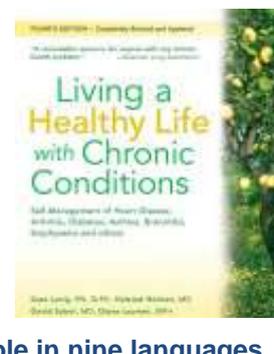
The Stanford Model, or Chronic Disease Self-Management Programme (CDSMP) and variants, are an **evidence-based approach** developed by Dr Kate Lorig and colleagues from Stanford University in the USA over the last 20 years. The programmes:

- Aim to equip individuals and their whānau with the necessary tools and skills to increase **control and confidence** in managing the daily challenges of living with a chronic condition.
- The generic programme has proven very popular and is now used in over 25 countries and translated into 22 languages.
- More recently specific programmes **for back pain, diabetes, pain, the Internet and HIV** have also been made available after testing for effectiveness through randomised, controlled trials over 2-5 years.

Held as small-group workshops, the courses are held in community settings and on the Internet (not yet for NZ participants). They are facilitated by two leaders, with at least one having health problems of their own. The workshops are highly interactive, focusing on building skills, sharing experiences, and support.

Accompanying Textbook

Living a Healthy Life with Chronic Conditions; 3rd Edition: Self-Management of Heart Disease, Arthritis, Stroke, Diabetes, Asthma, Bronchitis, Emphysema & Others. by Kate Lorig RN Dr PH, Halsted Holman MD, David Sobel MD, et al. Bull Publishing, 2012



Easy to read, this book provides an excellent companion resource for participants to the Chronic Disease Self-Management Course.

Available in nine languages, e-book and audio CDs

Programme Goals	Topics
Improve physical & emotional health of participants	<ul style="list-style-type: none"> • Problem solving, goal setting, action planning and decision making
Reduce disease progression	<ul style="list-style-type: none"> • Techniques to deal with common problems such as frustration, fatigue, pain and isolation
Maximise the wellbeing of patients and their families	<ul style="list-style-type: none"> • Appropriate use of medications • Developing healthy lifestyles
Reduce healthcare costs	<ul style="list-style-type: none"> • How to communicate effectively with family and health professionals • How to utilise community resources • How to remain self sufficient

Courses

The more enthusiastically health professionals recommend attending a course such as this, the more likely your patients/clients are to attend. This course is ideal for virtually all people with long-term conditions and their careers, so why not run a query builder and start referring now. Talk with your local facilitator and they can potentially run one in your practice, outpatients or local area. For information about courses available in the Auckland Region see the Services directory at the end.

Costs - Most courses run by PHOs are free. For groups such as Arthritis NZ, a small charge may apply.

Additional information

A number of webpages including leader information, research, feedback from participants and course locations are available at: www.healthnavigator.org.nz/keeping-well/generic-self-management-course



Health Navigator NZ

A number of webpages including leader information, research, feedback from participants and course locations are available at

www.healthnavigator.org.nz/keeping-well/generic-self-management-course



Stanford Patient Education Research Center

Website for all the programme information and research relating to the Stanford Chronic Disease Self –Management Programme.

<http://patienteducation.stanford.edu/programs/cdsmp.html>

References

Visit <http://patienteducation.stanford.edu/bibliog.html> for over 70 research studies and related articles including a number of randomised controlled trials.

Gordon C and Galloway T. *Review of Findings on Chronic Disease Self-Management Program (CDSMP) Outcomes: Physical, Emotional & Health-Related Quality of Life, Healthcare Utilization and Costs*. Centers for Disease Control and Prevention and National Council on Aging, 2008. ([View article – pdf](#))

Lorig KR, Ritter PL, Stewart AL, Sobel DS, Brown BW, Bandura A, González VM, Laurent DD, Holman HR. *Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes*. *Medical Care*, 39(11),1217-1223, 2001. ([View abstract](#))

Horsburgh M, Bycroft J, Mahony F, Roy DE, Miller D, Goodyear-Smith F & Donnell E (2010b): The Flinders Programme of chronic condition self-management in New Zealand: Survey findings. *New Zealand Journal of Primary Care* 2(4):288-93 (2010) ([View abstract](#))

Chapter 3: Condition-specific self-management programmes & resources

1	<u>Arthritis</u>
2	<u>Back pain</u>
3	<u>Cancer support</u>
4	<u>Depression & anxiety</u>
5	<u>Diabetes self-management</u>
6	<u>Gout</u>
7	<u>Heart disease</u>
8	<u>Neurological conditions</u>
9	<u>Respiratory disease</u>



3.1: Arthritis support

There are over 140 types of arthritis; however the most common forms are osteoarthritis, rheumatoid arthritis, and gout. General information about arthritis is provided in this section. For specific information about gout, see the [Gout Section](#).

About Arthritis Support

- Arthritis Educators from [Arthritis New Zealand](#) are a valuable community resource and will visit people in their homes to provide in-depth education and support when needed.
- Arthritis New Zealand offers a free service to educate individuals or groups, referral to exercise and hydrotherapy classes, and referral to other groups and support services. Support groups are also available in many areas of the country.
- Additional supports are available including mobility aids, newsletters, and online information.
- Support is also available from some DHB Rheumatology teams. Check with your local PHO and DHB.

Who are these services aimed at?

- People with moderate to severe arthritis (and families)
- Anyone waiting for joint replacements or surgery

Where is it?

- Arthritis Educators are available throughout the country. Visit www.arthritis.org.nz/contact-us/
- Phone **0800 663 463**



[Click on map](#)

Services & Resources

	<ul style="list-style-type: none"> • Arthritis Education Clinics – education one-on-one or in groups • Workplace and community seminars • Independent Living Services • Exercise & Hydrotherapy Classes • Mobility aids, newsletters, online information • Phone 0800 663 463 or website as above.
	<p>Kids with Arthritis Support Group (KWA)</p> <p>Group for young people with arthritis and their families. Contact: Karen Derrick ph. (09) 278 7751 or 027 429 2339 for more information</p>
	<p>Health Navigator NZ - Arthritis Sections</p> <ul style="list-style-type: none"> • Osteoarthritis • Rheumatoid Arthritis • Gout • Fibromyalgia • To view, visit: www.healthnavigator.org.nz/health-topics

3.2: Back pain

For people with recurrent acute back pain or chronic back pain, development of effective self-management strategies is very important to minimise recurrences and chronicity.

Currently there are no specific self-management programmes for back pain management in Auckland. However, as with all chronic pain conditions, patients can benefit from a generic self-management programme including pain self-management.

Additional Resources

	<p>Back Pain</p> <ul style="list-style-type: none">• Topic page www.healthnavigator.org.nz/health-topics/back-pain• The Pain Toolkit - www.healthnavigator.org.nz/wp-content/uploads/2009/09/Pain-Toolkit.pdf• Pilate Physiotherapists such as www.peakpilatesgroup.co.nz/
	<p>ACC Acute low back pain screening questionnaire (2005)</p> <p>Download the pdf at: www.acc.co.nz/PRD_EXT_CSMP/groups/external_ip/documents/form/wcm002132.pdf</p>
	<p>McKenzie's Method</p> <p>Book & Website - Treat Your Own Back & Neck</p> <ul style="list-style-type: none">• www.lower-back-pain-toolkit.com/index.html• McKenzie Institute NZ - www.mckenziemdt.org.nz/

3.3: Cancer support

Many cancers can now be managed for many years and patients need to develop excellent self-management skills to manage the often-complicated physical, emotional and social impacts well.

Cancer Navigation Services

There are four specific cancer navigation programmes in Auckland. These services aim to support patients and whānau on their cancer journey and include a whānau ora/fono incorporating approach by addressing some of the social and familial issues surrounding access to and uptake of cancer treatments.

Who is it aimed at?

Anyone can be referred to the services, but they are specifically designed to meet the needs of Māori and/or Pacific peoples. The Māori provider services offer a kaupapa Māori model of care.

Cancer navigation programmes for Māori and Pacific peoples

Programme funding and contact details can change at any stage. Check with your local PHO or Oncology Service if you have any difficulty contacting local services.

Waitemata DHB area	West Auckland - Whānau Ora Cancer Navigation Service Self-referral or healthcare practitioner referral including referral from other cancer service providers. Phone 0800 924 942 or (09) 8366683 Fax (09) 838 4313 Email wendy.hayward-morey@waiwhanau.com www.healthpoint.co.nz/default,160164.sm
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General Cancer support

 Cancer Society of New Zealand	All Cancers - Cancer Society NZ The leading NZ organisation available to support all patients with any type of cancer. There are multiple services, support groups, resources and tools available to health practitioners, patients and whānau. www.cancernz.org.nz/living-with-cancer www.cancernz.org.nz/support-services
	Breast Cancer New Zealand Breast Cancer Foundation is one of the main support organisations for breast cancer in NZ Wide range of resources, support and information. www.nzbcf.org.nz

	<p>Breast Cancer - Sweet Louise Charitable trust set up by the Louise Perkins Foundation to support women with secondary breast cancer and their families. Services range from baking to massage, spa and complementary therapies. Phone: 0800-122 77 info@sweetlouise.co.nz www.sweetlouise.co.nz/ServiceDirectory</p>
	<p>Health Navigator NZ Breast cancer webpage www.healthnavigator.org.nz/health-topics/breast-cancer Lung cancer webpage: www.healthnavigator.org.nz/health-topics/lung-cancer</p>
	<p>Healthpoint Cancer services: www.healthpoint.co.nz/cancer+services Genetic Services: www.healthpoint.co.nz/genetic_services</p>
	<p>Leukaemia and Blood Foundation Supports, educates, and provides research grants for blood cancers. Support groups available in Auckland: Multiple Myeloma, Chronic Leukaemia, Moving on...the Next Step - Bone Marrow Transplant (BMT) Survivorship, Lymphoma. P: 0800 151015 http://www.leukaemia.org.nz/section/patients_and_families</p>
	<p>Prostate Cancer Foundation of NZ A predominantly consumer based organisation, this organisation and website provide a Helpline, useful information and the prostate, diagnosis, staging and treatment, advocacy and support. Helpline 0800 477 678 (this number can also be used to contact the office). Website: www.prostate.org.nz/prostate-cancer</p>

3.4: Depression and Anxiety

Depression and anxiety are rapidly becoming some of the most common recurrent or long-term conditions people now face. Both are also very common co-morbidities for people with long-term physical conditions such as diabetes, heart disease and arthritis.

There are now a wide range of self-management programmes and approaches ranging from self-help workbooks through to online e-therapy that can really help. Here are just some to get you started.

The Journal (aka JK's Programme)

(Part of the National Depression Initiative website) www.depression.org.nz

This is a user-friendly, online self-help programme for people with depression or depressive symptoms. The Journal's content was developed with input from mental health professionals over a two-year period. It includes a range of evidence-based techniques people can apply in everyday life, with a focus on structured problem solving. The programme also features text and email messages to act as reminders to participants for continued participation.

 <p>www.depression.org.nz</p>	<h4>How to use it?</h4> <ul style="list-style-type: none">• Access The Journal via the website – look in the bottom left corner for the icon• The Journal can be used independently by anyone• It can also be used to complement treatment plans managed by a GP or mental health professional.• Back up and additional support from experienced counsellors is available to ensure participants have access to personalised help if they want it either online or by phone or text.
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Depression & Anxiety Help lines

Depression Helpline	P: 0800-111-757
Lifeline	P: 0800-543-354
Phobic Helpline	0800 14 ANXIETY (0800 14 269 4389)
Youth Helpline	P: 0800-376-633

Additional resources for depression and anxiety

	<p>Depression website (NZ) Includes a range of resources, information, discussion forums and self-tests along with a free helpline to help people or families with depression. www.depression.org.nz</p>
	<p>This Way Up – Online Modules, Self-Help Resources & Treatment Manuals A range of evidence-based online treatment programmes for anxiety, depression, panic and social phobia developed by University of Sydney Anxiety and Depression Centre.</p> <p>Visit https://thiswayup.org.au/clinic/ Sign up is free for doctors and nurses. Order prescription pads. Visit: https://thiswayup.org.au/clinic/clinicians/</p> <p>Self-help resources - https://thiswayup.org.au/self-help/</p> <p>Treatment Manuals & Workbooks – valuable resource with Manuals for Obsessive Compulsive Disorder, Post-Traumatic Distress Disorder, Panic Disorder, Social Phobia, etc. https://thiswayup.org.au/clinic/clinicians/resources/</p> <p>Eg: Generalised Anxiety Disorder Manual “this is both a guide to treatment and a workbook for persons who suffer from generalized anxiety disorder.... www.crufad.org/images/stories/pdf/manuals/crufad_GADmanual.pdf</p>
<p>MoodGym</p>	<p>MoodGym An Australian-based interactive web programme to learn cognitive behaviour therapy skills for preventing and coping with depression. Developed by the Centre for Mental Health Research, Australian National University. There are five modules:</p> <ol style="list-style-type: none"> 1. An interactive game 2. Anxiety and depression assessments 3. Downloadable relaxation audio 4. A workbook and 5. Feedback assessment. <p style="text-align: right;">Website: www.moodgym.anu.edu.au</p>
<p>Living life to the full</p>	<p>Living Life to the Full An online life skills programme that aims to provide access to high quality and user-friendly training in practical approaches you can use in your own life. Available for individuals and friends or relatives with mental health problems or concerns. www.livinglifetothefull.com</p>
<p>Support Groups</p>	<p>GROW – Depression Support Groups A support network for people whose lives have been affected by depression. Groups provide a safe environment where people can find empathy, acceptance friendship and support. Groups meet weekly across the country. For further information Phone: 09 846 6869 Email: auckland@grow.org.nz Website: http://grow.org.nz</p>
	<p>The Nutters Club (NZ) Founded to “forever change the way people, feel, think, talk and behave in relation to our mental, physical, emotional, spiritual, cultural and sexual well-being; and in doing so encourage us all to take ownership of our own health and well-being.” Weekly talkback show featuring Auckland Psychiatrist Dr David Codyre and host Mike King. Visit www.facebook.com/THENUTTERSCLUB?sk=wall - /THENUTTERSCLUB?sk=info</p>

3.5: Diabetes self-management

Even if you provide diabetes education in your practice nearly all patients with diabetes will benefit from referral to diabetes self-management education.

General advice

Key self-management approaches that benefit people with diabetes include:

- Referral to Diabetes Self-Management Education (DSME) courses (see table below)
- Comprehensive care planning, e.g., [Flinders Assessment](#)
- Having a [Diabetes action plan](#)
- Optimising medical management
- Support from local diabetes groups

Diabetes Self-Management Education (DSME)

There is good evidence that group-based diabetes self-management education courses are beneficial for people with diabetes and improve health outcomes and quality of life. A range of diabetes self-management programmes are available across Auckland and throughout the country, which can be generally grouped as follows:

Type 1 diabetes	Type 2 diabetes	Cultural or age specific courses
<ul style="list-style-type: none">• DHB or NGO specific eg: Dose Adjusted For Normal Eating (DAFNE) Courses	<ul style="list-style-type: none">• Many variants eg: Stanford Diabetes SME; PHO/DHB developed Diabetes SME;	<ul style="list-style-type: none">• Maori• Samoan• Hindi• Youth

DSME Programmes in Auckland Region

You will find information about the availability of DSME courses in the Services Directory at the end of this document.

Evidence & Recommendations

- **Summary of Cochrane Review** – “Group-based training for self-management strategies in people with type 2 diabetes is effective by improving fasting blood glucose levels, glycated haemoglobin and diabetes knowledge and reducing systolic blood pressure levels, body weight and the requirement for diabetes medication.”⁴ (These results were maintained at 2 years).
- Attending DSME or a generic SME course helps to develop people’s self-confidence, knowledge and skills to enable them to make informed decisions regarding their diabetes care and self-management.
- Courses and community support groups provide a safe forum for people with diabetes and their whānau to share their experiences and support others.

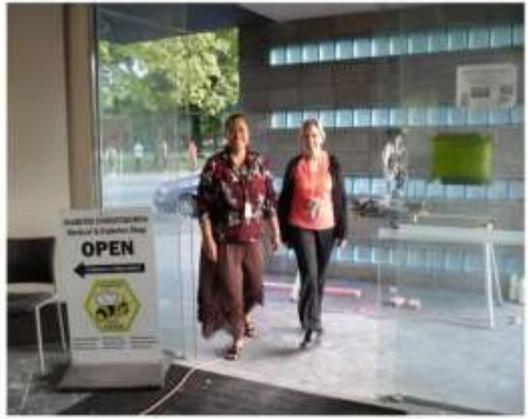
⁴ Deakin TA, McShane CE, Cade JE, Williams R. Group based training for self-management strategies in people with type 2 diabetes mellitus. Cochrane Database of Systematic Reviews 2005, Issue 2. Art. No.: CD003417. DOI: 10.1002/14651858.CD003417.pub2 ([View report](#))

- Encourage all patients with diabetes to attend a diabetes self-management programme and refresher sessions as appropriate.
- Contact your PHO to find out what DSME courses are available in your area.

Resources

	<p>Video explaining Diabetes</p> <p>Excellent video explaining diabetes, HbA1C and why taking your medicines as directed can help manage your diabetes.</p> <p>http://www.youtube.com/watch?v=rBKSutgPXCy&feature=player_embedded</p>
	<p>Diabetes Section – Health Navigator NZ</p> <p>Factsheets, educational resources, videos, tools</p> <p>www.healthnavigator.org.nz/health-topics/diabetes</p>
	<p>ADHB Diabetes Centre</p> <p>Referral, services and staff information. www.healthpoint.co.nz/default,38695.sm</p>
	<p>Diabetes Auckland - Support Groups & Nurse Educators</p> <p>Wide range of resources, support and educational programmes</p> <ul style="list-style-type: none"> • Diabetes Conversations Maps Series • Support Groups across Auckland • Information Centre • Shop • Supermarket Tours •
	<p>Diabetes Project Trust</p> <p>Wide range of resources, information sheets – see services directory at the end for information on group programmes</p> <p>www.dpt.org.nz</p>
	<p>Health Mentor Online</p> <p>An online self-management programme for people with pre-diabetes Also has a log in to access resources for Health Professionals</p> <p>http://www.healthmentoronline.com/</p>

Diabetes Educators in
Christchurch still smiling
despite 'new normal'



3.6: Gout

Most complications of gout can be avoided if preventative medication is started early. What percentage of your patients with gout are on allopurinol?

Marker for High Cardiovascular Risk and Diabetes

The presence of gout is now recognised as a marker of high risk for diabetes and high cardiovascular risk. In Counties Manukau, approximately 25% of all patients seen at rheumatology clinics with gout have a five year CVD risk of 15% or more.

Gout Self-Management Programme

Arthritis New Zealand and Counties Manukau DHB have developed a self-management programme for Māori and Pacific Island people with gout. This programme includes gout risk assessment, gout education, and an individually tailored self-management plan for people affected by gout or at risk of developing it.

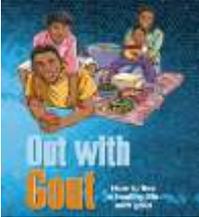
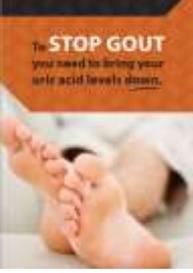
Who is it aimed at?

The self-management programme is available for anyone with a particular focus on Māori and Pacific Island communities and is currently provided in the Counties Manukau region. Elsewhere, patients can be referred to the generic Stanford Self-Management Programme, which is equally useful.

Where can I find out more?

All areas	Arthritis Educator, Arthritis NZ A valuable community resource that will visit people with gout in their homes to provide in-depth education and support when needed. P: 0800-663-463 www.arthritis.org.nz/about-us/what-we-do/
Auckland based Covers area from Waikato to Northland	Māori Arthritis Educator, Arthritis NZ Phone: 09 523 8912, Cell: 027 6033281 Email: George.Ngatai@arthritis.org.nz
Most DHBs	Arthritis Clinical Nurse Specialists Arthritis nurse specialists or nurse practitioners are available in most DHBs for those within the secondary care system. They are a great source of information and support for primary care as well.
Maori Gout Action Group	Action Group A group of health professionals, community providers and consumers have formed a gout action group to focus on the huge burden of gout within Counties Manukau and New Zealand. A number of hui, presentations and resources have been developed and are a valuable resource to use.

Additional Resources

	<p>Gout section – Health Navigator NZ</p> <p>A range of useful tools, information, videos and resources are available via the Health Navigator gout section.</p> <p>www.healthnavigator.org.nz</p>
	<p>Out with Gout: How to live a healthy life with gout</p> <p>A user-friendly book for people who have gout and their whānau. Explains what you can do to prevent and treat gout.</p> <p>Click to view English, Niuean, Samoan, Māori and Tongan or visit: www.pharmac.govt.nz/2008/06/25</p>
	<p>Gout Resources available from Ministry of Health website</p> <p>Are you at risk of Gout</p> <p>www.health.govt.nz/system/files/documents/topic_sheets/are-you-at-risk-of-gout.pdf</p>
	<p>Stop Gout</p> <p>Excellent booklet explaining gout and how to bring your uric acid levels down. Traditionally we have focused on diet and exercise, however this booklet nicely shows how 80% of the benefit is from taking uric acid lowering medications and only 20% benefit comes from foods.</p> <p>www.health.govt.nz/system/files/documents/topic_sheets/to-stop-gout.pdf</p>
	<p>Further information</p> <p>www.health.govt.nz/publication/health-literacy-and-prevention-and-early-detection-gout</p>
	<p>Gout Action Plan for starting Allopurinol</p> <p>Download the pdf version here: http://assets.healthnavigator.org.nz/2011/03/Allopurinol-patient-card-v2.pdf</p>
	<p>The Pain Toolkit (UK)</p> <p>Useful tools and Information booklet that provides handy tips and skills to support people to manage their pain.</p> <p>Website: www.pain toolkit.org NZ Version: www.healthnavigator.org.nz/wp-content/uploads/2009/09/Pain-Toolkit.pdf</p>

3.7: Heart disease

Cardiovascular Risk Assessment and Management (Primary Prevention)

Heart Disease is largely preventable. All eligible New Zealanders should be risk assessed every five years. Those identified as being at increased risk of CVD should be managed according to the guidelines in the New Zealand Primary Care Handbook.

www.health.govt.nz/system/files/documents/publications/cardiovascular-disease-risk-assessment-updated-2013-dec13.pdf

Management options should be discussed with patients and interventions should be proportional to the size of the estimated combined CVD risk. There are several useful tools and resources available including *Your Heart Forecast* – a risk communication tool and, *Taking Control* – a self-management care plan for people at increased risk of CVD. More information below

An e-learning tool for health professionals '*Cardiovascular Risk Assessment and Management*' is freely available on the Ministry of Health site. <http://learnonline.health.nz/>

Know Your Numbers & Heart Forecast



How healthy is your heart? Information about knowing your numbers, blood pressure, cholesterol, weight and body mass index.

Followed by a six weekly emails with tips and info for Your Heart Health Plan



www.knowyournumbers.co.nz/

Heart Foundation Resources

Resources for Primary Prevention including *Taking Control*

www.heartfoundation.org.nz/programmes-resources/health-professionals/primary-prevention



Cardiac Rehabilitation Programmes (Secondary Prevention)

Three key areas to consider for any patient with heart disease are:

1. Optimisation of medications & treatments;
2. Address any barriers to medication adherence such as health beliefs and health literacy;
3. Optimise people's self-management skills and behaviours through proven self-management programmes such as cardiac rehabilitation.

“If there were a pill that cost very little, reduced cardiac deaths by 27 percent, improved quality of life, and reduced anxiety and depression, every cardiac patient in Europe would be expected to take it. There is no such pill, but taking part in a cardiac rehabilitation programme can provide all these benefits.” (Professor Bob Lewin, European Society of Cardiology, Amsterdam 2005). Sadly, however, cardiac rehabilitation has not received the same profile as cardiac surgery or the arrival of new medications and many people miss out on referral or access to this valuable programme.

Cardiac rehabilitation has three phases:

- **Phase I: Inpatient rehabilitation** (medical management, condition stabilisation, assessment of risk factors and commencement of education programme).
- **Phase II: Outpatient rehabilitation** – typically a supervised education/ambulatory programme for 6-7 weeks in community settings. Support is also available as a home-based programme (Heart Guide Aotearoa) in some parts of NZ,
- **Phase III: Long term-maintenance.** Support is available through a network of “heart support groups” and other exercise programmes. These are available on the [cardiac directory online](#).

Who is it aimed at?

Cardiac rehabilitation is valuable for nearly all patients with cardiovascular disease, however studies suggest only approximately 30% of the target population (all patients with acute events) attend cardiac rehabilitation.

If you find you have a patient who has not previously attended cardiac rehabilitation sessions and may like to, or you would recommend they do so, please refer.

Where are groups located?

A variety of different programmes are run in the community, with the aim to meet the needs of different ethnic groups, ages and work commitments. The multidisciplinary rehab teams include Cardiac Rehabilitation Nurse Specialists, dietitians, physiotherapists, psychologists, pharmacists, cardiologists along with ward staff.

Where can I find out more?

Information about Cardiac Rehabilitation programmes nationwide is available in the Heart Foundation Cardiac Community Online Directory. www.heartfoundation.org.nz/ccod

Heart Support Groups

Community-based support groups provide an important forum for social support, physical activity, education, and secondary prevention. They are suitable for anyone who has a heart condition or is at high risk of developing one and their whānau/family.

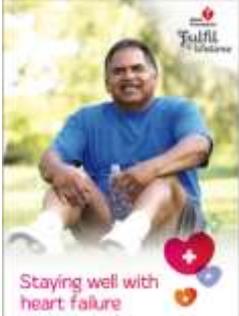
How can I refer to this programme?

Heart Support Groups and Cardiac Clubs can be contacted directly and participants are also referred following Phase II Cardiac Rehabilitation programmes.

Where can I find out more?

The Heart Foundation's [Cardiac Community Online Directory](#) links to a variety of heart support groups and services within New Zealand, with a focus on people living with heart disease and their families. The Heart Foundation endeavours to keep this directory up to date, however as these groups are independent of the Heart Foundation, they cannot be responsible if details change without their knowledge. You are encouraged to contact the group directly for more information.

Resources

	<h3>Staying Well with Heart Failure</h3> <p>Created by the Heart Foundation, Staying Well with Heart Failure is a self-management care plan for people with heart failure and can be downloaded and read online here.</p> <p>www.heartfoundation.org.nz/programmes-resources/health-professionals/secondary-prevention/heart-failure-tool/information-for-patients</p>
 	<h3>Interactive educational tools</h3> <ol style="list-style-type: none">1. Heart Attacks and Beta Blockers<p>An excellent tool to help explain why taking B blockers helps the heart</p><p>http://ixconversations.healthwise.net/scriptyourfuture/name/betablockers.htm</p>2. Why take Statins after a heart attack or diabetes<ol style="list-style-type: none">a. Brief video explaining how statins work and why it is important to keep taking them after a heart attack http://scriptyourfuture.org/?page_id=44b. Interactive Conversation that explains and personalises this further http://ixconversations.healthwise.net/scriptyourfuture/name/statins.htm
	<h3>Additional Resources</h3> <p>More can be found on the Heart Foundation website: www.heartfoundation.org.nz/programmes-resources/health-professionals/secondary-prevention</p>

Heart Failure Community Service

Heart Failure Nurse Specialists aim to maximise care (in-patient and community), improve continuity of care and provide ready access to advice, review, and support from a Cardiologist or Nurse Specialists.

Services include:

- Structured cardiac rehabilitation classes or a generic self-management course.
- Additional community-based support for patients with moderate to severe heart failure including home visits when needed.

More information and resources relating to heart failure for both patients and health professionals can be accessed here.

www.heartfoundation.org.nz/programmes-resources/health-professionals/secondary-prevention/heart-failure-tool

An e-learning tool for health professionals '*Heart Failure Support*' is freely available on the Ministry of Health site. learnonline.health.nz/

How to refer

You can now use the e-referral process within your practice management system. All referrals are triaged and patients are seen in clinic or at home. A cardiologist may phone/write with advice. One of the key aims is to prevent avoidable hospital admissions.

See Services Directory at the end for more details of programmes available in the Auckland region

3.8 Mental Health

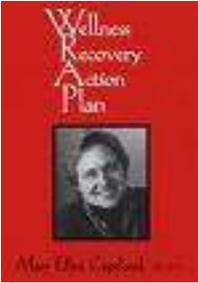
Approximately 20% of the general population experiences a mental disorder at any time, but only one person in three receives appropriate treatment.⁵

Effective self-management support can make a significant difference for people and their families living with mental illness.

Mental health conditions are very common with approximately 20% of the population experiencing diagnosable mental illness in any given year. Emotional and psychological wellbeing can be significantly enhanced by effective self-management support. Good resources already exist for supporting healthy eating, physical activity and smoking cessation. Over the last few years, the range and breadth of self-help, e-therapy and self-management resources for mental health have increased dramatically including e-therapy, or online/mobile or electronically enabled treatment. This section outlines some of the options now available.

<p>Screening Tools - eg: CHAT Tool</p>	<p>Case-finding and Help Assessment Tool (CHAT Tool) Used for life-style and mental health assessment of adults (16 years and over) in primary health care, this nine item validated tool was developed by a multi-disciplinary team from Auckland University (led by Prof Felicity Goodyear-Smith).</p> <p>The tool assesses for physical inactivity, tobacco use, alcohol and other drug misuse, problem gambling, depression, anxiety and stress, abuse and anger problems. For each item (one or two questions) patients are asked whether this is something with which they would like help, either during this consultation or at a later date.</p> <ul style="list-style-type: none"> • Download CHAT Tool Sep 2008 • More information & references – view here • Kessler 10 – online version www.crufad.org/index.php/take-a-free-test
<p>Self-Help Information</p>	<p>Mental Health Topics www.healthnavigator.org.nz/healthtopics</p> <p>Range of topics at: www.crufad.org/index.php/learn-about/panic-and-agoraphobia</p>
<p>All conditions</p>	<ul style="list-style-type: none"> • Education one-on-one, in groups, with whānau/family • Consider people’s learning style – visual, auditory, kinaesthetic • e-therapy – broad range of online programmes • Refer to support groups & green prescription if appropriate • Recommend appropriate self-help books
<p>Self-management skill training</p>	<ol style="list-style-type: none"> 1. Stanford Self-Management Programme very beneficial for virtually all patients with mental illness – see www.healthnavigator.org.nz/keeping-well/generic-self-management-course 2. Structured Problem Solving Another evidence-based approach that evolved from work in mental health – (see Appendices Worksheet)

⁵ Ministry of Health. 2004. Primary Health Organisations: Service development toolkit for mental health services in primary health care. Wellington: Ministry of Health. [View online](#)

<p>Wellness Recovery Action Plans (WRAP)</p> 	<p>Developed by Mary-Anne Copland, Wellness Recovery Action Plans (WRAPs) have become very popular around the world as an approach to help individuals and their families keep well and proactively plan for potential crises.</p> <p>Range of resources, books, DVDs, online learning & more. www.mentalhealthrecovery.com/index.php</p> <p>Downloadable forms: http://www.mentalhealthrecovery.com/recovery-resources/crisis-planning.php</p> <ul style="list-style-type: none"> ➤ The Crisis Plan & Post Crisis Plan ➤ Questions to Ask the Doctor about Medication ➤ Information for the Physician ➤ Optional Additions to Your Plan
<p>Treatment – e-Therapy</p> <ul style="list-style-type: none"> • Panic Disorder • Social Phobia • Obsessive Compulsive Disorder • Post-traumatic Distress Disorder 	<p>This Way Up – online modules</p> <p>University of Sydney and St Vincent’s Hospital have developed a series of evidence-based online treatment programmes for anxiety, depression, panic and social phobia based on cognitive behavioural therapy (CBT) principles. https://thiswayup.org.au/clinic</p> <p>Sign up is free for doctors and nurses to order prescription pads. Patients now pay \$55 AUD per course. (up to 6 modules, with 90 days to complete) The key to the high completion rates is for someone in your team to ring and maintain some contact during the 6 weeks of the modules. The more modules a person completes, the more benefit they tend to make.</p> <p>Visit: https://thiswayup.org.au/clinic/clinicians/ Publications: https://thiswayup.org.au/clinic/clinicians/resources/</p>
<p>Treatment Manuals & Self-help Workbooks</p> 	<p>Each manual is both a guide to treatment and a self-help workbook. During treatment, it is a workbook in which clients can record their own experience of their disorder, together with the additional advice for their particular case given by their clinician.</p> <p>Visit: https://thiswayup.org.au/about/range-of-services/-guidedhelp</p> <ul style="list-style-type: none"> ➤ Generalized Anxiety Disorder - (2.8 MB .pdf) - download ➤ Posttraumatic Stress Disorder - (414 kb .pdf) - download ➤ Obsessive-Compulsive Disorder - (839 kb .pdf) download ➤ Panic Disorder - (3.7 MB .pdf) - download ➤ Social Phobia - (2.5 MB .pdf) - download ➤ Specific Phobias - (1.8 MB .pdf) - download.
<p>Depression - Beating the Blues</p>	<p>Beating the Blues is an evidence-based online cognitive behaviour therapy programme now available in NZ. The Ministry of Health is funding this programme for primary care providers to use with their patients.</p> <p>For information about how to register visit: www.beatingtheblues.co.nz/ or ask your PHO staff.</p>
<p>Social Support</p>	<p>Social support is very valuable – encourage people to build and strengthen their own support network</p> <p>Support groups and helplines can be very helpful – visit www.healthnavigator.org.nz/self-management/support-networks</p>

3.9 Neurological conditions

There are a wide range of neurological disorders such as Multiple Sclerosis, Motor Neurone Disease, Parkinson's disease, Dementia (Alzheimer's) and Stroke.



Currently there are no specific self-management programmes for neurological conditions. However, generic programmes can be adapted and utilised to support patients and whānau to optimise the management of their condition(s). (See Section 2)

For many neurological conditions, such as dementia, acquired head injuries and Parkinson's disease, the personality/mood changes and increasing dependence places an enormous burden on family carers. Being available 24/7 takes its toll and an important part of self-management support is **making sure carers are adequately supported** as well. This can range from linking them with respite services, home-help, disability allowance and support groups through to counselling and managing depression, insomnia and stress.

Carers also need self-management support – check their emotional, physical and psychosocial wellbeing regularly.

Resources

<p>Societies and support groups for specific neurological conditions.</p> <ul style="list-style-type: none"> • Alzheimer's NZ www.alzheimers.org.nz • Carers NZ www.carers.net.nz • Epilepsy New Zealand www.epilepsy.org.nz • Multiple Sclerosis (MS) Society NZ http://www.msnz.org.nz/ • Motor Neurone Disease (MND) Association NZ http://mnda.org.nz • Parkinson's NZ www.parkinsons.org.nz • Stroke Foundation of NZ www.stroke.org.nz 	 <p>www.alzheimers.org.nz</p>  <p>www.carers.net.nz</p>
<p>Neurology Services Auckland DHB</p> <p>Information about neurological conditions, procedures and the Neurogenetics Clinic</p> <p>View at: http://www.healthpoint.co.nz/default,35720.sm</p>	 <p>www.epilepsy.org.nz</p>
<p>Stroke Foundation of NZ</p> <p>Range of useful resources, guides and support for individuals, carers and families</p> <p>Website: www.stroke.org.nz</p>	 <p>www.stroke.org.nz</p>

3.10: Respiratory disease

Asthma

Asthma self-management is a collaborative management between healthcare staff and patients and their whānau. It aims to maximise patient's ability to manage their condition through reducing risks/triggers and optimising treatment plans.

Most people with moderate or severe asthma will benefit from one-on-one self-management education sessions, or attending a generic self-management course and having a self-management plan.

Asthma resources

	<p>Asthma Self-Management Plans (for patients) and Guide (for health professionals) Download resources & action plans from: http://asthmafoundation.org.nz/wp-content/uploads/2012/03/AsthmaSelfManagementPlan08_final2.pdf http://asthmafoundation.org.nz/wp-content/uploads/2012/03/Seven_Steps_finalJan09.pdf</p>
	<p>Pictorial Asthma Medication Plan Website You can use this website to produce a personalised medication plan for children with asthma and their families. The medication plan, or PAMP, is designed to show the importance of regular "everyday" inhaler use and to recognise asthma warning signs and symptoms in a simple, colourful way (see the sample to the left). Developed by Waitemata DHB and West Fono Health Trust. </p> <p>If possible, print in colour for patients and laminate for durability. Available in 4 languages - (English, Samoan, Tongan, Tuvaluan) www.pamp.co.nz</p>
	<p>Explaining Asthma An excellent short video explaining how inflammation, mucus and muscular tightening contribute to asthma and relievers and controllers help this process. </p> <ul style="list-style-type: none"> • Video – brief overview - http://scriptyourfuture.org/respiratory/ • Video of a virtual coach conversation: http://ixconversations.healthwise.net/scriptyourfuture/name/controllermeds.htm
	<p>The Asthma & Respiratory Foundation of New Zealand</p> <ol style="list-style-type: none"> (1) Asthma support groups http://asthmafoundation.org.nz/your-health/living-with-copd/support-for-you/ - Affiliated%20Asthma%20Societies (2) Wide range of fact sheets about respiratory disease - http://asthmafoundation.org.nz/education/for-health-professionals/fact-sheets/
	<p>Asthma New Zealand – The Lung Foundation</p> <p>Range of services including mobile education vehicle, training courses in Asthma and COPD, education programmes in schools, marae, homes, work places, community groups and O2 The NZ Journal of Respiratory Health Visit website and view resources such as action plans www.asthma-nz.org.nz/</p>
	<p>Auckland, Counties, Waitemata, Northland and Capital & Coast DHBs</p> <p>Respiratory Services and contact information www.healthpoint.co.nz/default,32332.sm</p>

Chronic Obstructive Pulmonary Disease

Chronic Obstructive Pulmonary Disease (COPD) is often a life-limiting disease and can be very distressing and frightening for both the individual and their family.

- Over **200,000 New Zealanders have COPD, including 15% of New Zealanders aged over 45.**
- With the right information, support and self-management skills, many acute exacerbations of COPD can be managed early and often some hospitalisations avoided.

Every person with COPD should have a **COPD Action/Management Plan** so they know what their red flags or early warning signs are and what they should do. Likewise, most people with COPD will benefit from attending either a **self-management programme or Pulmonary Rehabilitation**.

Pulmonary Rehabilitation

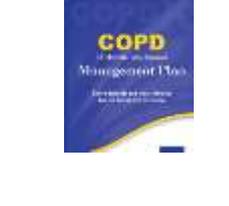
Pulmonary rehabilitation is an **evidence-based approach** to improve outcomes and quality of life for people with respiratory disease. The programme usually consists of 2 hour sessions, twice weekly for approximately eight weeks and caters for patients with moderate to severe COPD. Usually run by specially trained physiotherapists, participants receive:

- An individualised exercise programme, learn about improved breathing techniques, relaxation,
- Receive support with smoking cessation and nutrition,
- Educational sessions, support with medication management including inhaler technique.

For information about the availability of suitable group programmes see the Services Directory at the end.

Suggestion: *Develop a COPD register, encourage all clinical staff to code COPD the same way and check how many COPD patients/clients have attended a self-management programme or Pulmonary Rehabilitation. For those that haven't, make sure to refer and strongly encourage them to attend.*

COPD Resources

	<p>Chronic Obstructive Lung Disease</p> <p>Wide range of self-help resources, including links to videos, support groups, action plans and personal stories.</p> <p>www.healthnavigator.chronic-obstructive-lung-disease</p>
	<p>COPD Management Plan</p> <p>Range of useful information & resources</p> <ul style="list-style-type: none"> • Download COPD plan: www.asthmanz.co.nz/files/PDF-files/Resources/COPD_Management_Plan_14_October.pdf • Breathe Easier with COPD booklet - www.asthmanz.co.nz/files/PDF-files/Resources/Breath_Easier_with_COPD.pdf
	<p>The Asthma Foundation</p> <p>Various: http://www.asthmafoundation.org.nz/manage_your_copd.php</p>
	<p>Auckland DHB Respiratory Services</p> <p>Range of information about hospital based services</p> <p>www.healthpoint.co.nz/default,32332.sm</p>



Auckland DHB Clinical Nurse Specialists

Each DHB have a team of clinical nurse specialists for respiratory, renal, diabetes and more. They are a valuable source of information, support and liaison with hospital-based services. P: (09) 307-4949



Counties Manukau Health

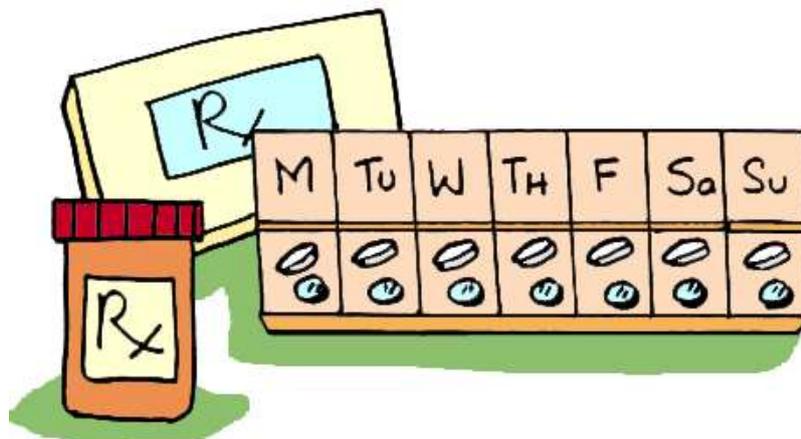
All Pulmonary Rehab programmes consist of both an exercise and education component. Currently all programmes run for 6 weeks with patients attending twice weekly

Contact: Sarah Candy Sarah.Candy@middlemore.co.nz

Chapter 4: Issue-specific resources for patients and whānau

Click on headings below to go directly to sections

1. [Green Prescription](#)
2. [Managing grief](#)
3. [Medication adherence](#)
4. [Pain management](#)
5. [Interpreter services](#)



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4.2: Green Prescription & Active Families

A Green Prescription is written advice from a health professional (usually a GP or Practice Nurse) recommending a person become more physically active as part of their health management.

About the programme

The Green Prescription Programme is carried out in two ways:

1. Phone Support

A free service offering support by phone for a period of three to four months. Support staff help people to find enjoyable physical activity options, assist them to fit these activities into their routine and form a regular habit.

2. Face-to-Face

Other organisations partner with healthcare to provide free and low-cost physical activity and wellness programmes in the community. These consist of an educational workshop and physical activity that can include aqua aerobics, gym workouts, walking and low impact aerobics.



Who is it aimed at?

Anybody who is interested in increasing his or her physical activity can go on the Green Prescription programme. Often people have medical conditions such as diabetes, high blood pressure, high cholesterol, obesity, and mental illness.

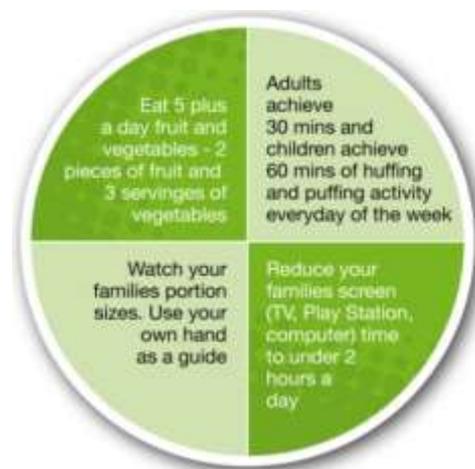
Active Families

Programme for children and their families. Criteria for referral are inactive children with a Body Mass Index (BMI) over 25 and within the 95th percentile, and a family able to make lifestyle changes.

Most GRx Active Families referrals come from GPs, paediatricians or practice nurses. Families are also able to self-refer.

Active Families Coordinators – August 2011

<http://www.health.govt.nz/your-health/healthy-living/food-and-physical-activity/green-prescriptions/active-families>



Who to contact for more information

A list of contacts and service providers in the Auckland region is available in the Services Directory at the end.

4.3: Managing grief

“Grief is a natural response to loss. It’s the emotional suffering you feel when something or someone you love is taken away. This can include loss of ability to work, or role in life. You may associate grief with the death of a loved one – and this type of loss does often cause the most intense grief” – Helpguide.org

What is it?

Any loss can cause grief. In long term conditions patients are often dealing with complex feelings and emotions regarding their loss of function and/or loss of roles in life. This can include loss of ability to work and financially provide for one’s whānau/family, feeling dependent on others and being less able to fulfil previous roles within the whānau/family.

For example, young children may have grandparent(s) as primary carers resulting in grief for the chronically ill parent. Others may be on dialysis, have loss of a limb or suffered paralysis, blindness or deafness. In addition there may be issues of chronic pain, dyspnoea and lack of mobility.

Look out for grief reactions in your patients - like depression, it is a common co-morbidity in patients with long-term conditions, is easily missed and often under-treated to the detriment of our patients and their families.

Getting help for grief

Counselling may help anyone who has had an extended period where the feelings of grief have not resolved, or they have become worse. Organisations that offer support for grief are listed below.

	<p>Skylight Offers a wide range of services to support those facing tough times of change, loss, trauma and grief. Equips, trains and supports those wanting to assist them, such as friends or family members, community volunteers and professionals. www.skylight.org.nz/</p>
	<p>Procare Psychological Services P: (09) 375 7761 E: confidential@procare.co.nz www.psychologynz.co.nz/auckland-psychology.html</p> <p>Download the pdf referral form here: www.psychologynz.co.nz/pdfs/ReferralForm.pdf</p>
	<p>After a suicide: Practical information for people bereaved by suicide http://www.health.govt.nz/publication/after-suicide-practical-information-people-bereaved-suicide</p>



Māori Services

Kaumatua can often provide help and support for grief management. Contact your local Maori Community Health Workers, PHO, DHB Maori team or Māori health provider.



Pacific Health

Discuss what support the person would like such as their local church leaders, PHO Community workers or support through ADHB – Pacific Family Support Unit

www.adhb.govt.nz/planningandfunding/pacific%20health.htm



Waitemata's Asian Health Support Services

<http://www.asianhealthservices.org.nz/main/index.php>

Asian Mental Health Cultural Support Coordination Services

www.amhcs.org.nz/main/index.php



Primary Mental Health Programmes

Most PHOs offer a range of mental health therapy and programmes. Check with your local PHO.

Within CMDHB ADHB and WDHB

- ProCare practices can contact ProCare Psychological Services as above Phone: 09) 375 7761
- Te Hononga PHO – Phone 09 973 0787
- Auckland PHO - Phone: 09 379 4022



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4.4: Medication adherence

Taking medications correctly can be hard work! Nearly three out of four people do not take their medications as directed and at 12 months 50% have stopped taking their long-term medications such as statins, preventers, BP medication. All this results in serious health consequences and lost opportunity for improved health outcomes.

General advice

Communication is KEY! **We only remember approximately 20%** of what we are told in a consultation so ensuring patients/clients have easy to understand written information can help.

You can improve patient medication adherence by:

- Encouraging **patients to ask questions**
- Make sure patients really **understand** why they are on particular medications, how to take it and what to watch for.
- Learn more about [health literacy](#) and the large impact this has on taking medications correctly
- Provide **appropriate written information** to support what patients are told during consultations
- Encourage patients to establish **routines** for taking medications, e.g., beside their toothbrush or kettle
- Use the **Teach Back Method**: ask patients to demonstrate how they will take their pills
- Give people [written action plans](#) about how to manage specific situations, e.g., pain, red flags or warning signs, asthma symptoms.
- **Screen for depression** and treat as appropriate ([link to online Kessler 10](#))
- Ensure **financial barriers** are removed (where possible)
- **Rationalise** medications & simplify regimes to once or twice a day (where possible)

Resources



Script Your Future

Script Your Future is a national campaign to raise awareness about medication adherence. In partnership with nearly 100 public and private stakeholder organizations in the USA, the campaign offers adherence resources to help patients and the health care professionals who care for them.

(Note: American websites, however worth viewing as some excellent videos, tools and resources)

- For general public: <http://scriptyourfuture.org>
- For healthcare professionals: www.scriptyourfuture.org/hcp/index.php



Ask Me 3

Ask Me 3 is a “patient education program designed to promote communication between health care providers and patients in order to improve health outcomes. The program encourages patients to understand the answers to three questions:

1. **What is my main problem?**
2. **What do I need to do?**
3. **Why is it important for me to do this?**

	<i>Patients should be encouraged to ask their providers these three simple but essential questions in every health care interaction. Likewise, providers should always encourage their patients to understand the answers to these three questions.”</i> www.npsf.org/askme3/
Blister Packaging	Available by GP prescription to local pharmacist. Costs vary from approximately \$5 per week to month, depending on complexity.
Medication Reviews	Medication Reviews are available for some Waitemata DHB patients
Yellow Medication Cards	Provide all patients on more than 3 or 4 medications with a yellow card outlining their medications, what each one is for and when to take it. Encourage them to take this to every health visit and if any medication changes are made, for this to be updated on their yellow card. <ul style="list-style-type: none"> • Waitemata DHB – supplies of yellow cards available www.waitematadhb.govt.nz/LinkClick.aspx?fileticket=NwbEn6Msjsw%3d&tabid=93&mid=433
Tips	Improve Medication Adherence and Accuracy - Tool 16 www.nchealthliteracy.org/toolkit/tool16.pdf

The problem of medication adherence typically gets little attention compared with other, more pressing issues in health care. Yet higher adherence rates could dramatically improve patient outcomes while reducing overall health care spending....
(Mitka, M JAMA, 2010)

References

Mitka, M. **Improving Medication Adherence Promises Great Payback, but Poses Tough Challenge.** JAMA. 2010;303(9):825.

Book - Shawn Christopher Shea - **Improving Medication Adherence: How to Talk with Patients About Their Medications** www.amazon.com/Improving-Medication-Adherence-Patients-Medications/dp/0781796229

Cutler, D.M. Everett, W. **Thinking Outside the Pillbox — Medication Adherence as a Priority for Health Care Reform** NEJM | April 7, 2010
<http://healthpolicyandreform.nejm.org/?p=3280>

Haynes RB, Ackloo E, Sahota N, McDonald HP, Yao X. **Interventions for enhancing medication adherence.** Cochrane Database of Systematic Reviews 2008, Issue 2. Art. No.: CD000011. DOI: 10.1002/14651858.CD000011.pub3 Online at <http://www2.cochrane.org/reviews/en/ab000011.html>

World Health Organisation (2003): **Adherence to Long-Term Therapies: Evidence for Action.** Geneva, Switzerland www.who.int/chp/knowledge/publications/adherence_full_report.pdf



4.5: Pain management

Chronic pain is pain which lasts for longer than the usual time of healing. It is often defined as lasting for more than six months and can have a major impact on a person's ability to carry out their usual activities.

Common sources of chronic pain include back or neck pain, headaches, arthritis, and neuropathic pain. When patients are asked what they would like help with, pain is often top of the list as it is such a common underlying problem for many patients; however it is often poorly managed as it is not usually relieved by simple pain remedies.

Self-Management Approaches

	<p>The Pain Toolkit – website & booklet</p> <p>A booklet to support chronic pain self-management. Suitable for any patient diagnosed with a chronic pain condition and who has had other causative/acute factors excluded. www.pain toolkit.org</p> <ul style="list-style-type: none">• To download the modified NZ version• Also see Self-Care Toolkit section
	<p>Pain Self-Management Programme</p> <p>The generic Stanford self-management programme is useful for all patients with chronic pain. In some regions of Auckland, a specific version for Pain is also available.</p> <ul style="list-style-type: none">• Email: life@procare.co.nz for more information
	<p>ACC - Interventional Pain Management Project</p> <p>www.acc.co.nz/for-providers/clinical-best-practice/interventional-pain-management/index.htm</p>

The Auckland Regional Pain Service (TARPS)

TARPS provides quality pain management to the people of Auckland and beyond through a multi-disciplinary team approach. This includes clinical assessment and management plans for acute and chronic pain.

Common conditions treated by TARPS include musculoskeletal pain disorders, e.g., chronic back pain, chronic neck pain, fibromyalgia, neuropathic pain and Complex Regional Pain Syndrome (CRPS).

Where is it?

Outpatient sessions are held at Greenlane Clinical Centre. Attendance at the sessions is strictly by appointment.

Making a referral

TARPS work in collaboration with general practitioners. This includes the expectation that prior to referral patients will have had a medical work-up at the primary care level and that appropriate specialist consultation has occurred.

Appointments are **only booked on receipt of** a questionnaire which is routinely sent out to all prospective patients. Source: Healthpoint: TARPS. <http://www.healthpoint.co.nz/default,36876.sm>

4.6: Interpreter Services

Multiple studies document that quality of care is compromised when patients with limited English proficiency need, but do not get interpreters. The use of family members or untrained interpreters leads to inferior quality of care and more errors. Evidence suggests that optimal communication, patient satisfaction, and outcomes and the fewest interpreter errors occur when such patients have access to trained professional interpreters or bilingual providers.

(G Flores, Systematic Review, 2005)

Interpreting Service provides a 24-hour health interpreting service to Auckland District Health Board. For all enquires please contact our service on 630 9943 and ask to speak with Interpreting Service or e-mail PHIP@adhb.govt.nz

The Primary Health Interpreter Pilot provides free access to telephone and face-to-face interpreters for primary care providers and their patients. The service is available Monday to Friday 8am – 4.30pm (except public holidays).

Professionally trained interpreters - including specialist interpreting in areas of mental health and family violence issues, are available in over 80 languages.

Sign language is available for people with hearing impairment. Primary Health Interpreter Services aim to ensure primary health services are accessible to people with limited English language proficiency. It aims to improve communication, improve and maintain clinical safety and reduce inappropriate and preventable use of emergency and secondary care services.

Who is it aimed at?

- People with limited or no English language proficiency who are eligible to receive publically funded health services
- People with hearing impairment requiring sign language interpreting
- **Note:** Private Specialist and ACC clients are not eligible for this service

Where can I find out more?

 <p>Auckland DHB</p>	<p>Call Centre Ph 09 623 6453. Telephone interpreting: 0800 559 555. Email: phip@adhb.govt.nz Fax: 09 623 4695 Website: www.adhb.govt.nz/Sites-Services/interpreting.htm</p>
<p>Counties Manukau DHB</p>	<p>Call Centre Ph: 09 276 0014 Email: its@cmdhb.org.nz Website: http://www.countiesmanukau.health.nz/funded-services/primarycare/interpreting/phippilot.htm</p>

References

Flores, G. The Impact of Medical Interpreter Services on the Quality of Health Care: A Systematic Review. Med Care Res Rev June 2005 62: 255-299 <http://mcr.sagepub.com/content/62/3/255.short>

SECTION 3:

TOOLS

Use the information and tools in this section to improve your communication skills, learn approaches to support people with taking control of what they can and how to implement self-management support within your practice, service or organisation.

Chapter 5: Patient-Centred Care Communication & Behaviour Change Approaches

An introduction to key concepts and practical approaches you can use to improve communication, care planning and support behaviour change

[Click on any of the headings below to go straight to the section]

1	Tips for communicating more effectively
2	Health literacy and communication
3	Assessing health literacy
4	Goal-setting & action planning
5	Collaborative care planning Flinders Advance care planning
6	
7	Structured problem solving
8	Teach-Back & Closing the Loop



5.1: Tips for communicating more effectively

Studies suggest that 40-80% of the medical information patients receive is forgotten immediately⁶ and nearly half of the information retained is incorrect.⁷ This has major implications for patient safety, medication adherence and how we communicate.

Universal Communication Principles

- Everyone benefits from clear information
- Many patients are at risk of misunderstanding, but it is hard to identify them
- Testing general reading levels does not ensure patient understanding in the clinical setting

Virtually everyone experiences difficulty with comprehension, retention and communication when facing stressors such as acute health events, surgery, trauma, mental illness, sleep deprivation or illness of oneself or a loved one.

10 tips for improving communication

1. **Partner with your patients** – shift from the traditional role of advising and telling patients what to do. Form an equal partnership with shared knowledge, responsibilities, learnings and care. Encourage patients to share in the decision-making and be proactive about their health. Respect patients as experts about themselves, their situation, values and preferences. Offer suggestions and choices and then together agree the best option(s).
2. **Avoid jargon, abbreviations and explain medical terms** - use plain, non-medical language, common words and socio-culturally appropriate language eg kai (food) and whānau (family). Words such as coronary, cervical (neck or uterine), otolaryngology, gynaecology etc. can be very confusing.
3. **Use trained translators** - for non-English speaking patients/clients, organise phone or in-person translators. Using family members, friends or other non-trained people to translate is a common source of miscommunication.
4. **Look for non-verbal cues** and modify communication accordingly - 70% of communication is non-verbal – consider tone, body language, reactions, cultural differences (eye-contact) etc.
5. **Practice active listening, use open-ended questions (cannot be answered with Yes or No) and encourage questions.** Avoid: “Do you have any questions?” Rather – “Most people have a number of questions. What would you like to know more about?” OR “what questions or topics would you like us to cover today?”



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⁶ Kessels RP. Patients' memory for medical information. J R Soc Med. May 2003;96(5):219-22.

⁷ Anderson JL, Dodman S, Kopelman M, Fleming A. Patient information recall in a rheumatology clinic. Rheumatology. 1979;18(1):18-22.

6. **First things first** – when giving information or advice, start with what is of most concern, importance or interest to the person.
7. **Prioritize** what needs to be discussed and limit information giving to three to five key points.
8. **Consider learning styles and use communication aids** - modify communication accordingly. Draw diagrams, use interactive tools (such as [Heart Forecast Tool](#)), decision aids, illustrations, plastic models, or video clips as much as possible.
9. **Summarise key points and check understanding.** Use the [Teach-Back method](#)
10. **Give individualised or tailored written or online information** (at an appropriate health literacy level) to reinforce key messages and actions.

Using Open Questions:

Open questions can transform a conversation. Just one question can elicit a response that provides insight into what really matters to the person you are working with.

See open question cards in the appendix

Resources

	<p>Health Navigator NZ Wide range of resources, tools and information to facilitate improving communication www.healthnavigator.org.nz</p>
	<p>Toolkit for Making Written Material Clear and Effective Centers for Medicare and Medicaid Services (CMS) www.cms.gov/WrittenMaterialsToolkit</p>
Speaking Plainly	<p>Speaking Plainly: communicating the patient's role in healthcare safety www.ncbi.nlm.nih.gov/bookshelf/br.fcgi?book=aps4&part=A6812</p>
	<p>Developing Immunisation Communication Tools Margie Comrie, Niki Murray, Janice Handley & John Waldon, Massey University. Presentation on the results of a community-university liaison project. Download the pdf here: www.massey.ac.nz/massey/fms/Colleges/College_of_Business/Communication_and_Journalism/Literacy/Developing_Immunisation_Communication_Tools.pdf</p>
	<p>The Center for Healthcare Communication Range of resources and articles www.communicatingwithpatients.com/index.html</p>

Tools and Strategies

Assessing health literacy

There are a number of tools for assessing health literacy ranging from a few minutes to detailed assessments, however it is better to assume most patients will have difficulties at some time and ensure all communication (oral and written resources) is clear, simple and where possible tailored to the individual person.

The following screening questions can be useful.

1. "How confident are you in filling out medical forms by yourself?"

(Not at all confident, a little confident, somewhat confident, quite a bit and extremely confident).

This has been used successfully as a single screening question with a summary likelihood ratio (LR) for limited literacy of 5.0 (95% confidence interval [CI], 3.8-6.4) for an answer of "a little confident" or "not at all confident"; a summary LR of 2.2 (95% CI, 1.5-3.3) for "somewhat confident"; and a summary LR of 0.44 (95% CI, 0.24-0.82) for "quite a bit" or "extremely confident."

2. "How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?"

(The Single Item Literacy Screener - A single item questionnaire intended to identify adults in need of help with printed health material. Possible responses are 1-Never, 2-Rarely, 3-Sometimes, 4-Often, and 5-Always. Scores greater than 2 are considered positive, indicating some difficulty with reading printed health related material is likely. More information at www.biomedcentral.com/1471-2296/7/21

3. "We now know that most adults have difficulty with understanding medical information, forms or prescriptions when unwell or stressed. How happy are you with your reading and writing in these situations?"



The Health Literacy Questionnaire (HLQ) is a new measure of health literacy. It is available only under licence and more information can be found at

<http://www.deakin.edu.au/health/research/phi/health-literacy-questionnaire.php>

Goal Setting and Action Planning

"Goals give you a compass in order to direct your path through life. Goals focus your thoughts and actions on areas that have precise purpose and meaning." - Catherine Pulsifer

Working with patients to identify something they want to do is one of the simplest, yet most effective techniques we can use to improve communication and behaviour change. A systematic review on improving diet, published by the Agency for Healthcare Research and Quality in 2002, included goal setting in a list of a few intervention components shown to be associated with improved behavioural outcomes.

An earlier review by Cullen et al of 13 studies utilizing goal-setting in adult nutrition education found persons engaged in goal setting to improve diet did better in terms of self-reported dietary change, weight loss and improved serum cholesterol than control groups.

Goal setting was most successful if it included follow-up, problem solving, and adjusting activities if goals were not being achieved.

When working with patients to develop their own goals, it is useful to remember the mnemonic SMART or SMARTER as shown below. To ensure ownership and motivation, it is also critical to ensure the patients/clients choose their own goals, rather than being given them by the health provider.

SMARTER Goal Setting

S - Specific What am I going to do? (What, when, where, how)

M – Measurable How will I know when I have got there?

A – Achievable Is this something I can do and in my control? What will I need?

R – Realistic Am I being realistic? What are the likely problems?

T – Time Bound Can I do this in a reasonable time frame?

E – Enjoyable and evaluate Is this something I want to do? What worked, what didn't?

R – Record and Rewards Writing it down and placing somewhere prominent helps keep us on track. Building in rewards also helps!



Self-Management Goal-Setting Technique

1. **Ask:** "Is there something you would like to work on to improve your health this month?"
2. **Guide** development of a short-term goal that is SMARTER.
3. **Gauge the level of importance** and score on a scale of 1 to 10. If rated less than 7, adjust goal to something that is more important to the patient/client.
4. **Assess Confidence.** Again, score from 1 to 10 and adjust the goal to something that is 7 or more. A score of 6 or less suggests the goal is too hard. Likewise, if someone scores 10, then this goal is very easy for them and you could check if they wish to make it a little more challenging.
5. **Arrange short-term follow-up.** A phone call, email, or text within one or two weeks of setting a new significant goal and change can make a significant difference to likelihood of achieving it. Help the person problem solve if they are facing barriers or struggling to achieve their goal and action plan.
6. **Document goal** in patient/client's notes and be sure to ask about it at the next visit.

(See Goal Setting & Action Planning template in appendices)

Examples

When someone comes up with a goal such as "*I want to lose weight*" ... or "*I want to be happier...*" help the person identify what a realistic target is (or what being happier would mean for them) and what specific action or behaviour they will do on a regular basis to help them reach this goal. For instance:

- **Goal:** "I will lose 5 kg over the next two months by eating healthy dinners at home at least 5 nights per week."
- An additional action can be: "I will walk for at least 30 minutes on Tuesday, Thursday and Saturday lunchtimes."
- **Goal:** "I will improve my asthma control over the next 6 weeks by taking my preventer twice a day so I will not get so puffed when I play with my kids."
- **An additional action could be:** "I will do this by setting an alarm on my phone to help me remember my puffer and by gradually increasing my walking and following my new exercise programme over the next 6 weeks."

Ultra Brief Action Planning

This is a simple and brief approach to developing a personal action plan that can be used in virtually any consultation and is based around three core questions.

1. "Is there anything you would like to do for your health in the next week or two?"
(What, when, where, how often, etc.?)
2. "On a 0-10 scale of confidence, where 0 means no confidence and 10 means a lot of confidence, about how confident are you that you will be able to carry out your plan?"
(If confidence <7, initiate collaborative problem solving).
3. "When would you like to meet again to review how you've been doing with your plan?"

For more information: Download Ultra Brief Action Planning guide: www.ama-assn.org/ama1/pub/upload/mm/433/ub_pap.pdf

Resources for Goal-Setting

<p>Coaching Approach</p> 	<p>Coaching Patients for Successful Self-Management</p> <p>Useful video presented by Tom Bodenheimer demonstrating coaching techniques to help encourage behaviour change and medication adherence by:</p> <ul style="list-style-type: none"> • Engaging the patient by continuously asking questions; • Helping the patient develop a realistic action plan; • Following up to monitor progress; • Finding out whether the patient understands the medication plan and agrees with it; • Asking the patient about barriers to medication adherence; • Following up - calling the patient a few days after a medication change to see how things are going. <p>Read more at: www.chcf.org/publications/2008/08/video-on-coaching-patients-for-successful-selfmanagement</p>
<p>Exploring Importance & Confidence</p> 	<p>Video with Techniques for Effective Patient Self-Management</p> <p>Presented by William H. Polonsky, University of California</p> <p>Useful video vignettes demonstrating how to:</p> <ul style="list-style-type: none"> • Engage the patient and understand why behaviour change might or might not be perceived as worthwhile from the patient's perspective; • Explore and enhance the importance of making healthy behaviour changes; and • Engage in collaborative action planning to support the patient's efforts in making a concrete, personally meaningful and achievable plan for change <p>Link: www.chcf.org/publications/2006/08/video-with-techniques-for-effective-patient-selfmanagement</p>
<p>Chronic Condition Self - Management Guide</p>	<p>Royal Australasian College of Psychiatrists</p> <p>Online training modules that cover useful topics and skills to assist health professionals with skills for collaborative chronic condition self-management. View at http://chroniccondition.ranzcp.org/module-6/66-goal-setting</p>
<p>Other Resources</p>	<p>Other Resources</p> <p>Understanding goal setting and action planning – www.improvingchroniccare.org/downloads/understanding_goal_setting_action_planning.doc</p> <p>Examples of collaborative goal setting dialogues www.improvingchroniccare.org/downloads/selfmanagementpaper.doc</p>

References

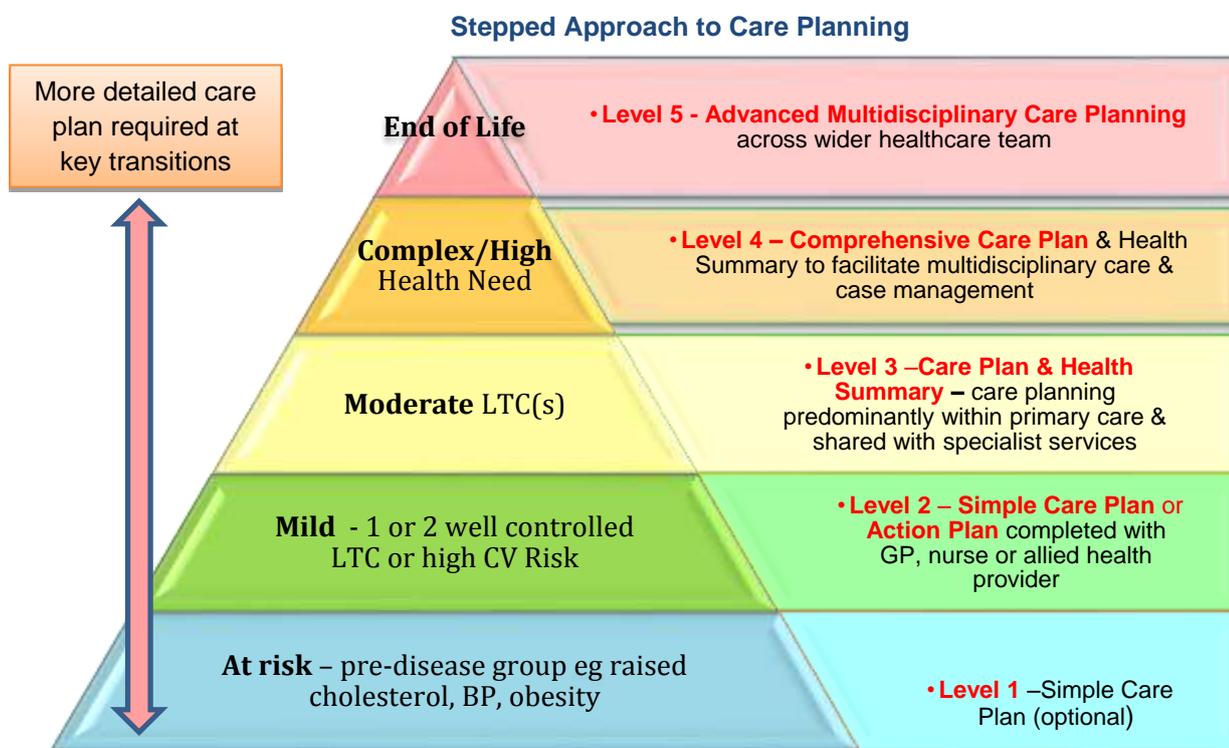
Ammerman et al. **The efficacy of behavioral interventions to modify dietary fat and fruit and vegetable intake (a review of the evidence)**. *Prev Med* . 2002;35:25–41

Cullen KW, Baranowski T, Smith SP. **Using goal setting as a strategy for dietary behavior change**. *J Am Diet Assoc* 2001;101:562–6.

Systematic Evidence Review Number 18. **Counseling to Promote a Healthy Diet**. AHRQ April 2002

Collaborative Care Planning

Approaches to Care Planning

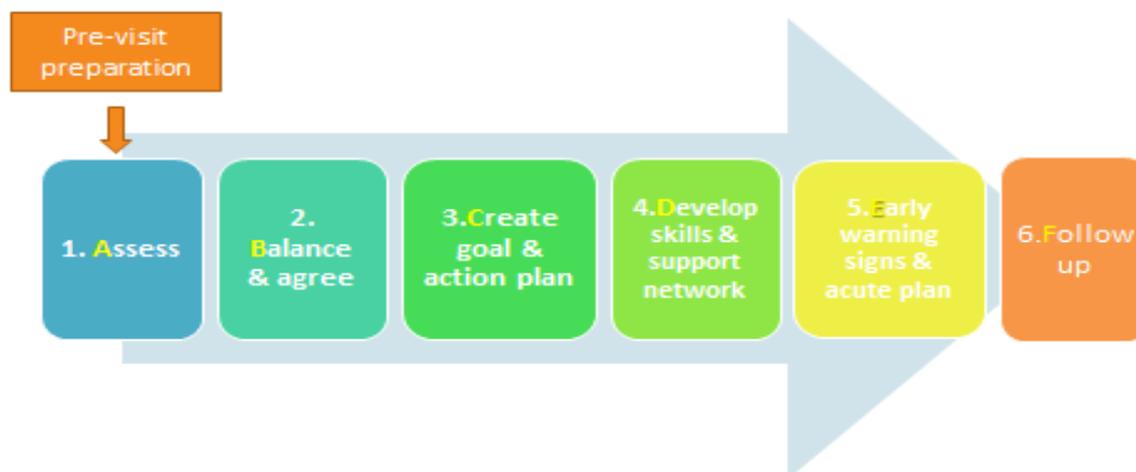


Comprehensive Care Planning

For patients in Levels 3 – 5 (Figure 3), a range of paper and computer-based care plans are available. Case management is common for patients in Level 4 or 5.

Within both community and specialist services, one systematic approach for care planning is the [Flinders Programme](#). This provides a structured, holistic patient centred approach to care planning that fits well with the principles outlined earlier. For levels 1, 2, and 3 a resource such as the Heart Foundation's 'Taking Control' could be used. Both of these are described later in this chapter.

ABC of Care Planning – A useful process



A: Assess

- Wide range of entry points & assessment tools
- Medications – how are they taking them?
- Ideas, concerns and expectations
- Assess self-management capacity
 - barriers,
 - enablers,
 - what's working, what's not,
 - concordance with medication/treatment regimes)
- Medical perspective

There are a variety of tools for assessing and identifying important issues, beliefs, knowledge, lifestyle and mental health risk factors as well as self-management capacity and motivation. Some can also be used to assess progress over time.

B: Balance perspectives and agree priorities

- Balance best practice & medical perspective with patient/whanau's perspective (values, preferences and beliefs)
- Discuss assessment findings
- Collaboratively agree priorities

Skills & Approaches

- ✓ Use motivational interviewing skills
- ✓ Brief advice techniques
- ✓ Balance approach with stage of change

C: Collaborative goal setting and action planning

- Identify a medium to long-term goal the patient/client wishes to work towards
- Hand the 'pen' over for patient/client to write the goal themselves (where suitable)
- Write from the client's perspective ("I will...")
- Check importance and confidence
- Identify smaller steps and key actions to go on care plan

Principles

- Start with what's most important from patient/client's perspective
- SMARTER goal setting
- Must be the person's goals, not the clinician's

D: Develop self-management skills and support network

- Identify potential barriers & problem solve
- Provide self-management skills training and education
- Help develop the person's support network and ensure appropriate services

Principles

- Use structured problem-solving
- Utilise SME and other structured programmes (eg Cardiac rehab, pulmonary rehab, SME programmes)
- Create supportive environment by linking with community groups & programmes
Local navigators, community workers etc

E: Early warning signs and Follow up

- Plan ahead for exacerbations
- Red Flags/Early Warning Signs and Crisis plan
- Use Closing the Loop/Teach-Back to check understanding
- Phone call within 1-2 weeks post visit

Principles

- Consultations in which clinicians use Closing the Loop do not take longer and significantly improve adherence and communication
- Planned, proactive follow-up makes a difference to goal attainment
- Use a coaching approach

Assessment Tools

<p>Partners in Health Scale (PIH)</p>	<p>This is a brief validated tool consisting of 12 questions which takes approximately two-to-five minutes to complete. It provides a useful tool for assessing self-management capacity from the client's perspective and can also be used to assess progress over time. Useful tool to use with all patients with long-term conditions or significant risk factors. This tool is being used as part of CMDHB's ARI programme</p>	<p>Appendices</p>
<p>Health Needs Assessment</p>	<p>This is the health needs assessment form used by a number of organisations in the UK.</p> <p>www.kirklees.nhs.uk/your-health/helping-yourself-to-better-health/self-care-toolkit/overview-of-self-care-options/health-needs-assessment/</p>	
<p>Lifestyle Assessment Tool (CHAT Tool)</p>	<p>As described earlier, this tool has been tested and validated for New Zealand populations, including Māori and Pacific peoples. It takes approximately 10 minutes to complete and most can do it without assistance. The addition of a help question ("Do you want help with this now?") has proved particularly useful.</p>	<p>Click here to view</p>
	<p>The Health Literacy Questionnaire (HLQ) is a new measure of health literacy. It is one of the assessment tools being used as part of CMDHB's ARI programme. It is available only under licence and more information can be found at http://www.deakin.edu.au/health/research/phi/health-literacy-questionnaire.php</p>	

Useful Resources & References

Follow up	<p>Outline for Follow up Visit and setting recalls http://www.newhealthpartnerships.org/provider.aspx?id=216</p>
Online Training	<p>Self-Management Training Website Excellent Canadian website and online training modules covering self-management goal setting, action planning and care planning. www.selfmanagementtoolkit.ca</p>
	<p>Capabilities for Supporting Prevention & Chronic Condition Self-Management: A Resource for Educators of Primary Health Care Professionals – Flinders University & Commonwealth of Australia, 2009</p>
	<p>Registered Nurses' Association of Ontario. (2010). Strategies to Support Self-Management in Chronic Conditions: Collaboration with Clients. Toronto, Canada. Registered Nurses' Association of Ontario</p>

Some Examples of Care Planning Initiatives

Counties Manukau District Health Board At Risk Individuals (ARI) Programme

The current CCM programme for patients with long term conditions has been reviewed and the programme is being changed to introduce a greater focus on At Risk Individuals to:

- Provide more early intervention and planned, proactive, patient centered care
- Re-establish general practice as the central focus on co-ordinated mechanism of healthcare with
 - Improved access to SMO, specialist and community services
 - Greater general practice input to the management of their patients
 - More flexibility in the use of funding and interventions
 - Delivery of services closer to the healthcare home and ultimately the patients home

Patients enrolled on the ARI programme will:

- Be assessed using either the Partners in Health or Health Literacy Questionnaire
- Have a named care co-ordinator assigned
- Have an eSummary health record which is able to be viewed across health care providers
- Have a patient centered, goal based care plan.

All practices within CMDHB will transition from CCM to ARI between 1 July 2014 and 30th June 2015. Transition will occur on a practice by practice basis with practices nominating when they would like to transition.

If you are a Counties practice talk to your PHO for more information and support

Heart Foundation *Taking Control*

In 2012 the Heart Foundation developed a self-management care plan, *Taking Control*, to support cardiovascular risk management. *Taking Control*, co-designed with health providers and patients, contains a number of validated self-management support strategies including collaborative goal setting and action planning, problem solving, self-monitoring, and information that is designed to be worked through, at home, by the individual with their family.

Taking Control has been successfully used as a care planning resource within primary care in New Zealand. It is freely available from the Heart Foundation and more information can be found at

<http://www.heartfoundation.org.nz/programmes-resources/health-professionals/primary-prevention/cardiovascular-risk-management>



Co-Creating Health Model

Co-Creating Health is an improvement programme developed by the Health Foundation in the UK that is helping people living with long-term conditions to take control of their health and health organisations with implementing self-management support.

They identified four key elements:

1. **Establishing the programme:** The vision of clinicians, managers and commissioners must be aligned in order to deliver the programme effectively.
2. **Improving clinical practice:** Local clinical champions, who promote the value of the approach and advocate its feasibility among their peers, are essential.

3. **Helping people to improve their health:** Building the Self-Management Programme (SMP) into care pathways is essential for success. With this in mind, people are more likely to attend the SMP if they are encouraged to do so by their clinicians.
4. **Changing the system:** Service improvement experience and expertise are needed to make real progress.

For more information: www.health.org.uk/publications/snapshot-co-creating-health/

Flinders Programme

The Flinders Programme is an evidence-based approach that provides a structured, holistic approach to partnering and planning care with patients/clients that is truly person/family-centred and supports effective behaviour change.

What is it?

The Flinders Programme provides a generic set of tools and processes that enables clinicians and clients to undertake a holistic, structured assessment of self-management behaviours, collaborative identification of problems and goal-setting leading to the development of individualised care plans.

The aim of the programme is to provide a consistent, reproducible approach to assessing the key components of self-management that:

- Improves the partnership between the client and health professional(s)
- Collaboratively identifies problems and therefore better (i.e., more successfully) targets interventions
- Is a motivational process for the client and leads to sustained behaviour change
- Facilitates communication and trans-disciplinary team care
- Allows measurement over time and tracks change
- Has a predictive ability. i.e. improvements in self-management behaviour as measured by the PIH scale, relate to improved health outcomes

Three Key Steps

1. Assessment of self-management capacity & barriers with [Partner's In Health Scale](#) (see appendices) and Cue & Response Interview©
2. Identify the main problem from the client's perspective using the Problems and Goals Assessment and formulate a key goal the client would like to work towards over the following 6- 9 months
3. Formulate a care plan with:
 - Identification of mutually agreed issues and goals
 - Key action steps, roles and responsibilities to address issues and goals for the next 12 months
 - Monitoring and reviewing



Case Studies

Te Hononga PHO are using the Flinders Programme as their enrolment, assessment and care planning tool for their Long-Term Conditions Programme and Manaia PHO are using the Flinders programme for their Care Plus programme.

Both groups have found the programme very useful at providing a holistic and structured approach to long-term condition management with many patients achieving some remarkable results. Often the patient/client's goal is quite different to what health providers would expect, however the value of addressing the biggest problems first (be it financial, housing, social, emotional or health) is in facilitating motivation and ownership. Often the complexity of their social, financial and personal situation is so overwhelming that their health concerns are a much lower priority.

Where can I find out more?

- The Partner's in Health Scale can be used by any health professional. The other tools mentioned, (Cue & Response and Problems & Goals) require a licence, which is received after completing the requirements for a Certificate of Competency including attendance at a two-day workshop. To find out when and where training workshops are available within the Auckland region contact:

	<p>ProCare Health practices life@procare.co.nz</p>
	<p>All areas - Health Navigator NZ www.healthnavigator.org.nz/centre-for-clinical-excellence/continuing-professional-development/flinders-programme</p>
	<p>Flinders Human Behaviour and Health Research Unit (FHBHRU) www.flinders.edu.au/medicine/sites/fhbhru</p> <p>The 'Flinders Model' of Chronic Condition Self-Management www.flinders.edu.au/medicine/sites/fhbhru/self-management.cfm</p>
	<p>All areas Healthmatters www.healthmatters.co.nz/</p>

Flinders training is also included in the University of Auckland's Long Term Conditions paper

References

For a fuller list, visit [FHBHRU Publications](#)

Lawn, S., Battersby, M., Harvey, P., Pols, R. & Auckland, A. (2009) *A behavioural therapy approach to self-managing chronic conditions: The Flinders Program*. *Diabetes Voice*, 54, 30-32. ([View article – pdf](#))

Battersby, M., Hoffmann, S., Cadilhac, D., Osborne, R., Lalor, E., & Lindley, R. (2009). "Getting your life back on track after stroke" *A Phase 2 Multi Centred, Single Blind, Randomised Controlled Trial (RCT) of the Stroke Self-Management Program (SSMP) Vs the Stanford Chronic Condition Self Management Program (CCSMP) or Standard Care in Stroke Survivors*. *International Journal of Stroke*, 4(2) 137-44. ([View abstract](#))

Battersby, M. W., J. Ah Kit, C. Prideaux, P. W. Harvey, J. P. Collins and P. D. Mills (2008). "Implementing the Flinders Model of self-management support with Aboriginal people who have diabetes: findings from a pilot study." *Australian Journal of Primary Health* 14(1): 66-74. ([View abstract](#))

Battersby, M., P. Harvey, P. D. Mills, E. Kalucy, R. G. Pols, P. A. Frith, P. McDonald, A. Esterman, G. Tsourtos, R. Donato, R. Pearce and C. McGowan (2007). "SA HealthPlus: a controlled trial of a statewide application of a generic model of chronic illness care." *Milbank Quarterly* 85(1): 37-67. ([View abstract](#))

Roy, D. E., Mahony, F., Horsburgh, M. and Bycroft, J. (2011), Partnering in primary care in New Zealand: clients' and nurses' experience of the Flinders Program™ in the management of long-term conditions. *Journal of Nursing and Healthcare of Chronic Illness*, 3: 140–149. ([View abstract](#))

Advance Care Planning

“Because of illness or an accident, most patients will be unable to make their own decisions at some time in their life” – Annals of Internal Medicine.

What is it?

An Advance Care Plan (ACP) is a record of a person’s wishes and decisions regarding future treatment preferences for a number of situations or conditions. Individuals should complete an ACP after discussion with whānau/family members and in collaboration with a trusted healthcare provider. This will ensure that those representing the person know of their wishes and have the document to support their decision-making in this process.

Advance Care Planning is designed to facilitate reflection and discussion of what is important to an individual. This includes:

- Level of intervention and treatments they wish to receive, such as cardio-pulmonary resuscitation, ventilation, feeding tubes, dialysis and number of chemotherapy cycles
- Organ donation wishes
- Funeral wishes and practical advice



Advance Care Planning has been recognised as an important issue and included in the 2011/12 regional health plan. Most clinicians are still relatively unfamiliar with advance care planning so a comprehensive project to provide clinicians with templates, toolkits, and training is underway. The aim is to more consistently provide patients and whānau with the opportunity to discuss and make informed choices surrounding future care.

Resources

	<p>Advance Care Planning – NZ Resources and information being developed for metro Auckland and NZ.</p> <ul style="list-style-type: none"> • Advance care planning guide • Advance care planning Leaflet • Making the most of your final years leaflet • My advance care plan form <p>Website: http://www.advancecareplanning.org.nz/</p>
<p>National ACP Cooperative</p>	<p>National ACP Cooperative & Micro site A national ACP cooperative was established in 2010 and is coordinating work streams across the country with relation to ACP. Areas of focus include clinical tools and resources, workforce development and training options, communication and public relations.</p> <p>A microsite is available. To access, email: acpcoop@adhb.govt.nz</p>
<p>The Royal Australian Collage of General Practitioners</p>	<p>Guidelines for Advance Care Plans Excellent, informative website on Advance Care Planning with range of resources & guidelines from different Australian states (download) www.racgp.org.au/guidelines/advancecareplans</p>

References

Advance Care Planning for Adults: An overview. Ministry of Health and Hospice New Zealand ([View online](#))

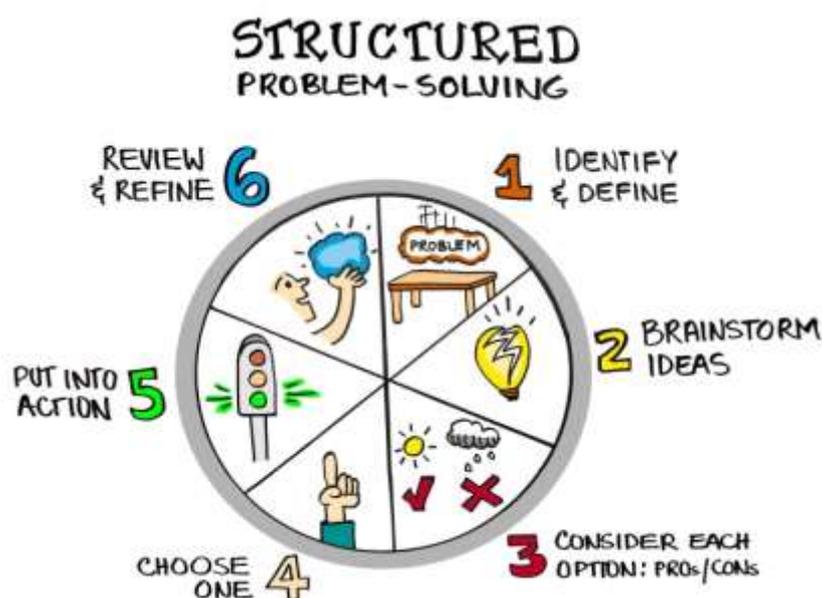
Structured Problem Solving

Structured problem solving is an evidence-based approach, widely used in psychological therapy, which involves a structured approach for helping patients who are overwhelmed by problems to identify, and systematically evaluate realistic solutions.

As described by Blashki and colleagues, structured problem solving is a collaborative approach between the health practitioner and the patient, specific problems are identified and possible solutions are generated and evaluated through a series of short steps. Worksheets are often used to guide people through these steps. Patients/clients benefit not only from dealing better with their current problems, but also learn better problem solving skills to assist them with future issues.

Common problems managed with structured problem solving:

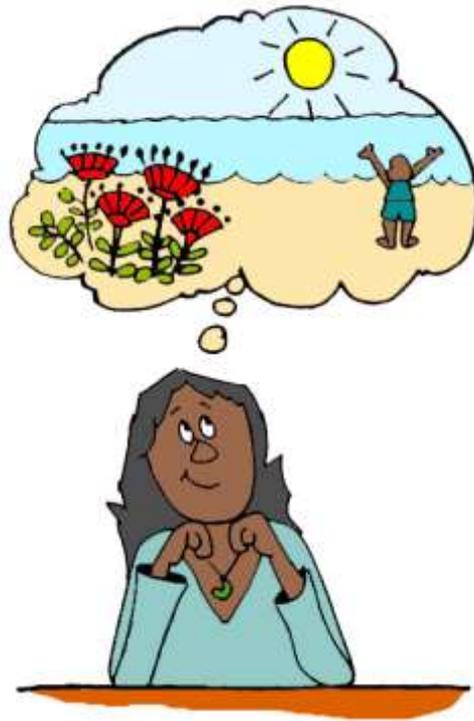
- Relationship problems or problems with children
- Unemployment or change of job/occupation
- Housing problems
- Sexual problems
- Isolation from friends
- Problems with studying
- Drug and alcohol problems



Useful Worksheets and References

1. Worksheet – a one page worksheet is also available in the appendices section.
2. **6 Step Problem Solving** – 10 pages, easy to read –Downloadable from following link.
www.med.umich.edu/painresearch/patients/Problem%20Solving.pdf
3. **Wellness Module 4: Problem Solving** from BC Partners for Mental Health and Addictions Information “Here to Help” website.
http://www.heretohelp.bc.ca/sites/default/files/WellnessMod4_ProblemSolving.pdf

Structured problem solving in general practice – Blashki G, et al. Australian Family Physician Vol 32, No.10, October 2003 www.racgp.org.au/afp/200310/20031001blashki.pdf



© Reflection Graphics 8

Ask – Tell – Ask

Ask Tell Ask

Ask-Tell-Ask” is a back-and-forth cycle between the patient and health professional that addresses four essential components:

- the patient’s perspective
- information that needs to be delivered
- response to the patient’s needs
- recommendations/relevant information from the health professional.

The strategy provides a structure for the health professional to tailor information to the patient's needs by:

- 1) **asking** the patient what he or she already knows or wants to know about his or her illness,
- 2) **telling** the patient what he or she needs to know and
- 3) **asking** or ascertaining whether the patient understands the information or has additional questions.

The first step allows the health professional to assess the patient's understanding of his or her condition and its treatment. The health professional then responds by providing focused and tailored information relevant to the patient's issues regarding his or her health. A further question such as “what else would you like to know about?” helps keep the patients engaged in the discussion and build on their knowledge.

The discussion should end with **Teach Back** to help assess the patient's response to, and understanding of, the information just received and keep the patient involved in the conversation.

Teach Back Method – Closing the Loop

- Studies have shown that 40-80 percent of the medical information patients receive is forgotten immediately and nearly half of the information retained is incorrect.
- One of the easiest ways to close the gap of communication between clinician and patient is to employ the “teach-back” method, also known as the “show-me” method or “closing the loop.”
- It is the health care provider’s responsibility, not the patient’s, to communicate information in a clear and understandable manner. The Teach-Back method is a way to confirm that you have explained to the patient what they need to know in a manner that the patient understands.
- Patient understanding is confirmed when they explain it back to you. It can also help the clinic staff members identify explanations and communication strategies that are most commonly understood by patients. (North Carolina Health Literacy Toolkit)

The teach-back technique

- Do not ask a patient, “Do you understand?”
- Instead, ask patients to explain or demonstrate how they will undertake a recommended treatment or intervention.
- If the patient does not explain correctly, assume that you have not provided adequate teaching. Re-teach the information using alternate approaches.

(From <http://www.aspiruslibrary.org/literacy/Teach.pdf>)

Example

In Other Words...Confirming Understanding With the Teach-Back Technique

Many providers begin with statements such as, **“I want to make sure I explained this clearly. When you go home today, what will you tell your [friend or family member] about [key point just discussed]?”** If patients cannot restate your instructions correctly, then explain again by drawing pictures or using simpler words.

Use the teach-back again and repeat this process until you confirm that the key message is correctly understood. If you know you explained this well but after two or three tries the patient still does not “get it,” then look for other explanations (beyond your teaching) about why the message was not understood.

(From Helen Osborne <http://www.healthliteracy.com/article.asp?PageID=6714>)

Resources



The Teach-Back Method – Tool 5

An excellent tool from the Health Literacy Universal Precautions Toolkit, Agency for Healthcare Research and Quality.

Download from <http://www.nchealthliteracy.org/toolkit/tool5.pdf>

Other useful tools include:

- [Brown Bag Medication Review](#)
- [Telephone Considerations](#)
- [Improve Medication Adherence and Accuracy](#)

Chapter 6: Implementing self-management

A brief guide to getting started with implementing self-management support within your practice, service or organisation.

(Click on headings below to go straight to page)

1	<u>Getting started</u>
2	<u>Core workforce skills</u>
3	<u>Resources for implementing self-management support</u>
4	<u>Teamwork</u>
5	<u>PDSA cycles</u>
6	<u>Transform your organisation</u>
7	<u>Quality improvement resources</u>
8	<u>High performing systems</u>



6.1: Getting started – the case for change

Key drivers for change

Alleviating the burden of long term conditions has been on the New Zealand health system's agenda for many years. A national study (ABCC)⁸ published in early 2010 identified poor performance by most District Health Boards in New Zealand in the increasingly expensive domain of long term conditions. 70-80% of all healthcare spending goes to long term conditions and the prevalence rates of conditions such as diabetes, COPD and other lifestyle related diseases continue to rise. This growing threat to the viability of the healthcare system urgently requires sustainable interventions and new models of care.

There is good evidence that supporting people to self-manage their long term conditions can improve their motivation to look after their health and change the way they use health services. A number of factors at a micro, meso and macro level influence a person's ability to self-manage. These are nicely summarised by Hinder and Greenhalgh⁹:

“At the micro level, self-management depends crucially on individuals' dispositions and capabilities, and will have relatively little purchase in those with low health literacy and other relevant capabilities. At the meso level, self-management depends on key roles, relationships and material conditions within the family and also on the presence of a supportive infrastructure in the workplace, school and healthcare organisation. And at the macro level, self-management is likely to be influenced by prevailing economic conditions, cultural norms and expectations, and the underpinning logic of the healthcare system (e.g. the extent to which support for self-care is an expected and adequately remunerated aspect of the service).”

Additionally there are multiple pressures on our health system, including: population, work environment and societal factors. These are illustrated in the following diagram.



⁸ http://dhbrf.hrc.govt.nz/media/documents_abcc/ABCC_Study_NZ_Literature_Review_2011.pdf

⁹ "This does my head in". Ethnographic study of self-management by people with diabetes
Susan Hinder and Trisha Greenhalgh, London E1 2AB, UK <http://www.biomedcentral.com/1472-6963/12/83>

As our understanding grows of the impact of broader determinants of health on the burden of disease, so does our thinking around models of care, workforce skill and profile, funding streams resources and approaches. In New Zealand the Whanau Ora Collectives are working across organisations and government departments with the aim of the integrating health, education and social services and improving outcomes and results for New Zealand families/whānau. In Canada the Expanded Chronic Care model was developed in part in recognition of the need to address these broader determinants of health as part of the health systems response to long-term condition management.

Expanded Chronic Care Model



Created by: Victoria Barr, Sylvia Robleson, Brenda Marks-Liak, Lisa Uederick, Anita Dotts & Darlene Reynolds (2002)
 Adapted from Glasgow, R., Orleans, C., Wagner, E., Curry, S., Solberg, L. (2001). Does the Chronic Care Model also serve as a template for improving prevention? *The Milbank Quarterly*, 79(4), and World Health Organization, Health and Welfare Canada and Canadian Public Health Association. (1986). *Ottawa Charter of Health Promotion*.

This figure shows the **Expanded Chronic Care Model**, a Canadian adaption of the Chronic Care Model developed by Barr and colleagues. Inclusion of the five health promotion strands from the Ottawa Charter has been a popular adaptation. ([View abstract](#)) Benefits of applying the Chronic Care Model or one of its variants include the strong evidence base demonstrating usability, scalability, adaptability and effectiveness for a wide range of long-term conditions and health care settings or organisations.

There are dozens of implementation guides and resources. (Some are highlighted in the next few pages) Pick one or use some of the tools below to help you and your team move towards systematically focusing on self-management support for every patient at every encounter and **become a prepared, proactive team**.

The bottom line from using the chronic care model is healthier patients, more satisfied providers and cost savings. MacColl Institute, 2011

6.2: Core workforce skills

Ensuring your team (whether you work in the community or a hospital) has the right training and resources is essential for implementing or adopting any new approach, quality improvement initiative or system efficiency.

A comprehensive needs assessment, audit, consultation process and curriculum review in Australia identified three groups of core skills and capabilities that are needed for the primary healthcare workforce to develop for effective chronic disease self-management.

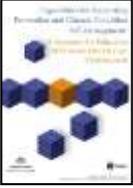
Core skills and capabilities for the primary healthcare workforce

General Patient-Centred	Behaviour Change	Organisational/systems
Health promotion approaches	Models of health behaviour change	Working in multidisciplinary teams/interprofessional learning and practice
Assessment of health risk factors	Motivational interviewing	Information, assessment and communication management systems
Communication skills	Collaborative problem definition	Organisational change techniques
Assessment of self-management capacity (understanding strengths and barriers)	Goal setting and goal achievement	Evidence-based knowledge
Collaborative care planning	Structured problem solving and action planning	Conducting practice based research/quality improvement framework
Use of peer support		Awareness of community resources
Cultural awareness		
Psychosocial assessment and support skills		

Table from: *Capabilities for supporting Prevention and Chronic Condition Self-Management: A Resource for Educators of Primary Health Care Professionals*

Suggestion: Do a baseline assessment using the online version of the Primary Care Resources and Support for Chronic Disease Self-Management Assessment (PCRS) tool to check where you and your team are at and GPs can earn Continual Quality Improvement Points (CQI). Repeat in 6-12 months and earn another 10 CQI points!

Resources

	<p>Capabilities for supporting Prevention and Chronic Condition Self-Management: A Resource for Educators of Primary Health Care Professionals Flinders University for Department of Health & Ageing. Download the pdf from: www.flinders.edu.au/medicine/fms/sites/FHBHRU/documents/publications/Capabilities%20Self-Management%20Resource.pdf</p>
 <p>Earn CQI MOPS Points! (for GPs)</p>	<p>Primary Care Resources and Support for Chronic Disease and Self-Management An excellent resource providing an interactive version of the PCRS tool for teams to assess and build capacity for self-management support and monitor progress toward improvement. http://improveselfmanagement.org/index.aspx</p>

6.3: Resources for Implementing Self-Management & Person Centred Care

Over recent years there has been significant development in tools and resources to support self-management and person-centred care. Here are some resource centres to help you get started.

	<p>Institute for Healthcare Improvement – Self Management Toolkit Range of tools for use in clinical practice including a clinician's toolkit. www.ihl.org/resources/Pages/Tools/SelfManagementToolkitforClinicians.aspx</p>
	<p>Person Centred Care Resource Centre Extensive range of resources on this website. http://personcentredcare.health.org.uk/</p>
	<p>MacColl Institute – Improving Chronic Care Another group with extensive range of tools and resources for improving quality and service delivery. http://www.improvingchroniccare.org/index.php?p=Practice_Change&s=3</p>
	<p>Navigating Self-Management (AUS) Whitehorse Division of General Practice in Australia (2008) An excellent guide to the area of self-management and chronic care with a large range of resources, tools and information to support organisations with planning, implementation and evaluation of clinical programmes. To download the pdf click here: www.flinders.edu.au/medicine/fms/sites/FHBHRU/documents/publications/Navigating_self_management%20March%202008.pdf</p>
	<p>Helping Patients Help Themselves: How to Implement Self-Management Support Tom Bodenheimer and Sharone Abramowitz, California Healthcare Foundation This report explores ways that primary care organisations are making self-management support a routine function of clinical care for patients with chronic illness in the USA. To download the report visit: www.chcf.org/resources/download.aspx?id=%7b64D7E9F4-17BA-45A1-9325-73650BC96076%7d</p>

6.4: Teamwork

“Patients reap the benefits of more eyes and ears, the insights of different bodies of knowledge, and a wider range of skills. Thus team care has generally been embraced by most as a criterion for high quality care.”

- Ed Wagner, BMJ, February 2000

As Ed Wagner¹⁰ has eloquently described “*the traditional image of a solitary family doctor —concerned, vigilant, thoughtful—seated at the bedside of a desperately ill child ...bears little resemblance to modern medicine, and not just because house calls are a thing of the past. Modern medical care involves complex, rapidly changing interventions and treatment plans, and the activities of multiple people, disciplines, and institutions.*”

Research has clearly demonstrated that **one of the key enablers of safer, more effective medical care is teamwork**. Studies have also shown that simply working together in a clinic for a number of years does not automatically ensure that the group functions as an effective team.

Characteristics of High Functioning Teams

The [Australian Primary Care Collaborative Programme](#) has shown that successful practice teams demonstrate four key characteristics:

1. They are clear about their role, and they have an agreed strategy on how to run the practice
2. They have enough information, skills and experience to do the job
3. They have constructive group dynamics that create and maintain effective and efficient levels of communication
4. Members of the team are committed to the practice and to producing high quality, responsive patient care.

Effective Teams – Structure ¹¹	Effective Teams – Processes ¹³
<ul style="list-style-type: none"> • Small, manageable number of members • Appropriate mix of skills and expertise • Measurable performance goals and specific tasks • Clear roles • Suitable leadership (person with most expertise) • Good communication structures • Collective responsibility for achieving goals • Adequate resources – financial, training, administration, technical 	<ul style="list-style-type: none"> • Share clear purpose and objectives* (*Strongest predictor of team effectiveness) • Regular communication, problem-solving • High level of participation in team • Emphasis on quality • Support for innovation • Clear leadership (incl. lack of conflict about leadership)

¹⁰ Wagner, EH. (2004) Effective teamwork and quality of care. Medical Care. 42(11):1037-9..

¹¹ Zwar NA, et al. Do multidisciplinary care plans result in better care for type 2 diabetes? Australian Family Physician. 2007; 36: 85-9

Research demonstrates that “effective teamwork in general practice encompasses general practitioners (GP), clinical and non-clinical staff, each with clearly defined roles and opportunities to provide feedback and input into how the practice is run and chronic disease managed.”¹²

Facilitators of teamwork

Factors identified as facilitators of teamwork in an Australian study include:

- Greater understanding of benefits (patient outcomes)
- Systemic changes (IT, protocols & processes, communication)
- Use of funding streams for chronic disease management (including nurse care)
- Greater role clarity
- Clinical benchmarking
- A designated leader in the practice
- Different models
- GP champions & case studies of success
- Support from Divisions (similar to Primary Health Organisations) & professional colleges
- Involvement of Divisions with smaller practices (e.g. contract PN)
- More physical space

Key Messages

The following are some useful key messages identified by a large Canadian review:¹³

- A healthcare system that supports **effective teamwork can improve the quality of patient care**, enhance **patient safety** and **reduce workload issues** that cause burnout among healthcare professionals.
- Teams work most effectively when they have a **clear purpose; good communication; co-ordination**; protocols and procedures; and effective mechanisms to resolve conflict when it arises. The **active participation of all members** is another key feature.
- Successful teams **recognize the professional and personal contributions of all members**; promote individual development and team interdependence; recognize the benefits of working together; and **see accountability as a collective responsibility**
- The **make-up and functioning of teams varies** depending on the needs of the patient. The complexity of the health issue defines the task. The more interdependency needed to serve the patient, the greater the need for collaboration among team members.
- **Patients and their families are important team members** with an important role in decision-making. To enable patients to participate effectively, they need to learn about how to participate in the team; how to obtain information about their condition; and how each healthcare professional will contribute to their care.
- **Teams function differently depending on where they operate.** Teams in hospitals have clearly defined protocols and procedures, professional hierarchies, and shared institutional goals, while teams in community-based primary care practices face challenges related to the role-blurring in community settings.

¹² Taggart J., Schwartz A., Harris M.F., et al. (2009) Facilitating teamwork in general practice: moving from theory to practice. *Australian Journal of Primary Health* **15**, 24–28.

¹³ Teamwork in Healthcare: Promoting Effective Teamwork in Healthcare in Canada – Policy synthesis and recommendations. Canadian Health Services Research Foundation. 2006. http://www.chsrf.ca/Migrated/PDF/teamwork-synthesis-report_e.pdf

- This wide variety of settings and tasks means that transferability of processes is not always straightforward. It also highlights the **need for a common definition of “team.”**
- Teamwork is **influenced by organizational culture**. A clear organizational philosophy on the importance of teamwork can promote collaboration by encouraging new ways of working together; the development of common goals; and mechanisms to overcome resistance to change and turf wars about scopes of practice.
- **Teams need training** to learn how to work together and understand the professional role/responsibility of each member. They also require an effective administrative structure and leadership.
- The **larger policy context can promote teamwork** by providing consistent government policies and approaches; health human resource planning; legislative frameworks to break down silos; and models of funding/remuneration that encourage collaboration.
- **Successful team interventions** are often embedded in initiatives working to improve quality of care through better co-ordination of healthcare services and the effective utilization of health resources with a focus on the determinants of health

Additional Team Members

A number of successful teams have found expanding their team to include new roles is beneficial. Examples include inclusion of nurse practitioners, healthcare assistants, information system staff and other allied health professionals for general practice teams and specialist teams.

References

Pullon, S. McKinlay E, et al. 2011. Patients’ and health professionals’ perceptions of teamwork in primary care. Journal Prim HCare, Vol 3, No.2

<http://www.rnzcgp.org.nz/assets/documents/Publications/JPHC/June-2011/JPHCOSPPullonJune2011.pdf>

Wagner EH. (2000) The role of patient care teams in chronic disease management. BMJ. 320, 569-572

Harris, M. Transforming health systems –teamwork as a focus for integration and system redesign. Presentation at the Australasian Long-term Conditions Conference, April 2011

<http://www.healthnavigator.org.nz/wp-content/uploads/2011/04/Mark-Harris-Transforming-health-systems.pdf>



Effective teamwork and collaboration - <http://youtu.be/NsndhCQ5hRY>

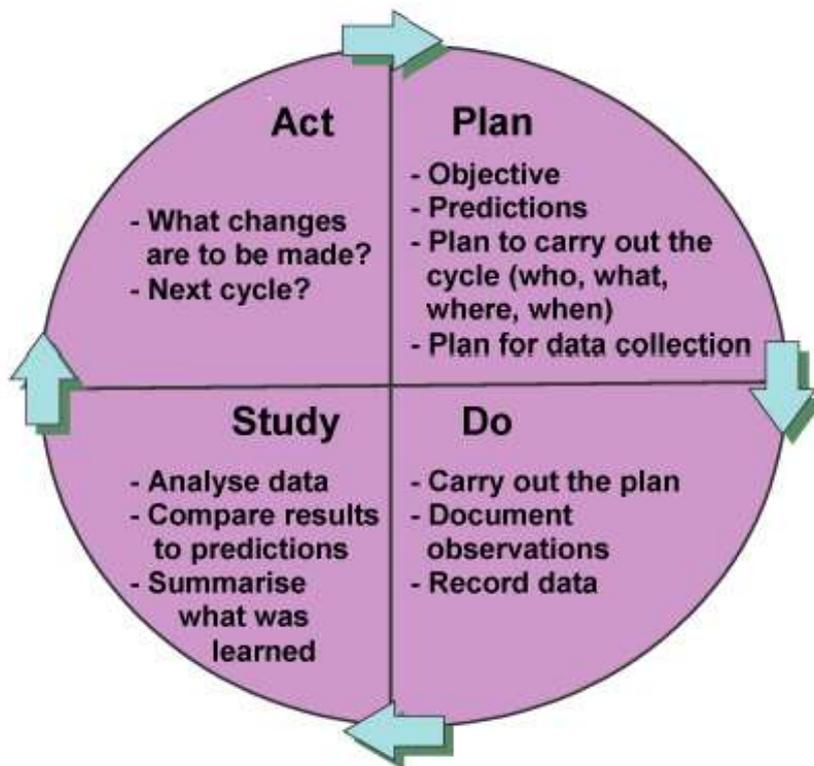


6.5: PDSA Cycles

The Plan, Do, Study, Act (PDSA) cycle is a method for rapidly testing a change - by planning it, trying it, observing the results, and acting on what is learned. This is a scientific method used for action-oriented learning across multiple sectors such as engineering, business, health and education. After changes are thoroughly tested, PDSA cycles can be used to implement or spread change.

The key principle behind the PDSA cycle is to test on a small scale and test quickly. The PDSA philosophy is to design a small test with limited impact that can be conducted quickly to work out unanticipated “bugs”. Repeated rapid small tests and the learning’s gleaned build a process ready for implementation that is far more likely to succeed.

The PDSA Cycle for Improvement



Tools: A PDSA Template is available in the [appendices](#) for you to print off and use.

Plan

Define your objectives and make predictions about what will happen, and why it will happen. Get your team to answer the following questions:

- What exactly will you do?
- Who will carry out the plan?
- When will it take place?
- Where?
- What data/information will you collect to know whether there is an improvement?

Tip: Make your goals SMART: Specific, Measureable, Action-based Realistic and Time-based.

Do

Carry out the plan and collect the data. This will include documenting experiences, problems, and surprises that occur during this test cycle.

Study

Analyse the test cycle and reflect on what you have learned. Compare results with the predictions made in the planning stage, and draw conclusions based on the collected data.

Act

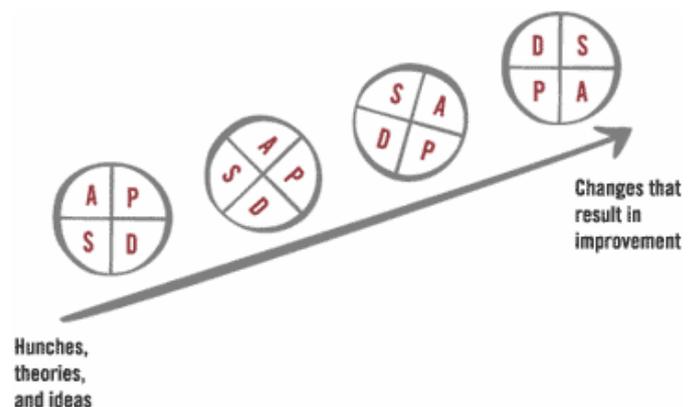
Decide if there are any refinements or modifications needed to the change you have tried. This may lead to additional test cycles, which starts the process all over again with *Plan*.

Linking PDSA Cycles and Tests of Change

Testing changes is an ongoing process: the completion of each PDSA cycle leads directly into the start of the next cycle.

A team learns from the test: What worked and what didn't work? What should be kept, changed, or abandoned? This new knowledge is used to plan the next test. The team continues linking tests in this way, refining the change until it is ready for broader implementation within the practice.

People are far more willing to test a change when they know that changes can and will be modified as needed. Linking small tests of change helps overcome an organisation's natural resistance to change and ensures team buy-in.



Source: Institute of Healthcare Improvement

Resources

Read more and view examples of PDSA cycles at:

1. [Long-Term Conditions Collaborative website](#) and [Better Diabetes Care](#)
2. <http://chroniccondition.ranzcp.org/module-5/plandocheckact-pdca>
3. How hot are your [PDSA Improvement Action Plans?](#)
4. A [Model for accelerating improvement](#)

6.6: Transform your organisation

For any team or organisation wishing to make significant improvements to their service, quality of care or efficiency and effectiveness, the following eight steps identified by Kotter are valuable. These eight steps have been recognised internationally as key stages, irrespective of the industry or sector for successful change management.

1. Establish a Sense of Urgency

- Examine market and competitive realities
- Identify and discuss crises, potential crises, or major opportunities

2. Form a Powerful Guiding Coalition

- Assemble a group with enough power to lead the change effort
- Encourage the group to work as a team

3. Create a Vision

- Create a vision to help direct the change effort
- Develop strategies for achieving that vision

4. Communicate the Vision

- Use every vehicle possible to communicate the new vision and strategies
- Teach new behaviours by the example of the guiding coalition

5. Empower Others to Act on the Vision

- Get rid of obstacles to change
- Change systems or structures that seriously undermine the vision
- Encourage risk-taking and non-traditional ideas, activities, and actions

6. Plan for and Create Short-Term Wins

- Plan for visible performance improvements
- Create those improvements
- Recognize and reward employees involved in the improvements

7. Consolidate Improvements and Produce Still More Change

- Use increased credibility to change systems, structures, and policies that don't fit the vision
- Hire, promote, and develop employees who can implement the vision
- Reinvigorate the process with new projects, themes, and change agents

8. Institutionalize New Approaches

- Articulate the connections between the new behaviours and organizational success
- Develop the means to ensure leadership development and succession

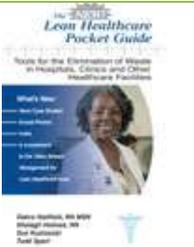
Source: Kotter, John P. "Winning at Change" *Leader to Leader*. 10 (Fall 1998): 27-33.

6.7: Quality improvement resources

New Zealand

	<p>Health Service Co-design: Working with patients to improve services Hilary Boyd, Stephen McKernon & Andrew Old, Waitemata DHB, 2010</p> <p>This guide is designed to help staff work with patients to understand their experiences and make improvements to healthcare services. It includes examples, practical tips, and range a flexible tools.</p> <p>www.healthcodesign.org.nz</p>
	<p>Health Improvement and Innovation Resource Centre (HIIRC) Sponsored by the Ministry of Health the HIIRC website has been developed to support performance and quality improvement efforts.</p> <p>www.hiirc.org.nz</p>
	<p>Health Equity Assessment Tool (HEAT) A planning tool that enables rapid assessment of health initiatives for their current or future impact on health equity.</p> <p>Download the pdf here: http://www.health.govt.nz/publication/health-equity-assessment-tool-users-guide</p>

Worldwide

	<p>Institute for Healthcare Improvement (IHI) A USA not-for profit organisation regarded as one of the world leaders in healthcare improvement.</p> <p>www.ihl.org</p>
	<p>The New Lean Healthcare Pocket Guide: Tools for the elimination of waste in hospitals, clinics and other healthcare facilities Hadfield. D, Holmes. S, Kozlowski. S, Sperl. T & Tapping. D. Education for Lean Healthcare institute (ELHI)</p> <p>This, and a range of other useful books and products, is available for purchase from: http://www.theleanstore.com/lean-products/healthcare/</p>
	<p>The Experience Based Design Approach: Using patient and staff experience to design better healthcare services NHS Institute for Innovation and Improvement, 2009</p> <p>This guide gives and introduction to the experience based design approach and is supported by tools and templates on the following website: www.institute.nhs.uk/ebd</p>
	<p>NHS Quality and Service Improvement Tools An online library, which can be accessed here; www.institute.nhs.uk/option.com_quality_and_service_improvement_tools/Itemid,5015.html</p>

6.8: High performing systems

For any organisation interested in improving their performance, a review by Ham et al identified the following 10 characteristics of high performing chronic care systems.

1. Ensure universal coverage	The first and arguably most important characteristic of the high-performing chronic care system is ' ensuring universal coverage '.
2. Reduce financial barriers	Reduce financial barriers – either care that is free at the point of use', or "at least care that is provided at a cost that does not act as a major deterrent to sick patients seeking medical help."
3. Stronger focus on prevention	Delivery systems should focus on the prevention of ill health' and not just the treatment of sickness. High performing systems use population health approaches and wider healthcare teams to also target medical support at individuals at high risk of chronic disease.
4. Increased self-management support	"The fourth characteristic is that 'priority is given to patients to self-manage their conditions with support from carers and families'. As Sobel shows, self-management support is critical because most care is and always has been self-care, and a small reduction in the propensity of people to self-care and manage effectively at home will result in a significant and potentially insupportable increase in demand for organised care services (Sobel, 1995).
5. Priority is given to primary health care	"This characteristic derives from evidence on the contribution that primary care makes to overall system performance (Starfield <i>et al.</i> , 2005), and to the everyday reality that most chronic disease management takes place in primary care in most health care systems." (Ham, 2010)
6. Population health management	For example, use of risk stratification tools, measurement, audit and disease registries.
7. Integrated delivery systems	Integrated delivery systems with primary health care teams being able to access specialist advice and support when needed as people's health needs typically fluctuate.
8. Use of information technology to support chronic care	"Information technology underpins effective population management in enabling primary health care teams to develop disease registers and to stratify the population according to risk. In some applications, it also supports patient self-management through easing communication between patients and health care professionals and facilitating shared decision-making." (Ham, 2010)
9. Care is effectively coordinated	"Coordination is particularly important in the care of people with multiple conditions who are at much greater risk of hospital admission than people with single diseases (Wolff <i>et al.</i> , 2002). The role of primary care physicians in providing coordination has been emphasised in a number of studies (Starfield <i>et al.</i> , 2003). Also important are patient activation through coaching interventions and support by key staff such as specialist nurses for transition care.
10. Linking these nine characteristics into a coherent whole	"... link these nine characteristics into a coherent whole as part of a strategic approach to change '. This is important in view of evidence that it is the <i>cumulative</i> effect of different elements that explains the degree of impact of the Chronic Care Model rather than individual components." (Ham 2010)

Ham, C (2010). The ten characteristics of the high-performing chronic care system. *Health Economics, Policy and Law*, 5, pp 71-90

Appendices: Additional Tools & Resources

1	<u>Goal-setting & action planning template</u>
2	<u>Setting Goals - Health concerns of older adults</u>
3	<u>Structured problem solving worksheet</u>
4	<u>Partners in Health Scale</u>
5	<u>Self-Management Programme Referral Form</u>
6	<u>PDSA Template</u>

Goal Setting & Action Plan Template

Goals: Long-term goal: Where do I want to be with my health in the future?

Date:

If I have more than one long-term goal, which one do I want to focus on first?

How important is this to me? (circle number below)



How can I achieve this / what do I need to achieve this?

What would be the first step(s)?

Action Plan: What exactly am I going to do? How, what, when, where, how often?

What will get in the way?

How will I overcome this?

What support do I need?

How confident do I feel? (circle number below)



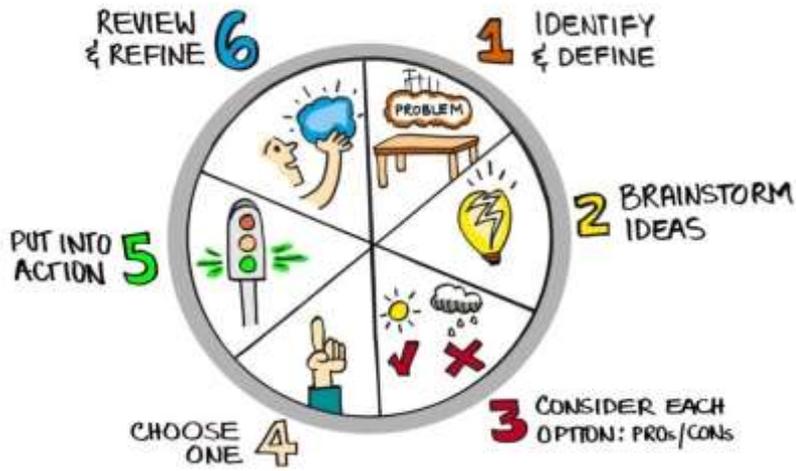
Setting Goals - Health Concerns of Older Adults

Here are some things older adults have told us they think about. Maybe some of these things concern you. You can also add any other concerns you may have in the empty bubbles. Would you like to talk today about the one that matters to you the most? Would you like to make a change in one of them?

The image contains several distinct shapes, each with a health concern or goal written inside:

- A rectangular box at the top center containing the text "Preventing falls" in green.
- A speech bubble at the top right, which is empty.
- A cloud-shaped thought bubble on the left containing the text "Independence" in blue.
- A star-shaped thought bubble in the center containing the text "I want to stop smoking" in purple.
- An oval-shaped thought bubble on the left containing the text "Manage my weight" in green.
- A rounded rectangular box in the center containing the text "My biggest concern is:" in red.
- A cloud-shaped thought bubble on the right containing the text "Improve my mood" in orange.
- A cloud-shaped thought bubble on the left containing the text "Reduce my pain" in blue.
- A speech bubble at the bottom right containing the text "Pay my bills" in red.
- A cloud-shaped thought bubble at the bottom center, which is empty.
- A speech bubble at the bottom left containing the text "Forgetting things" in purple.
- A rectangular box at the bottom right containing the text "Exercise & keeping active" in green.

Structured Problem Solving Worksheet



Step 1: Identify & define the problem

Step 2: Brainstorm ideas & possible solutions

.....

.....

Step 3: Consider each option

Idea	Pros	Cons
.....
.....
.....
.....

Step 4: Choose one

Step 5: Put into action

Step 6: Review & refine



Tip

Start with:

- How..?
- When..?
- Where..?
- What..?
- Describe..
- Tell me about..



Set a joint agenda

What would you like to cover today?

What would you like to know about?

What worries have you had since your last visit?

What else would you like to go over?



Explore health beliefs

What do you think about..?

What do you make of it..?

How does your situation make you feel?

Describe how you feel about...

Different people react differently to finding out about....how does it make you feel?



Tip

Ask yourself:

Who is doing most of the talking in this conversation?



Explore ambivalence -develop discrepancy

What is good about.....

- staying the same?
- making change?

What worries do you have about

- staying the same?
- making change?

What is the worst thing that could happen?

What is your vision for the future?



Set goals

What do you want to do?

When will you do it?

How often will you do it?

How important is it to you?

How confident do you feel about doing this?

Who /what can support you with this?





Solve problems

- What might help you to..?
- How else do you think you could handle it?
- What ideas do you have?
- What might you be overlooking?
- What are the pros and cons of doing that?
- How have you handled something like this before?



Tip

Ask yourself:
Who else needs to be part of this conversation?



Assess understanding

We have covered a lot today, it can be hard to remember everything, can you tell me the key points we have discussed?

To make sure I have explained things clearly, can you tell me what you will say to your family about your visit when you go home?

Can you show me how you will ...



Tip

Remember, the argument for change comes from the person not from you.



Follow-up on goals

- How has it gone?
- Tell me about.....
 - what went well.
 - what is getting in the way.
- What will make you more confident?
- What have you done to reward your success?
- What else can I do to support you?



Tip

Remember, pause and allow the person time to think.



Services Directory

Diabetes Self-Management Courses

Area	Programme	Contact
Central Auckland	Type 2 Diabetes - ADHB regional service for Diabetes SME <ul style="list-style-type: none"> ➤ http://www.tehononga.org.nz/diabetes-self-education.aspx 	Phone: 09 973 0789 Fax standard referral letter to 09 973 0789 Email: dsme@tehononga.org.nz
	<ul style="list-style-type: none"> • Diabetes Stanford Programme 	ProCare: Ph: 09 3746815 Email: life@procare.co.nz
	<ul style="list-style-type: none"> • Diabetes Auckland - Living Well Programme 	Diabetes Auckland
	<ul style="list-style-type: none"> • Type 1 Diabetes - Youth Programme ADHB 	Contact ADHB Diabetes Centre
South Auckland Counties Manukau Health	East Health PHO Group Diabetes SME Programme	David Harrison DDI: 538 0446 davidh@easthealth.co.nz Parvin Kapila parvink@easthealth.co.nz Electronic referral using advanced forms in Medtech
	Procare PHO Diabetes Stanford Programme	ProCare: Ph: 09 3746815 Email: life@procare.co.nz Referral through local general practice or PHO
	Alliance Health + Group SME in some practices and via Parish Nurses	Mesepa Channing mesepac@alliancehealth.org.nz (09) 588 4299
	Whitoria Clinic at Counties Manukau DHB – range of diabetes programmes for Type 1, youth, Type 2, weight loss etc.	Manukau, Botany, Mangere, Pukekohe Ph: 09 277 1613 (Manukau) Ph: 09 277 1660 (Botany) www.healthpoint.co.nz/default,19961.sm
West Auckland	HealthWest Diabetes EPIC Programme	HealthWest
North Shore	<ul style="list-style-type: none"> • Diabetes SME Programme 	Check with your PHO or DHB
	<ul style="list-style-type: none"> • Type 1 Diabetes – DAPHNE Course 	Waitemata DHB Diabetes Service

Diabetes Projects Trust group programmes: <http://www.dpt.org.nz/our-programmes>

- **Diabetes and Prevention Train the Trainer** This free programme helps health professionals and others working with individuals or groups at risk of diabetes to hone their prevention and management skills. Th ...
[Read More »](#)
- **The Diabetes Projects Trust Cook'n'Kiwi programme** helps those who work with communities and individuals who are at risk of lifestyle related health problems to provide the latest and most practical advice and support to ...
[Read More »](#)
- **Gardens4Health** provides free, practical advice and support to community groups, organisations, workplaces and schools for the setting up of new community gardens and ongoing maintenance of existing gardens. The Gardens4H ...
[Read More »](#)

Mental Health

Primary Mental Health	Most PHOs offer a range of mental health therapy and programmes. Check with your local PHO.
Self-Management Skills Training	Stanford Self-Management Programme – very beneficial for virtually all patients with mental illness – see www.healthnavigator.org.nz/keeping-well/generic-self-management-course

Physical Activity Green Prescription

North Harbour	Carl Fenton Based at Harbour Sport PO Box 300-633 Albany, Auckland	P: 09 415 4611 F: 09 415 4594 M: 0272 413 409 grx@harboursport.co.nz www.harboursport.co.nz
Auckland City and Counties Manukau	Jacinta Harris Based at Sport Auckland PO Box 26599, Epsom, Auckland	P: 09 623 7927 F: 09 623 7950 M: 021 277 8485 jacintah@sportauckland.co.nz www.sportauckland.co.nz
Waitakere	Rocky Tahuri PO Box 104098, Lincoln North Auckland 0654	P 09 839 7494 F: 09 822 8040 rocky.tahuri@healthwest.co.nz
Other areas	http://www.health.govt.nz/your-health/healthy-living/food-and-physical-activity/green-prescriptions/green-prescription-contacts	

Group Self-Management Education Programmes

Area	Programme	PHO Contact
ADHB	ProCare PHO Living Improvements for Everyone (Stanford) Pain Self-Management Programme (Stanford)	Ph: 09 3746815 Email: life@procare.co.nz
ADHB	Alliance Health+ Stanford – Parish Nurses and some practices	Mesepa Channing mesejac@alliancehealth.org.nz (09) 588 4299
South Auckland Counties Manukau Health	ProCare PHO Stanford My Health, Our LIFE (MHOL) Stanford Pain Self-Management Programme	Ph: 09 3746815 Email: life@procare.co.nz
	Arthritis NZ Stanford Living a Healthy Life	Arthritis NZ
	East Health PHO Stanford Group Chronic Disease Self-Management Programme Group weight Management Programme Healthy Eating Healthy Action Lifestyles (HEALS) group prevention programme Smoking cessation groups	David Harrison DDI: 538 0446 davidh@easthealth.co.nz Parvin Kapila parvink@easthealth.co.nz
	National Hauora Coalition Whakamana Hauora Stanford Group Chronic Disease Self-Management Programme	Pauline Fitzgerald Paulinef@hauoracoalition.maori.nz
	Total Healthcare Charitable Trust Stanford Group Chronic Disease Self-Management Programme	Leona Didsbury leona@ethc.co.nz Tel: (-64-9) 274 7823 Mob: 027 48 19 014
North Shore	Procare PHO (Stanford) LIFE Programme	life@procare.co.nz
	Arthritis NZ (Stanford) Living a Healthy Life	Arthritis NZ
West Auckland	Procare PHO (Stanford) Living a Healthy Life	HealthWest & Arthritis NZ

Cardiac Services and Support

Auckland DHB area	<p>ACH Cardiac Rehabilitation Programme Cardiac Rehabilitation Nurse Specialists P (09) 307-4949 Locations & programmes - www.healthpoint.co.nz/default,37389.sm</p>
Counties Manukau Health	<p>Middlemore Cardiac Rehabilitation Programmes Katherine McLean for day, evening and ICD programmes Katherine.McLean@cmdhb.org.nz</p> <p>Lani loelu for Pacific programme Lani.Loelu@middlemore.co.nz</p> <p>Kylie Beehre for Pukekohe Kylie.Beehre@middlemore.co.nz</p>
Further information	<p>The Heart Foundation's Cardiac Community Online Directory links to a variety of heart support groups and services within New Zealand, with a focus on people living with heart disease and their families.</p>

Heart Failure

Auckland DHB Referrals	Heart Failure Service, Cardiology Department, Auckland City Hospital	E- referral Or fax: (09) 638-0402 Duty Heart Failure Nurse Specialist M: 021-748-355
Central Auckland	Dominion Rd, Mt Eden, Sandringham, Greenlane, Epsom, Ponsonby, Pt Chevalier	Heart Failure Nurse Specialist Nicky BProcareos M: 021-938-696
East Auckland	Glen Innes, Remuera, Meadowbank, Mt Wellington	Heart Failure Nurse Specialist Jane Hannah M: 021-938-903
Counties Manukau Health Referrals	Heart Failure Nurse Specialist	June Poole June.Poole@middlemore.co.nz

Procure Self-Management Education Enrolment & Referral

Referral to: Generic SME LIFE <input type="checkbox"/>	Diabetes (Stanford) <input type="checkbox"/>	Chronic Pain <input type="checkbox"/>	Flinders Assessment (by arrangement) <input type="checkbox"/>																				
Name: Address: Postal Code:		Phone: Mobile: Email:																					
Referral Date:	Ethnicity: (circle up to 3) <input type="checkbox"/> 21 NZ Māori <input type="checkbox"/> 11 NZ European <input type="checkbox"/> 12 Other European <input type="checkbox"/> 31 Samoan <input type="checkbox"/> 32 Cook Is Māori <input type="checkbox"/> 33 Tongan <input type="checkbox"/> 36 Fijian <input type="checkbox"/> 40 Asian <input type="checkbox"/> 37 Other Pacific Island <input type="checkbox"/> 42 Chinese <input type="checkbox"/> 41 South EastAsian <input type="checkbox"/> 43 Indian <input type="checkbox"/> 99 Not stated <input type="checkbox"/> Other		Patient consent/aware of referral: Yes <input type="checkbox"/> No <input type="checkbox"/>																				
Patient NHI:	Patient Date of Birth:		Gender: Male <input type="checkbox"/> Female <input type="checkbox"/>																				
Health Conditions <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">Arthritis <input type="checkbox"/></td> <td style="width: 25%;">Cancer <input type="checkbox"/></td> <td style="width: 25%;">Depression <input type="checkbox"/></td> <td style="width: 25%;">Gout <input type="checkbox"/></td> <td style="width: 25%;">Multiple Sclerosis <input type="checkbox"/></td> </tr> <tr> <td>Asthma <input type="checkbox"/></td> <td>Chronic Pain <input type="checkbox"/></td> <td>Diabetes <input type="checkbox"/></td> <td>Heart Disease <input type="checkbox"/></td> <td>Stroke <input type="checkbox"/></td> </tr> <tr> <td>Anxiety <input type="checkbox"/></td> <td>COPD <input type="checkbox"/></td> <td>Endometriosis <input type="checkbox"/></td> <td>Haemophilia <input type="checkbox"/></td> <td>SLE (Lupus) <input type="checkbox"/></td> </tr> <tr> <td colspan="2">Long Term Injury (Explain) <input type="checkbox"/></td> <td colspan="3">Other (Explain) <input type="checkbox"/></td> </tr> </table>				Arthritis <input type="checkbox"/>	Cancer <input type="checkbox"/>	Depression <input type="checkbox"/>	Gout <input type="checkbox"/>	Multiple Sclerosis <input type="checkbox"/>	Asthma <input type="checkbox"/>	Chronic Pain <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Heart Disease <input type="checkbox"/>	Stroke <input type="checkbox"/>	Anxiety <input type="checkbox"/>	COPD <input type="checkbox"/>	Endometriosis <input type="checkbox"/>	Haemophilia <input type="checkbox"/>	SLE (Lupus) <input type="checkbox"/>	Long Term Injury (Explain) <input type="checkbox"/>		Other (Explain) <input type="checkbox"/>		
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Are there any issues/problems that need to be considered for this person? (Please include language difficulties, transport issues, mental health etc)																							
Will whānau or family members be attending the group sessions with the patient? Yes <input type="checkbox"/> No <input type="checkbox"/>																							
Any other comments?																							
Course Preferred Day <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/>																							
GP name and practice:		Referred by: Signature:	Role: (e.g. GP, Nurse, Psychologist, etc)																				
<u>Please email, fax or post referral to</u> Attention: Self-Management Email: life@procare.co.nz Txt: 021 364 660 Phone: 021 364 660		ProCare Health PO Box 105 346 Auckland 1143 Phone: 09 374 6815 Fax: 09 377 7826	<u>Self-Management Team:</u> Gayle Sinclair Leona Didsbury Charlene Pretorius																				