“Te Tumu Waiora”
Increased Access and Choice of Primary Mental Health and Addiction Support

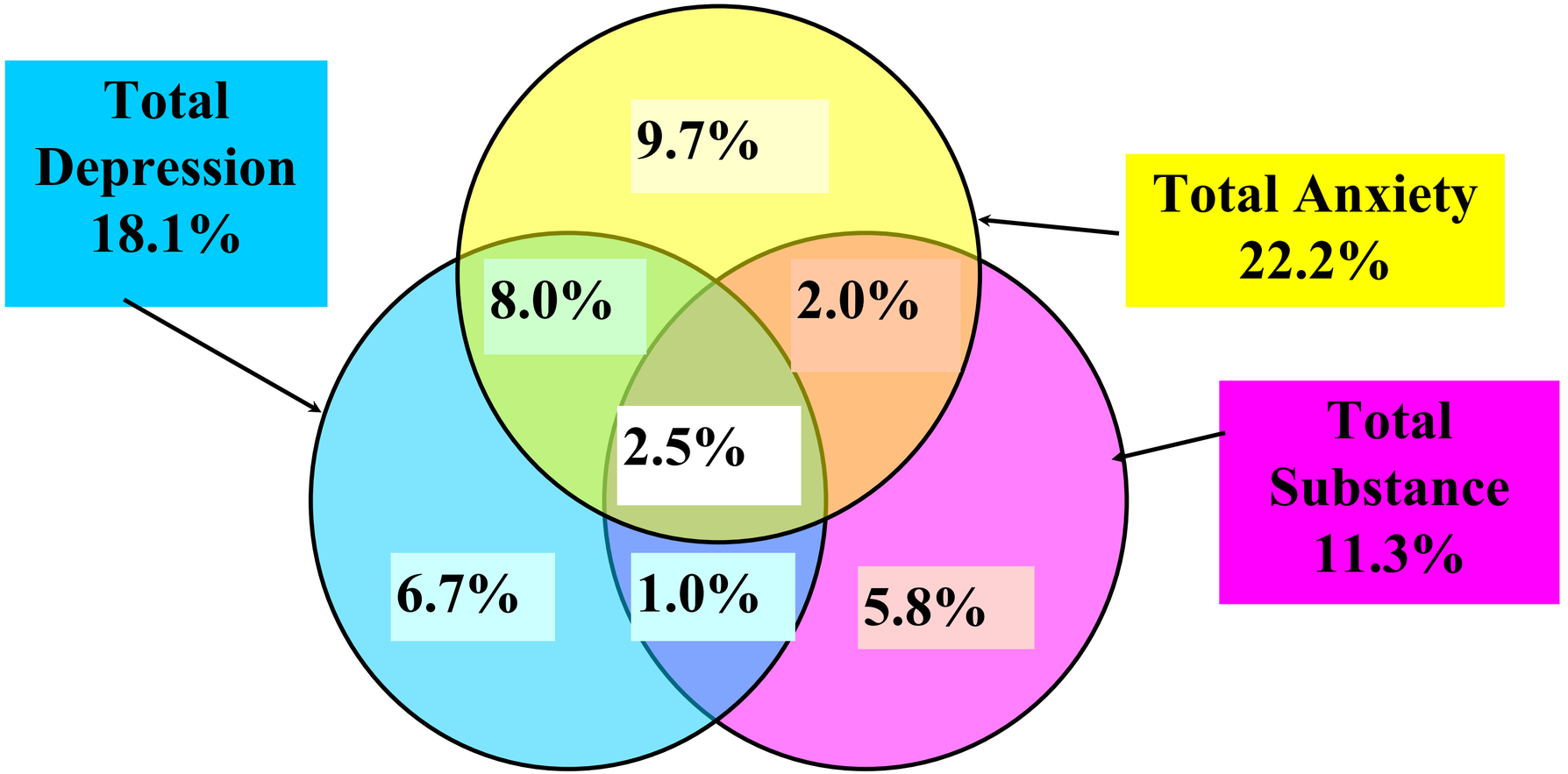
Long Term Conditions Forum
Te Papa - Feb 2020

What were the problems we were trying to solve?

Solution Looking for a Problem

"My team has created a very innovative solution, but we're still looking for a problem to go with it."

Mental Health need is very common in people attending NZ General Practice*:



35% of patients

* MaGPIe study, Dowell et al, 2001

(Unmet) Mental Health Problems are Costly

Global Burden of Disease Study:

- Psychiatric conditions account for 11% of "disease burden" worldwide
- Ranked depression as the leading cause of disability worldwide, and second only to CVD in the developed world (predicted to be No. 1 by 2020)
- MH&A conditions made up 5 of the 10 leading causes of disability globally

40% of people on SB more than 2 yrs in NZ have a MH&A condition – mostly "depression" and "stress"

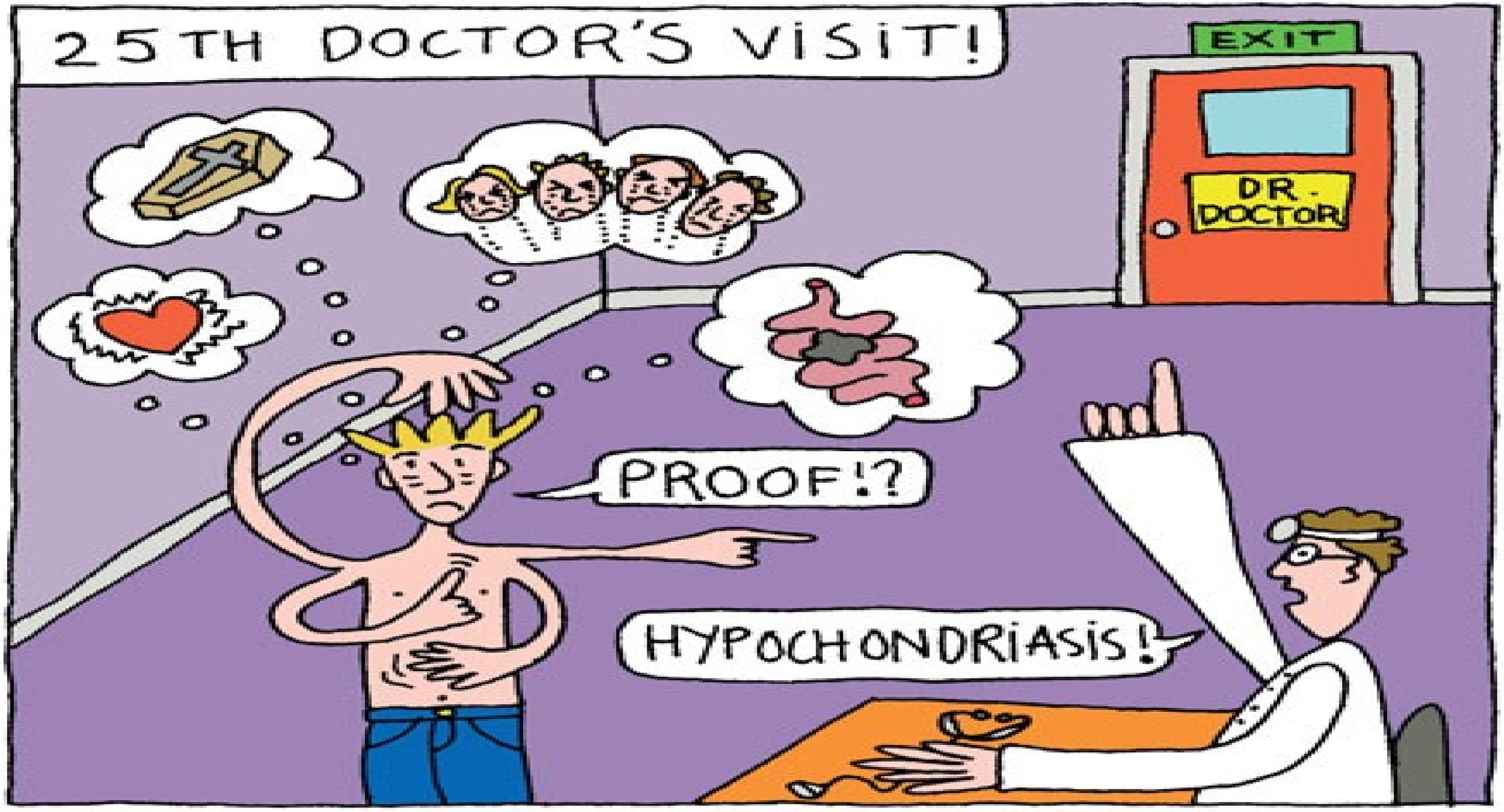
Co-Morbidity of Medical Illness and Depression

Illness	% with Depression
Cancer	40 – 50%
Heart Disease	18 – 26%
Diabetes	33%
Multi-infarct Dementia	27 – 60%
Multiple Sclerosis	30 – 60%
Parkinson's Disease	40%
Stroke	30 – 50%

Medically Unexplained Symptoms

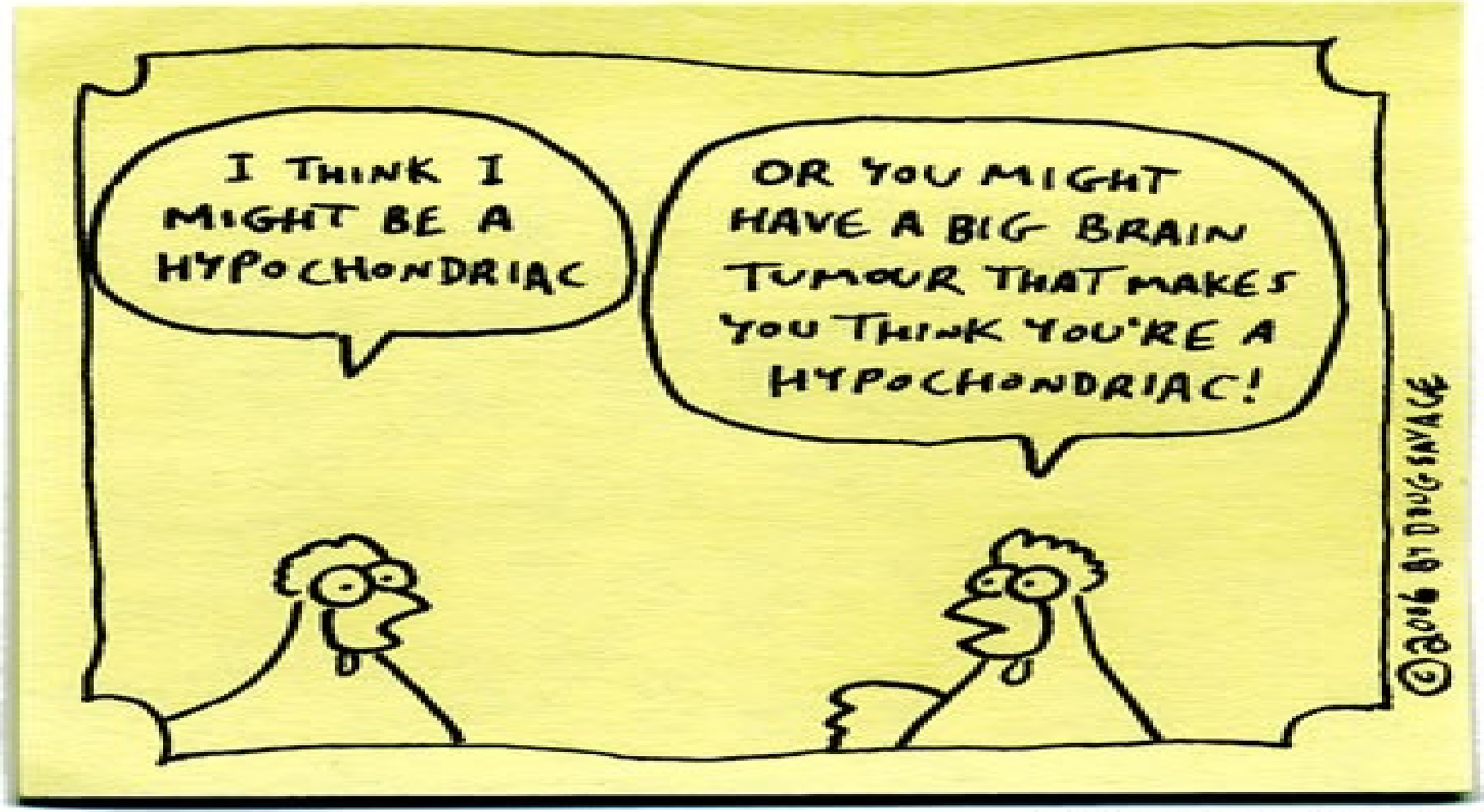
“Syndromes” with pain as a central feature, for which no underlying medical cause can be found:

- Chronic Pain Syndromes/ “Central Neural Sensitisation”
- Non-cardiac chest pain
- Fibromyalgia
- Irritable Bowel Syndrome
- Chronic Fatigue Syndrome
- SUBSTANTIAL comorbidity with depression/anxiety


25TH DOCTOR'S VISIT!
EXIT
DR. DOCTOR
PROOF!?
HYPOCHONDRIASIS!

Savage Chickens

by Doug Savage



www.savagechickens.com

The reality of Primary Care

- The GP/PN team 15 min appt model of care was designed over 100 years ago for acute medical issues
- The preponderance of need now is Mental Health and LTC related – “Behavioural Health”
- Medical practice has become enormously more complex
- GPs/PNs are time poor
- GP/PN training does not equip you with “Behavioural Health” skills

A SIMPLE MODEL OF PRIMARY CARE BASED MH&A RESPONSE: part 1 of the journey 2004-2014

Primary MH Programmes: 2003 - 2013

Key elements of all…

- Training for GPs/PNs in assessing and managing common MH conditions
- Funding for extended GP/PN consultations
- Funding and systems for referral to "packages of care" – most often brief "talking therapies", and linking to a variety of forms of psychosocial support/resources

…and they all worked – people got better!!

- Up to 80% of service users benefited from the variety of interventions offered… this represents a significant and beneficial treatment effect, which was generally sustained at six months (*Dowell et al, Evaluation of the Primary MH Initiatives, MoH (2009)*

Primary MH Programmes

GPs generally love us, patients really appreciate the help they get and do well – so really we have done pretty well with a small amount of resource…

BUT:

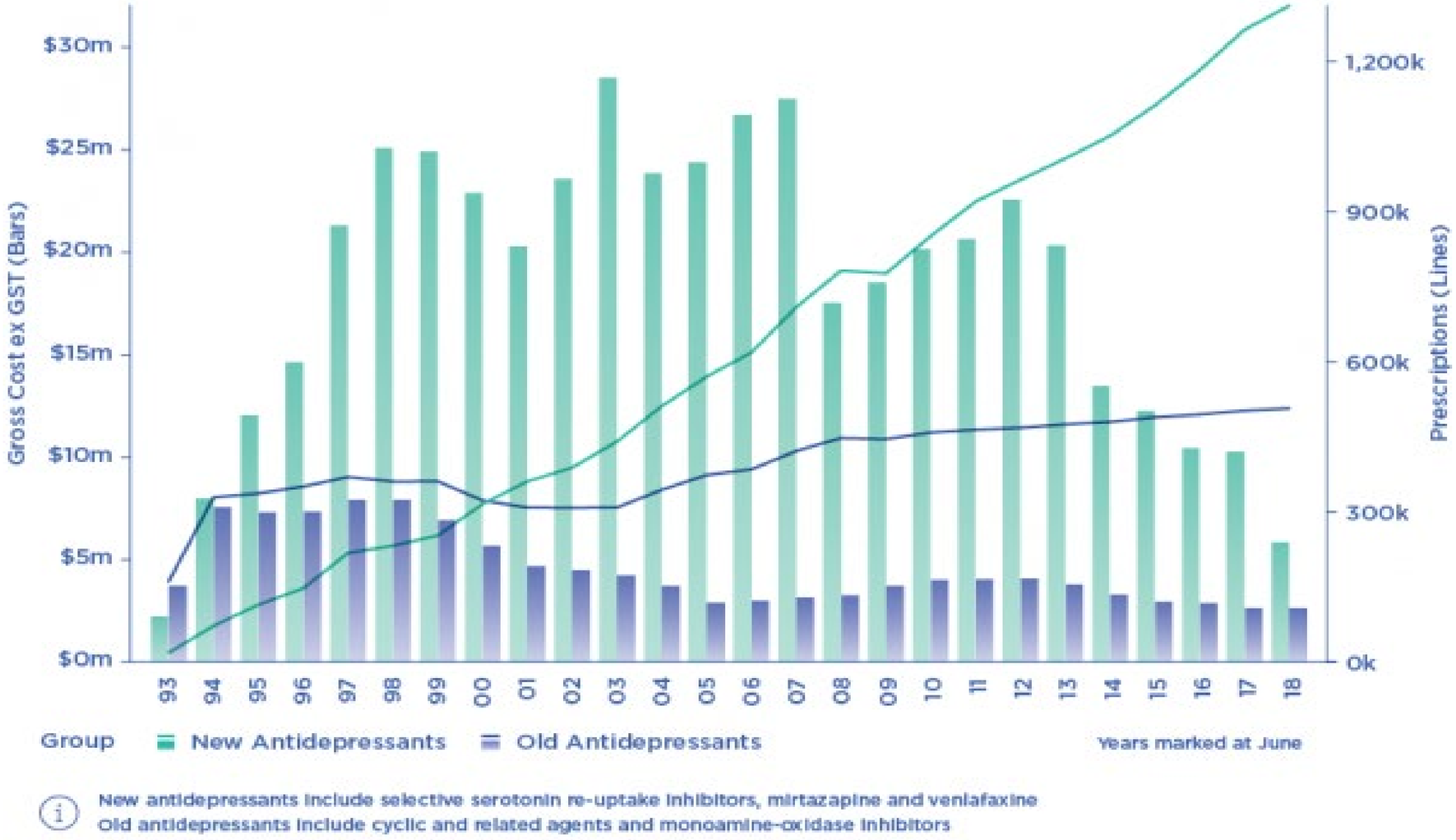
To that point we had mostly stood on the firm ground of what we knew – depression, anxiety, addiction, and other MH conditions.

AND:

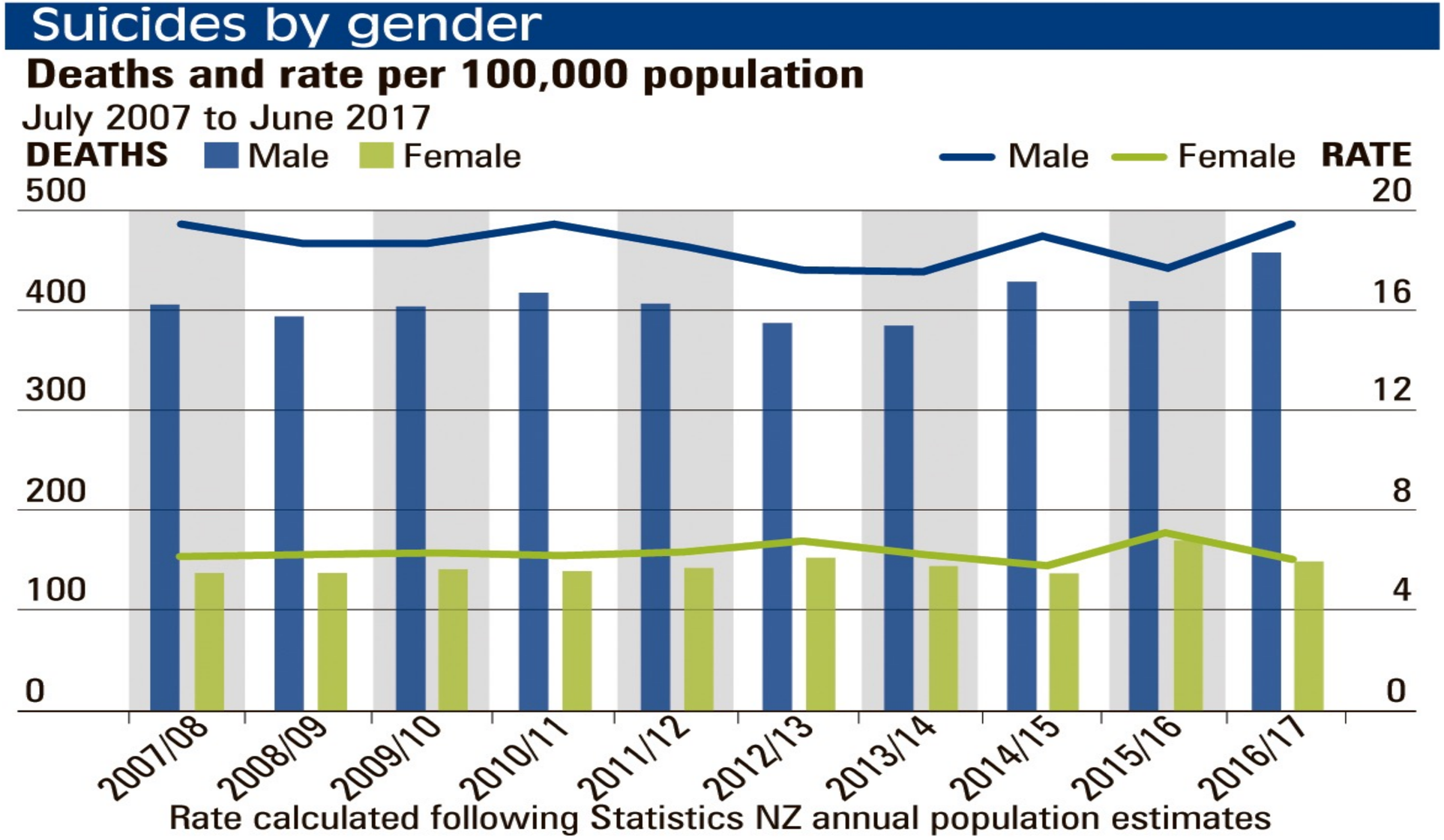
This still left our GP and PN colleagues struggling with unmet need –

- Acutely distressed patients
- Patients who needed help but would not attend referred services
- Social issues and stress, difficulties navigating social services
- Cultural need
- Poorly managed Long Term Conditions
- "Medically Unexplained Symptoms" – chronic pain etc

Primary Care Mental Health now – The Problems



Primary Care Mental Health now – The Problems



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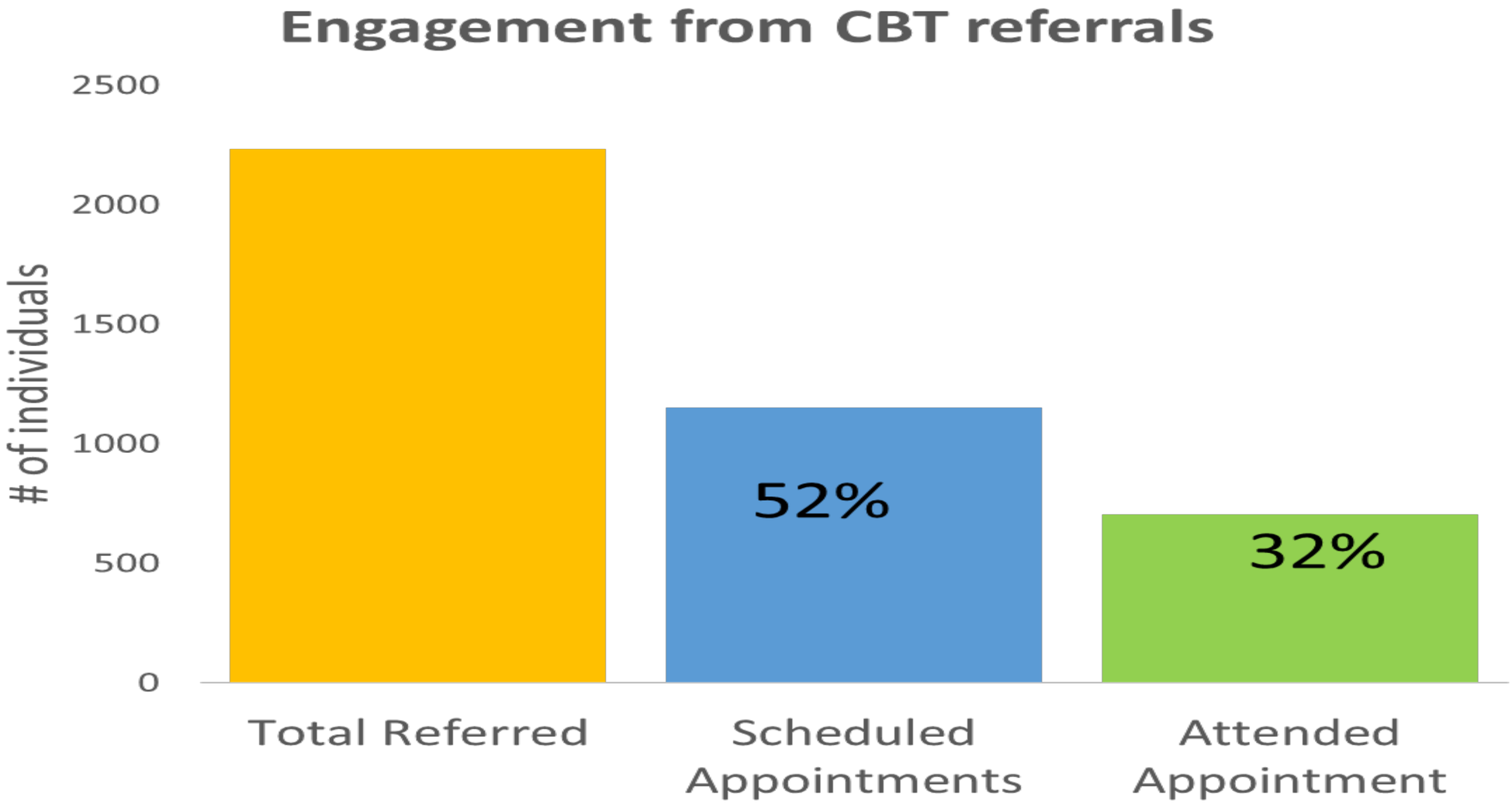
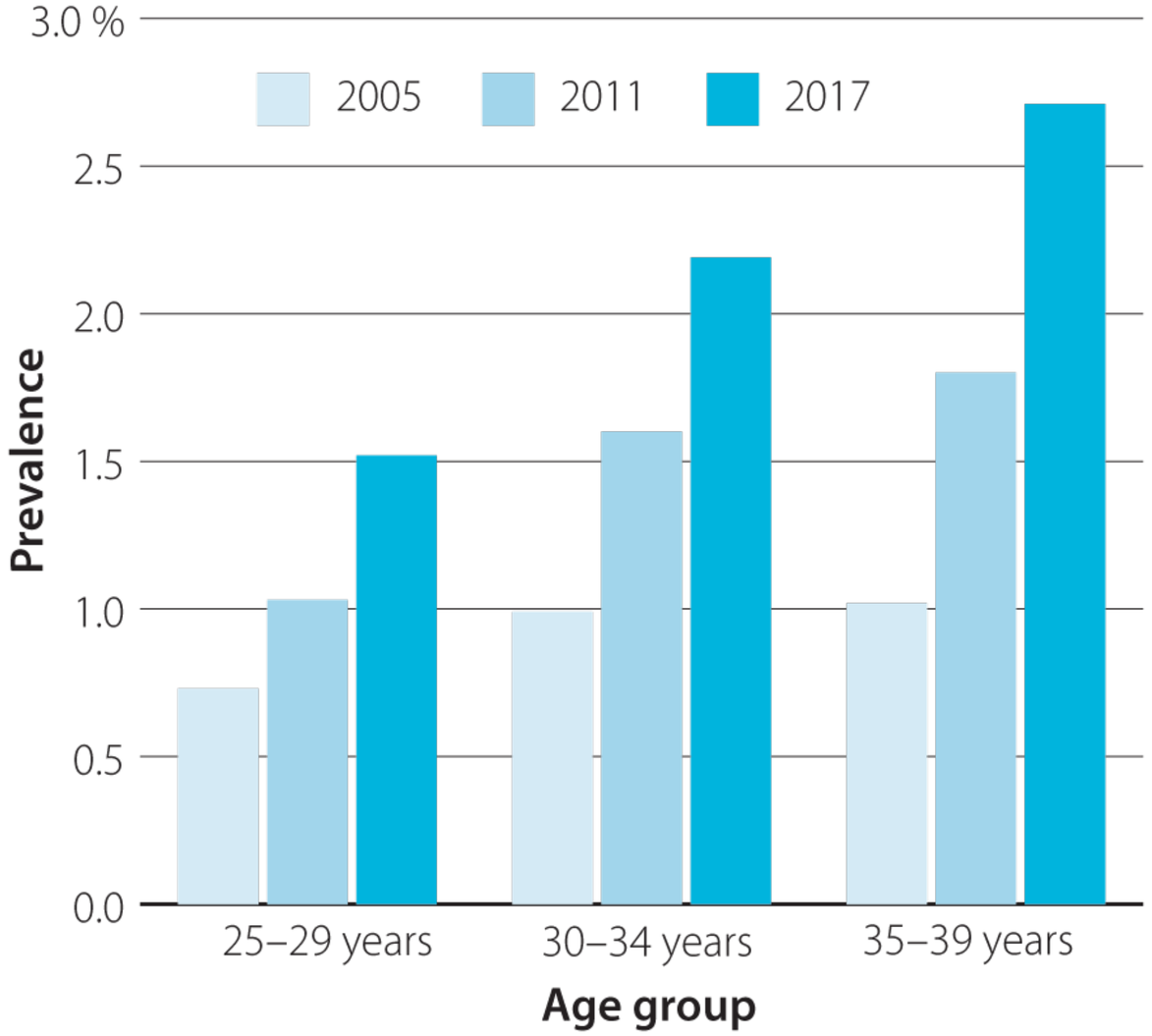
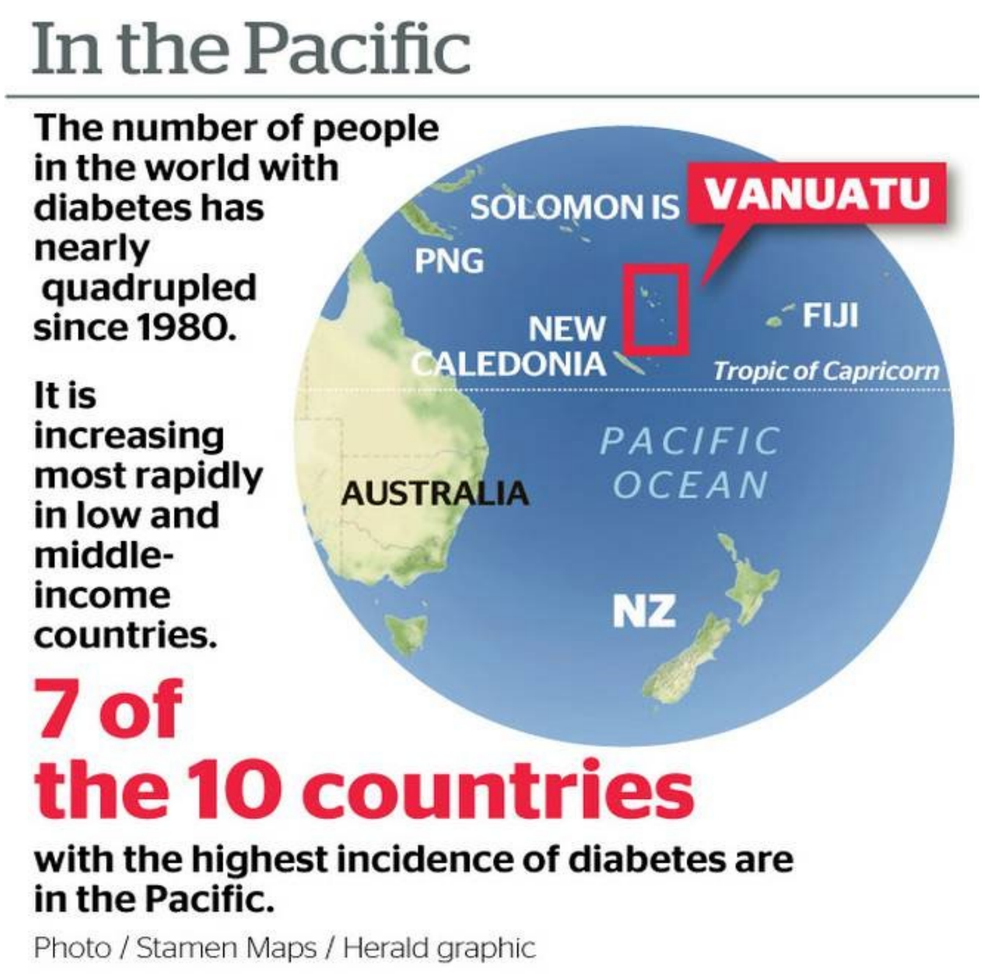


Primary Care now: The Diabetes Epidemic





Primary Care Mental Health now – The Problems

- Te Rau Hinengaro - Most MH need presents in primary care…
- As do other "behavioural health" issues – lifestyle related LTCs, MUS
- GPs/PNs are time poor, not trained in behavioural interventions, easier to refer…
- But the "higher needs" the practice, the lower the referral to patient seen ratio is – same issue in UK IAPT, Aust "Better Access"
- In the brief intervention model 1 FTE therapist can see 225 unique patients a year individually – groups help BUT low popn access rates and affordability still a major issue.
- Even funding more of this model, in UK and Aust NO impact on popn measures of wellbeing

NEW WAYS OF MEETING THE WIDER NEEDS OF PEOPLE PRESENTING IN PRIMARY CARE, IN METRO AUCKLAND:

part 2 of the journey 2013-2020 –

3 New Roles tested in Primary Care:

- Awhi Ora NGO Peer/Community Support Workers

- Peer-Cultural Health Coaches

- Behavioural Health Consultants (in NZ called “Health Improvement Practitioners or “HIPs”)

Role 1 – access to community/peer support

awhi ora

walk
alongside
support

Our network

Awhi Ora is made up of a large network of organisations around Auckland, NZ.

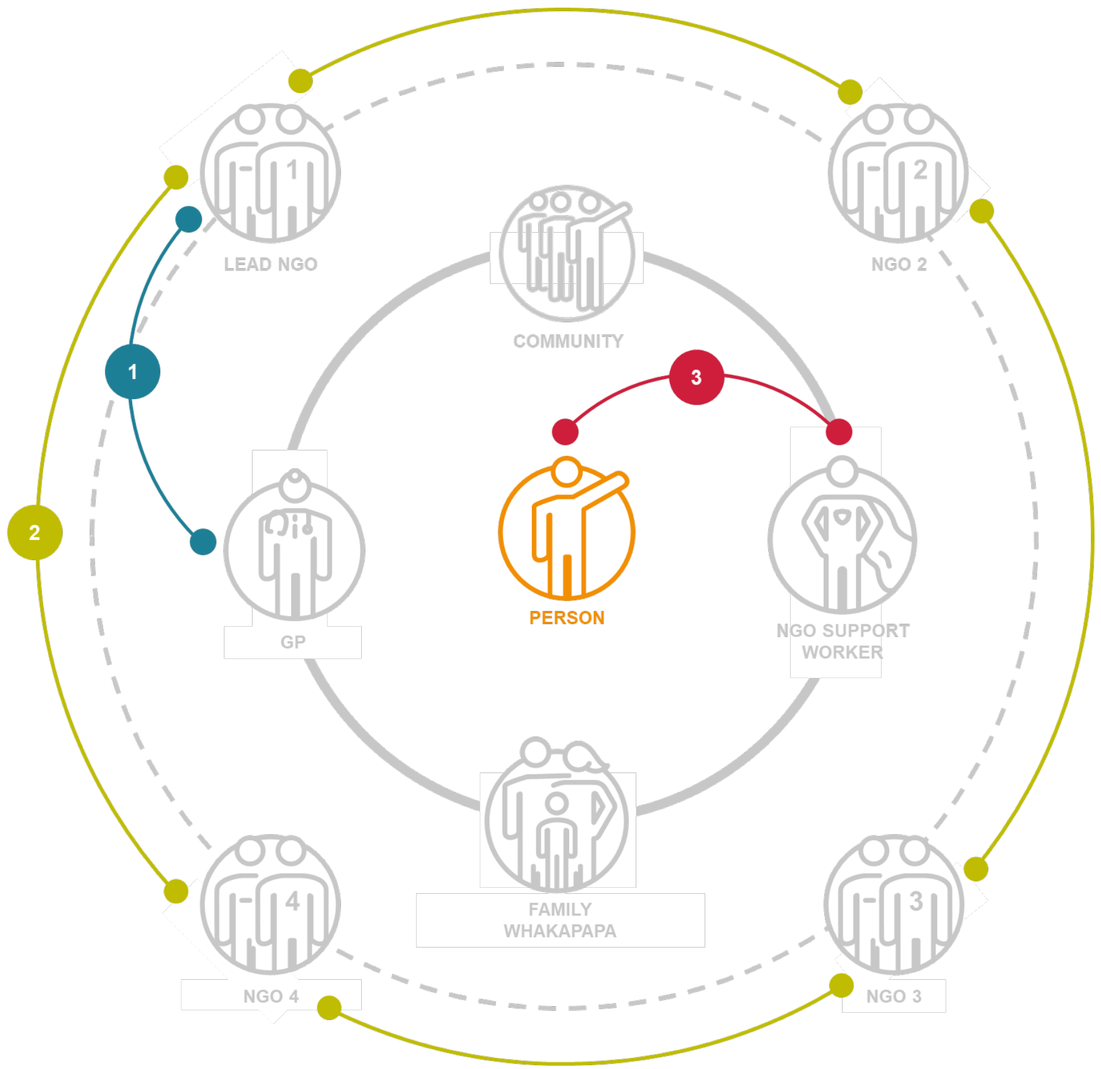
awhi ora walk alongside support

Awhi Ora is Based on these Co-Designed Principles

1. BE IN, AND OF, THE PLACE WHERE YOU ARE WORKING
2. BE HIGHLY CONNECTED
3. ESTABLISH SHARED UNDERSTANDING AND LANGUAGE
4. GIVE PEOPLE CHOICE INCLUDING CULTURAL CHOICE IN THE SERVICES REQUIRED
5. THIS WILL TAKE TIME, AND NEED A NETWORK OF PEOPLE
6. THIS IS A 'POINT IN LIFE'
7. AN OUTCOME FOCUS: MOVING FROM EXISTING TO THRIVING

awhi ora walk alongside support

How Does it Work?



This visual describes Awhi Ora – Supporting Wellbeing as a whole system.

There are 3 key relationships which are critical to the success of this service.

1. GP – Lead NGO

2. Lead NGO – Other NGOs

3. Person – Support Worker

awhi ora walk alongside support

Provides navigation and access to a wide range of support services

"I needed to go on a benefit, I had no money had nowhere to live with my 14-year old daughter and wasn't in the mental state to cope. I could not even talk without crying, I wasn't capable of doing anything at that point. I'd tried to do WINZ (Work and Income New Zealand) on my own but if you find yourself helpless they are not the people to help you. If you can't talk because you are crying, they just put the phone down. [The Awhi Ora provider] was wonderful. They held my hand [crying] and helped me through areas of life I'd never been through or thought I'd ever have to go through. What happens to people who don't have this help and don't have someone to talk to and help – its horrific. If it hadn't been for [Awhi Ora] picking up the pieces day to day, sometimes every day in the rough weeks, I don't know where I'd be now."

(Person accessing Awhi Ora support)

Role 2 - Health Coaching: Background

• 12-18% of people with Long-Term Conditions (LTCs) are likely to have severe Mental Health & Addiction (MH&A) conditions which significantly contributes to poor health outcomes and increased service utilisation.

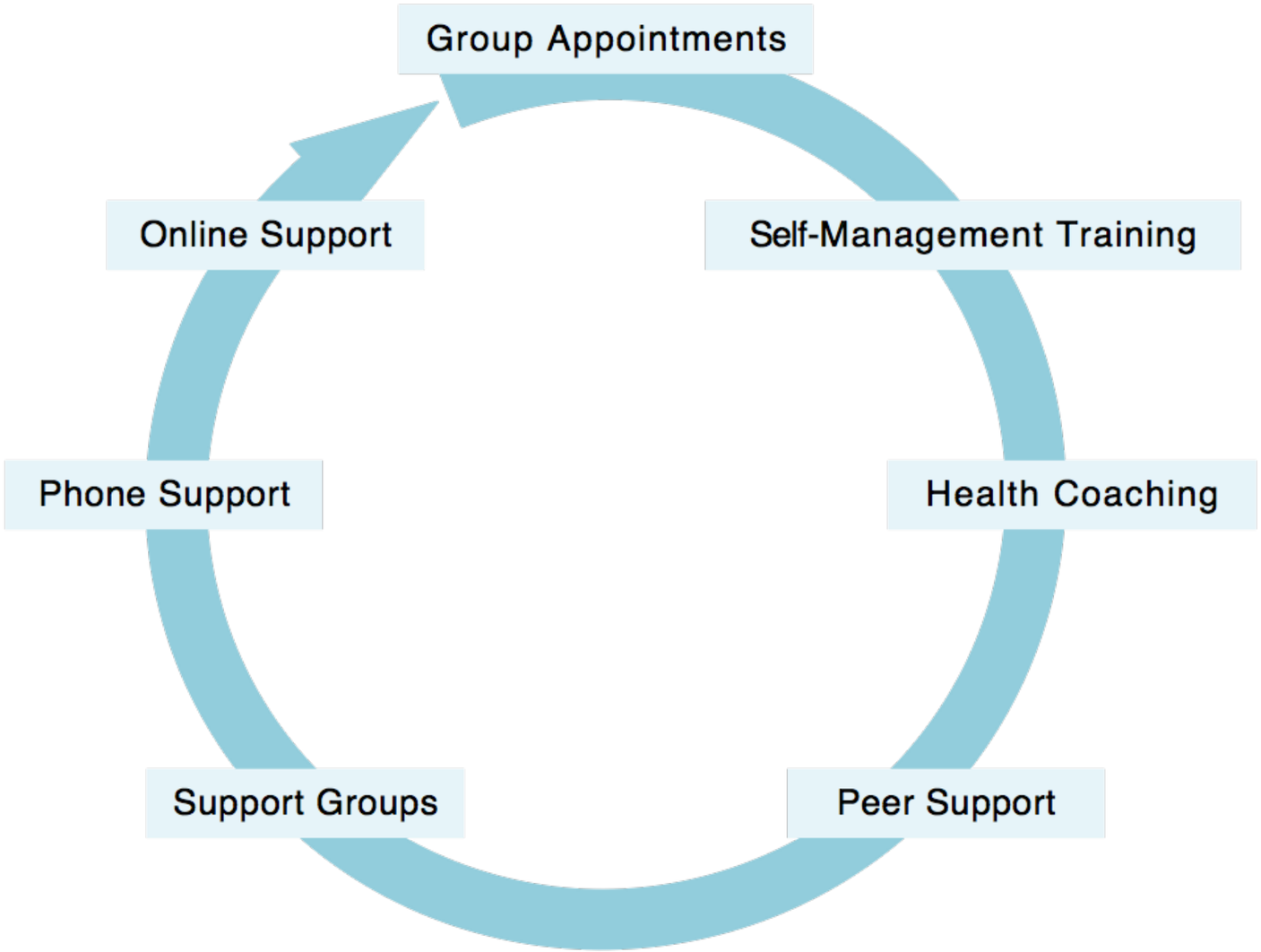
• On the other hand, people with severe MH&A conditions will die on average 15-20 years younger, mostly as a result of poorly managed LTCs – CVD, Diabetes, Cancer etc.

•The presence of a comorbid MH&A condition in people with LTCs increases risk of admission by up to 3x, increases LOS up to 2x, and increases use of Outpatient Services by up to 2x.

• The presence of unmet psychosocial and cultural needs further adds to poor outcomes and increased service utilization.

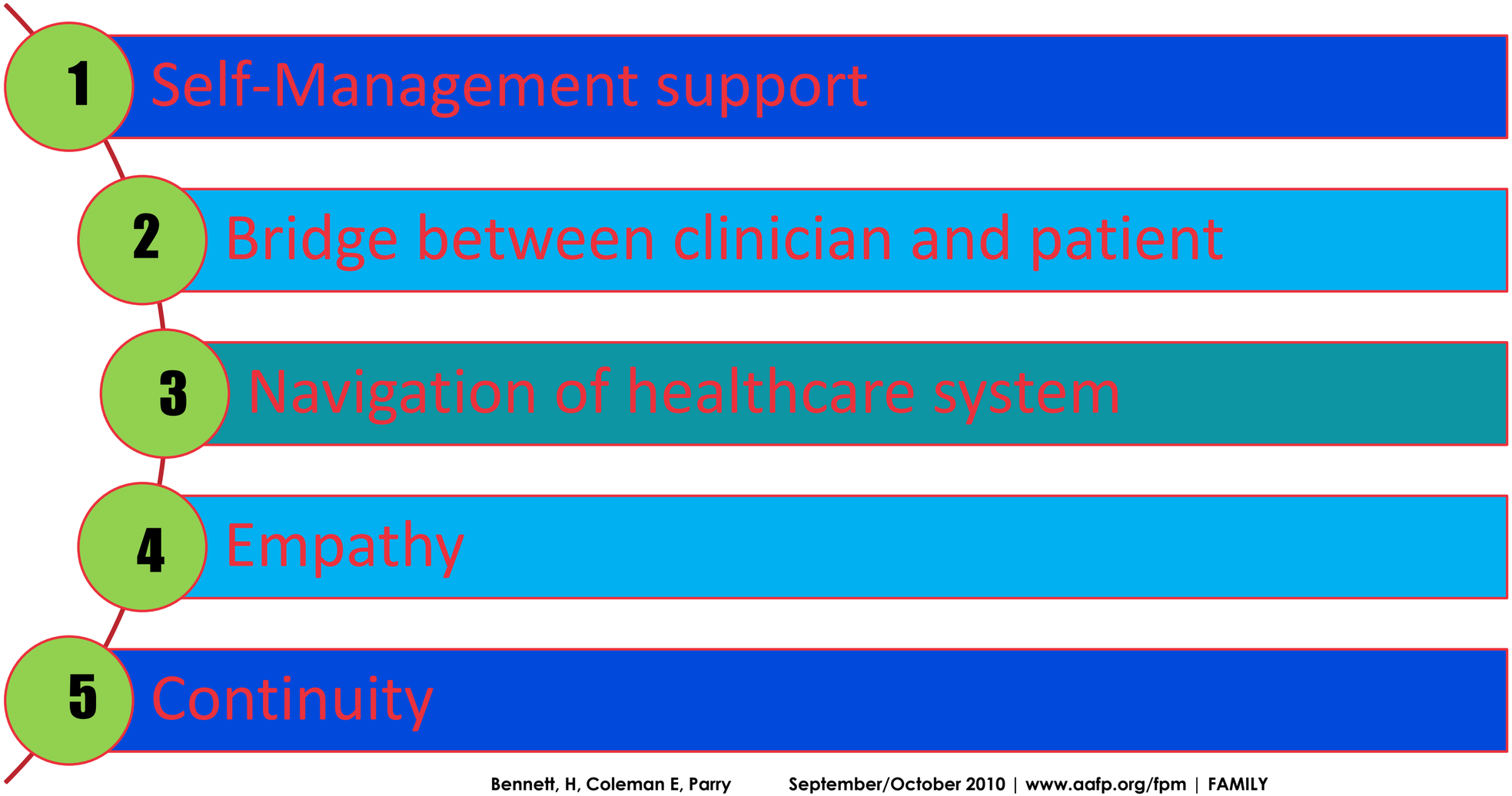
• Existing primary MH approaches have failed to address this co-morbidity

Health Coaching – Menu of Support Options



http://www.chcf.org/publications/2006/12/building-peer-support-programs-to-manage-chronic-disease-seven-models-for-success

UCSF Centre for Excellence in Primary Care – 5 Roles of a Health Coach



Bennett, H, Coleman E, Parry C,Bodenheimer T, Chen E.

September/October 2010 | www.aafp.org/fpm | FAMILY PRACTICE MANAGEMENT

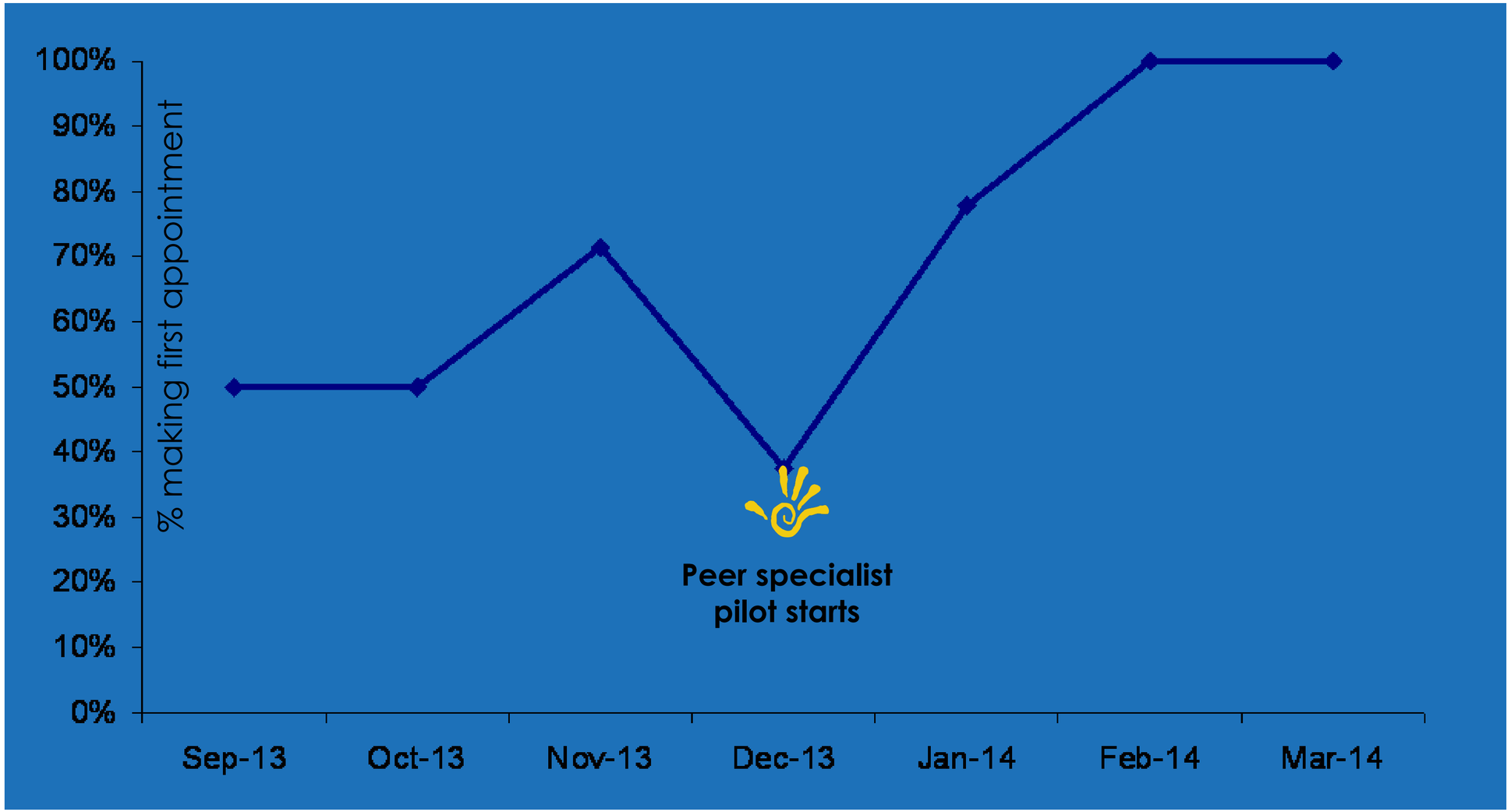
The Health Coaching Supported Appointment*

- ✓ VIP-Very Important Patient
- ✓ Ask Permission
- ✓ Setting the Agenda
- ✓ Assess mental health need
- ✓ Ask-Tell-Ask
- ✓ Know your Numbers

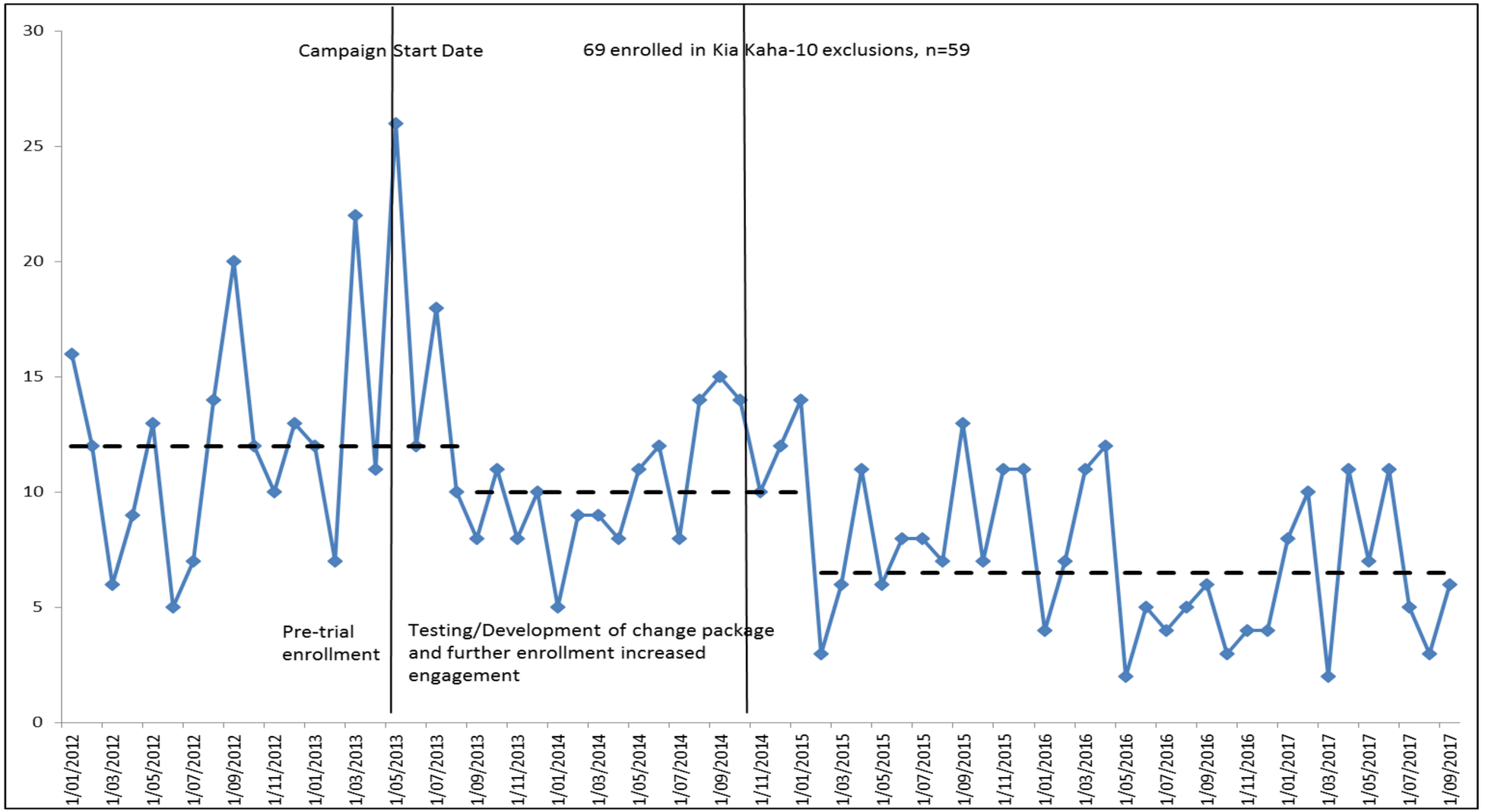
- ✓ Closing the Loop
- ✓ Action plans-Self-tailoring
- ✓ Medication counselling
- ✓ Using handouts effectively

* Based on the *Health Coaching Curriculum* from the Center for Excellence in Primary Care (CEPC) University of California in San Francisco (UCSF) NZ adaptation

Effect of Peer/Cultural Outreach on Engagement



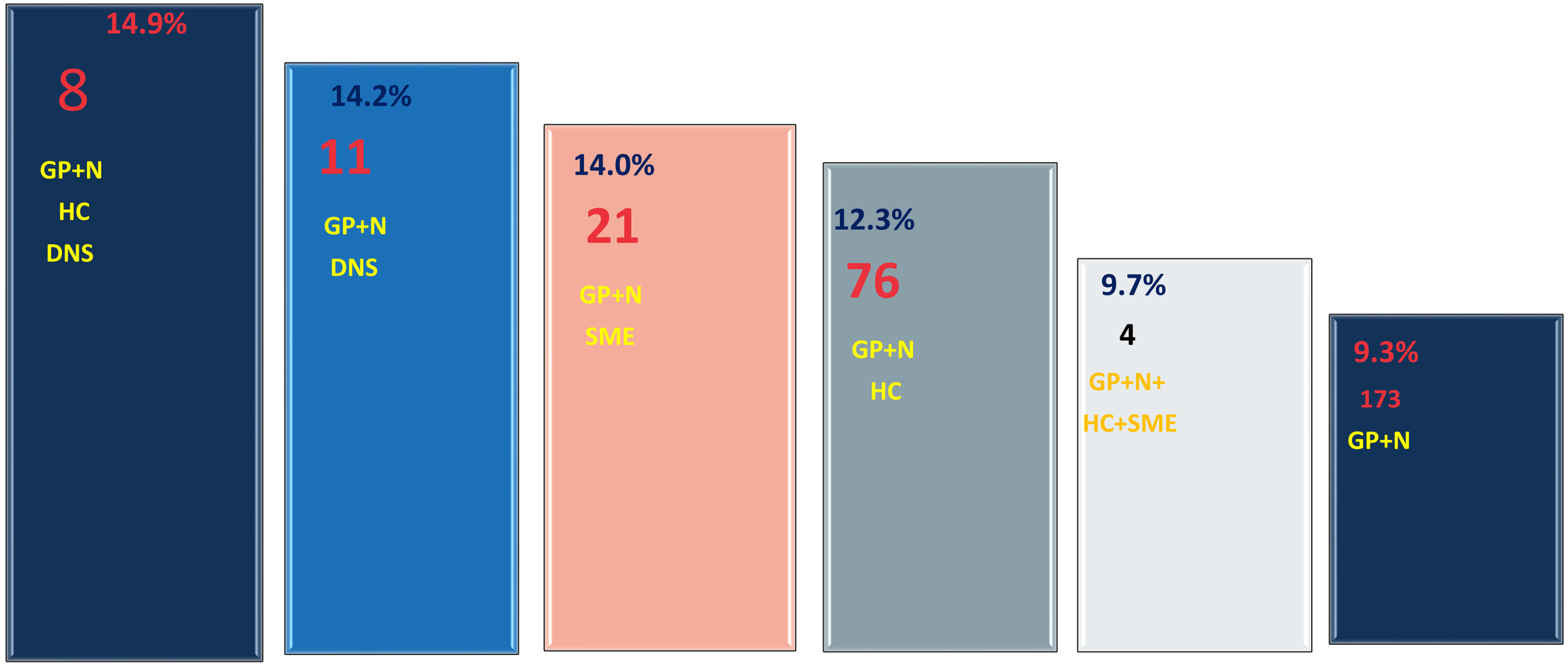
Kia Kaha cohort – ED presentation rates



I was hearing words like “terminal illness” and “you will just have to learn to live with the pain” from the specialists. However, Kia Kaha helped us to learn about pain management and make a strategic plan as a family. My wife is no longer worried about me dying, my whanau is re-connected and we have a tool box. My goal was to get healthier, I feel I have achieved that, now I have to maintain it.

Health Coaching in GP clinic
Diabetes trial

Reduction in HbA1c in 6 months:
ALL trained in Health Coach model



Role 3 - The Primary Care Behavioral Health Consultant (in NZ called HIP – Health Improvement Practitioner)

Generalist

Accessible

Team-based

High Productivity

Educator

Routine care component

The Behavioral Health Consultant

Dimension	Consultant	Therapist
Primary consumer	GP	Patient/Client
Care context	Team-based	Autonomous
Accessibility	On-demand	Scheduled
Ownership of care	GP	Therapist
Referral generation	Results-based	Independent of outcome
Productivity	High	Low
Care intensity	Low	High
Problem scope	Wide	Narrow/Specialized
Termination of care	Pt progressing toward goals	Pt has met goals

BHCs – "Therapists behaving like a GP" - Provide 2 Types of Services

INDIV - BRIEF INTERVENTIONS

Warm hand-over based sessions
Preferred same-day
Session length 20-30 min
Basic model – fACT – problem focussed
Follow-up as indicated BUT aim for 50% one-off consult with open door to return
Individuals, couples, families
Groups, workshops

POPN - LEVEL SERVICES

From PMS identify patient groups with specific behavioural needs (smokers, chronic pain, frequent flyers, poorly managed LTCs, ??long term MH conditions)
Often uses patient registry and recall contact lists
Outreach and engagement into behav hlth service
1:1 or group medical visits

PCBH Outcomes: All patients

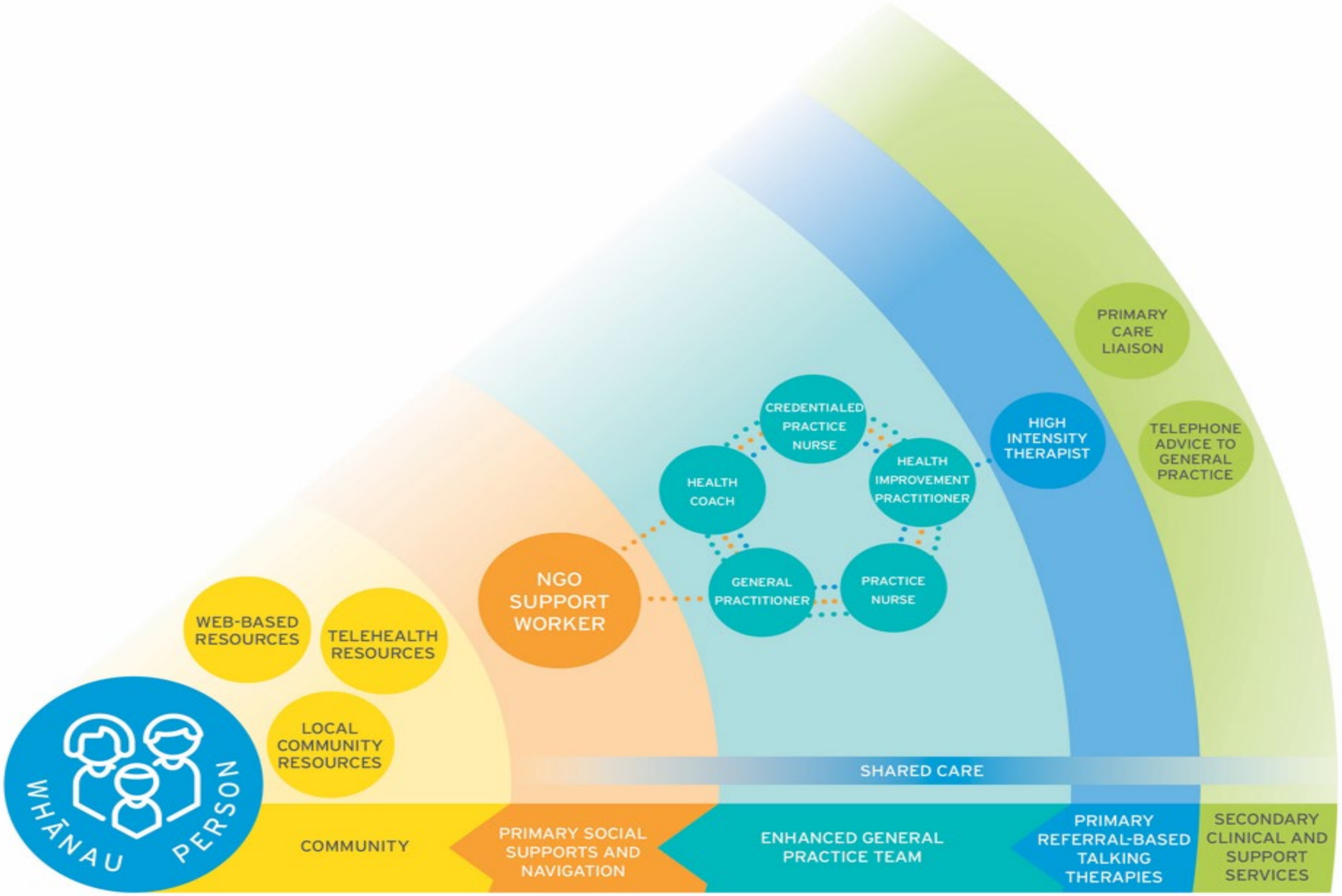
▪Clinical Outcomes

- **Patients receiving 1-4 visits show broad improvement in symptoms, functioning, well-being** (Angantyr, 2015. Bryan, et al, 2009, 2012; Burt, et al.., 2014; Cigrang, 2006; Corso, et al., 2012; McFeature & Pierce, 2011; Ray-Sannerud, et al, 2012)
- **Effective for both mild and severe presentations**
- **More severely impaired may improve faster (Bryan, et al., 20112)**
- **Changes are robust and stable at 2 years (Ray-Sannerud, 2012)**
- **Patients report stronger connection to the BHC than to traditional, specialty therapists (Corso, 2012)**

PCBH System Outcomes

- **Large reductions in secondary mental health referral rate (Brawer, et al., 2010; Serrano & Moden, 2010)**
- **Improved adherence to evidence-based guideline (Serrano, & Moden, 2010)**
- **More appropriate antidepressant prescribing (Brawer, et al., 2010; Serrano, & Moden, 2010)**
- **Improved GP willingness to engage with behavioral issues (Brawer, 2010, Torrence, et al., 2014)**
- **Improved detection (and treatment) of suicidal ideation (Bryan, et al., 2008)**
- **High patient and GP satisfaction (Brawer, et al., 2010, Torrence, et al., 2014, Angantyr, et al., 2015)**
- **More appropriate utilization of GP (McFeature & Pierce, 2010; Serrano & Moden, 2010)**

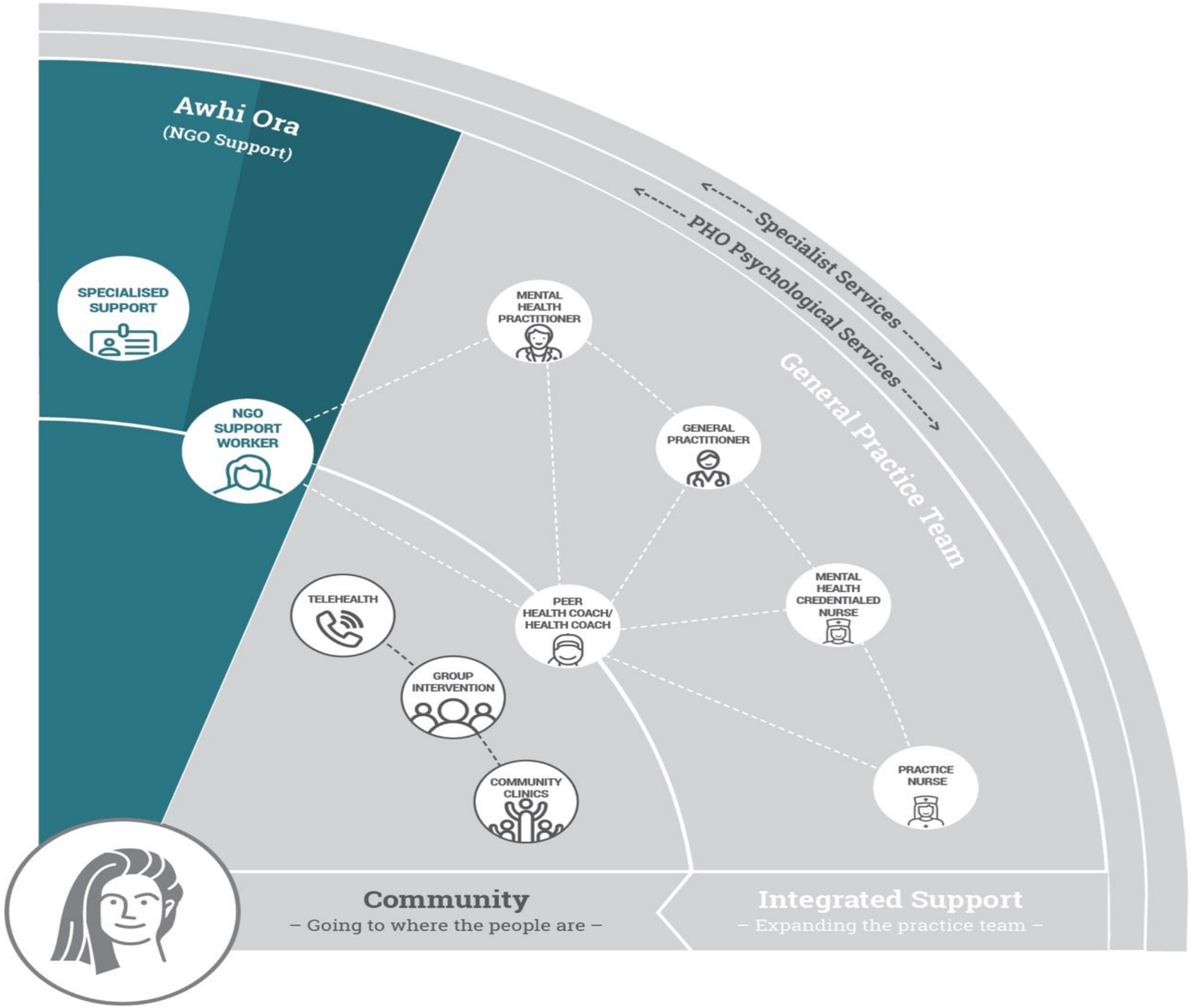
Te Tumu Waiora – bringing it all together 2017 - 2018



Te Tumu Waiora – bringing it all together

1

Providing walk alongside, community based NGO support through Awhi Ora



Awhi Ora: walk alongside support

Awhi Ora is a free early intervention system for people with mild to moderate mental health needs

The service is provided by a team of qualified, dedicated support workers who come from a collaborative network of DHB funded mental health NGOs across Auckland

We walk alongside people during all sorts of life challenges, providing practical tools that put the power back into their hands.

The main ways to support people are emotional health, physical health, housing, social engagement or Work and Income.

"If it hadn't been for Awhi Ora picking up the pieces day to day…sometimes every day in the rough weeks, I don't know where I'd be now."

- Person supported by Awhi Ora

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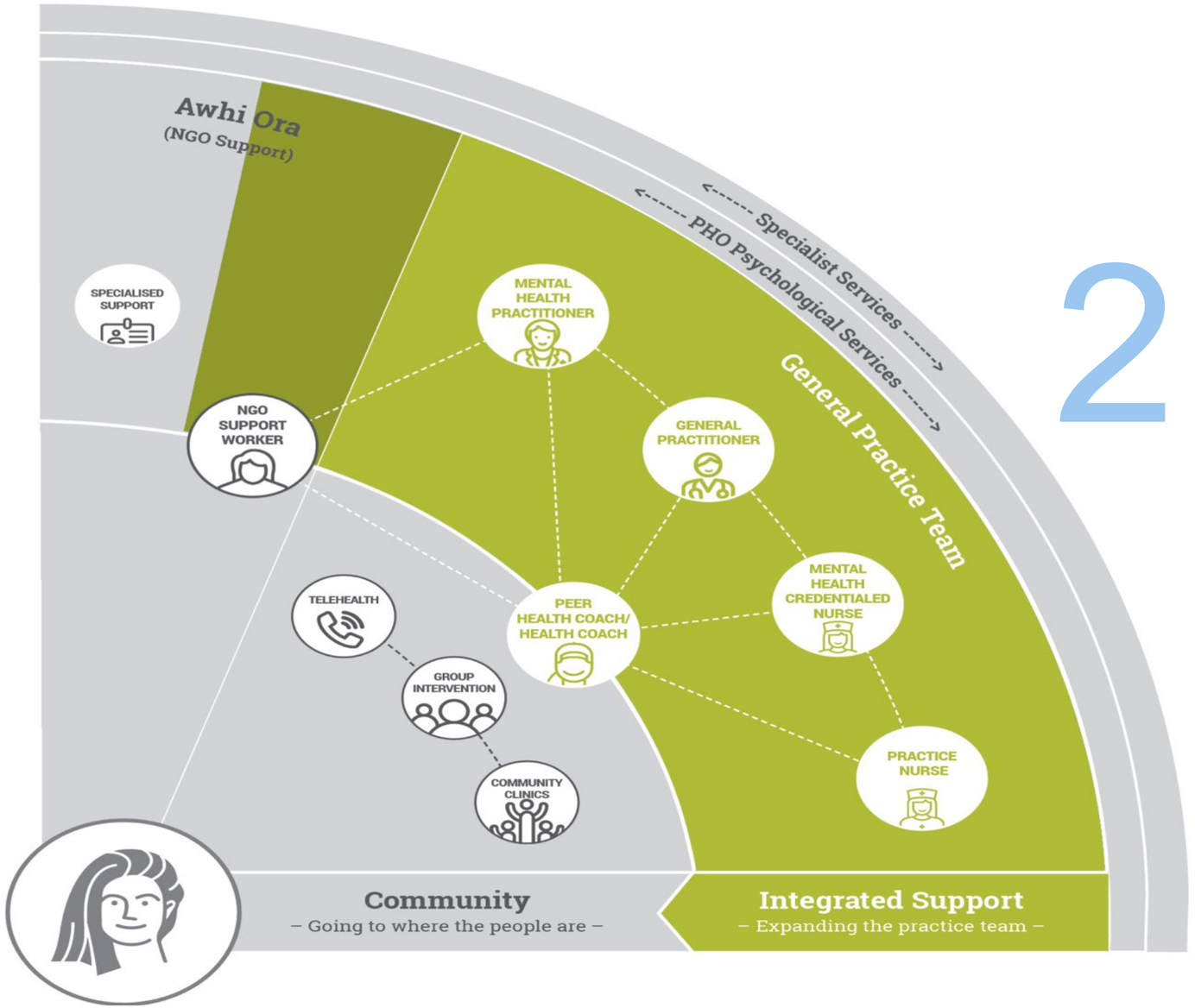

2

An integrated general practice team who can provide effective and timely support to people with health, wellbeing and social needs.

Health Improvement Practitioner (HIP)

- **Mental Health Clinicians**
- HIP's may be psychologists, nurses, GPs, social workers, psycho-therapists or other health professionals with a mental health qualification.
- Deliver focussed evidence informed **talking-therapies for all age groups**.
- Provide advice, training and **support for the general practice team.**
- **Does not work independently - GP has clinical responsibility**

"I've never had, or come across, anything like this before … I've never gone to a GP surgery and they've said, oh, we have someone that's onsite and that can help you."

- HIP client seeking support with anxiety

Health Improvement Practitioners

- **Low wait times** (warm handover)
- Services delivered **within the practice**
- **Brief interventions** 15 – 30 minutes, and only as many as are needed to get a result
- Individual, family/whānau and group based interventions
- **Write in the** shared general practice **medical record**.

"My first session [the HIP] gave me at least three different things that I needed to start practicing, and that made me feel like I was instantly making progress. And that's kind of what I needed, I needed to feel like I was actually getting somewhere".

- HIP client seeking support with anxiety

Health Coach

- A non-registered role working as **part of the integrated team.**
- Work in a **peer-professional partnership** model to ensure clinical safety
- Assists patients to gain knowledge, skills and confidence to **become informed active participants** in their healthcare.
- **Health "literacy", goal setting, and self management are** core focus.
- May be **peer/cultural** health coaches.

"Kia Kaha helped us to learn about pain management and make a strategic plan as a family. My wife is no longer worried about me dying, my whānau is re-connected and we have a tool box."

- Person supported by Health Coaches

Health Coach

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"I felt I was supported and the tone of the Health Coach was very conversational.
I was able to open up without being uncomfortable or judged."

- Person supported by Health Coaches

Te Tumu Waiora – bringing it all together

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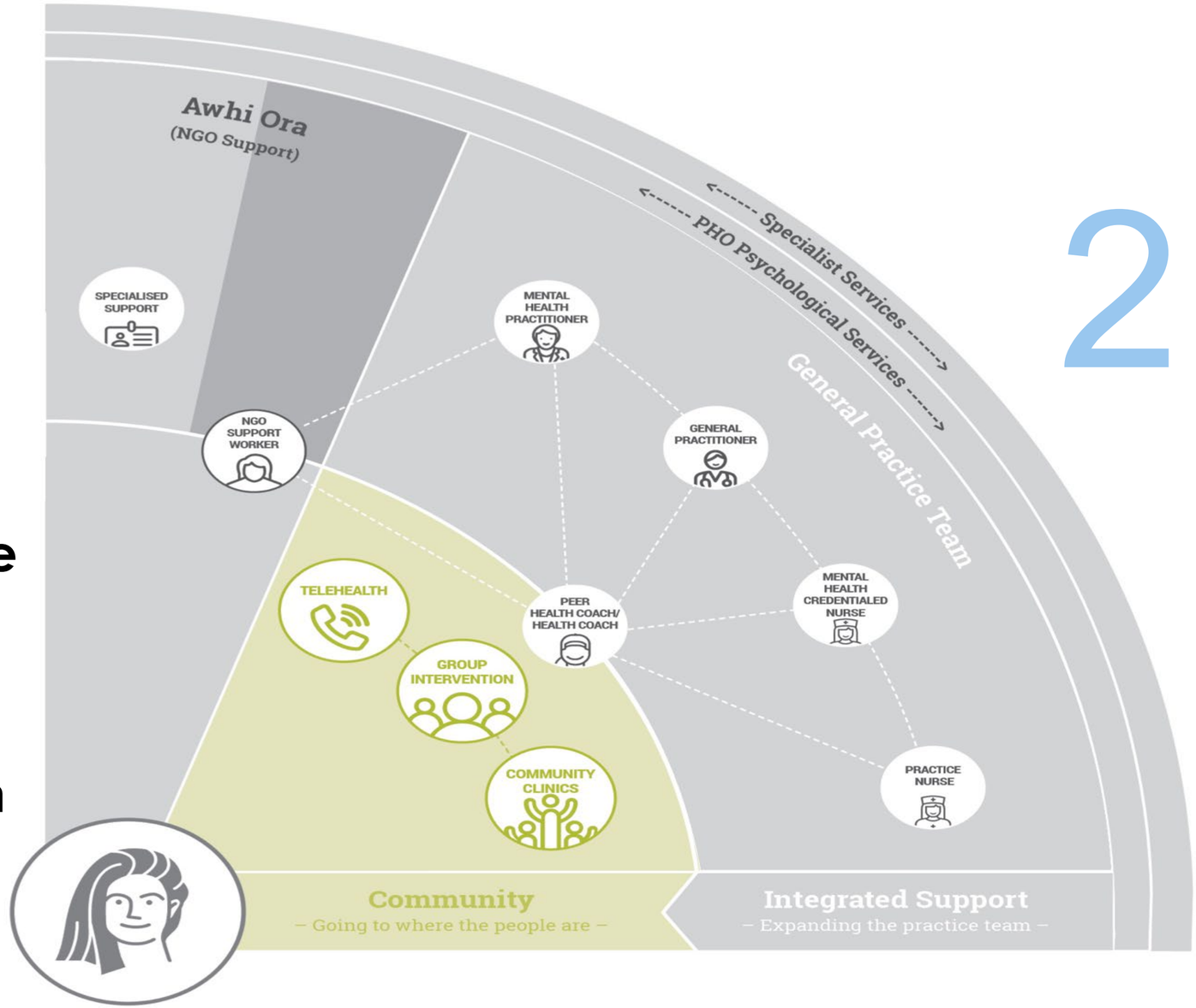
Providing walk alongside, community based NGO support through Awhi Ora



2

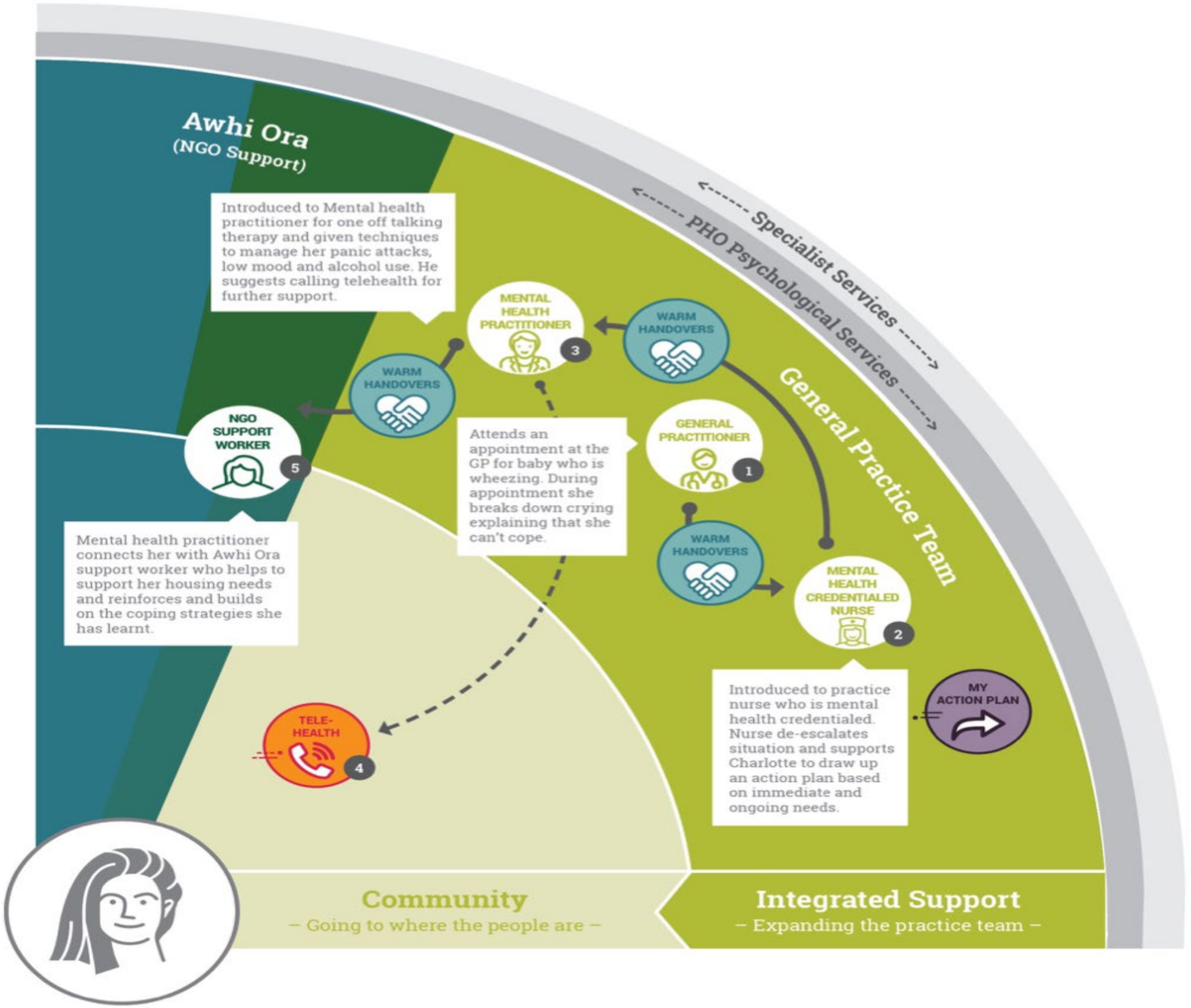
An integrated general practice team who can provide effective and timely support to people with health, wellbeing and social needs.

3

‘Going to where people are’ by increasing points of access within communities

What does this mean for Charlotte?

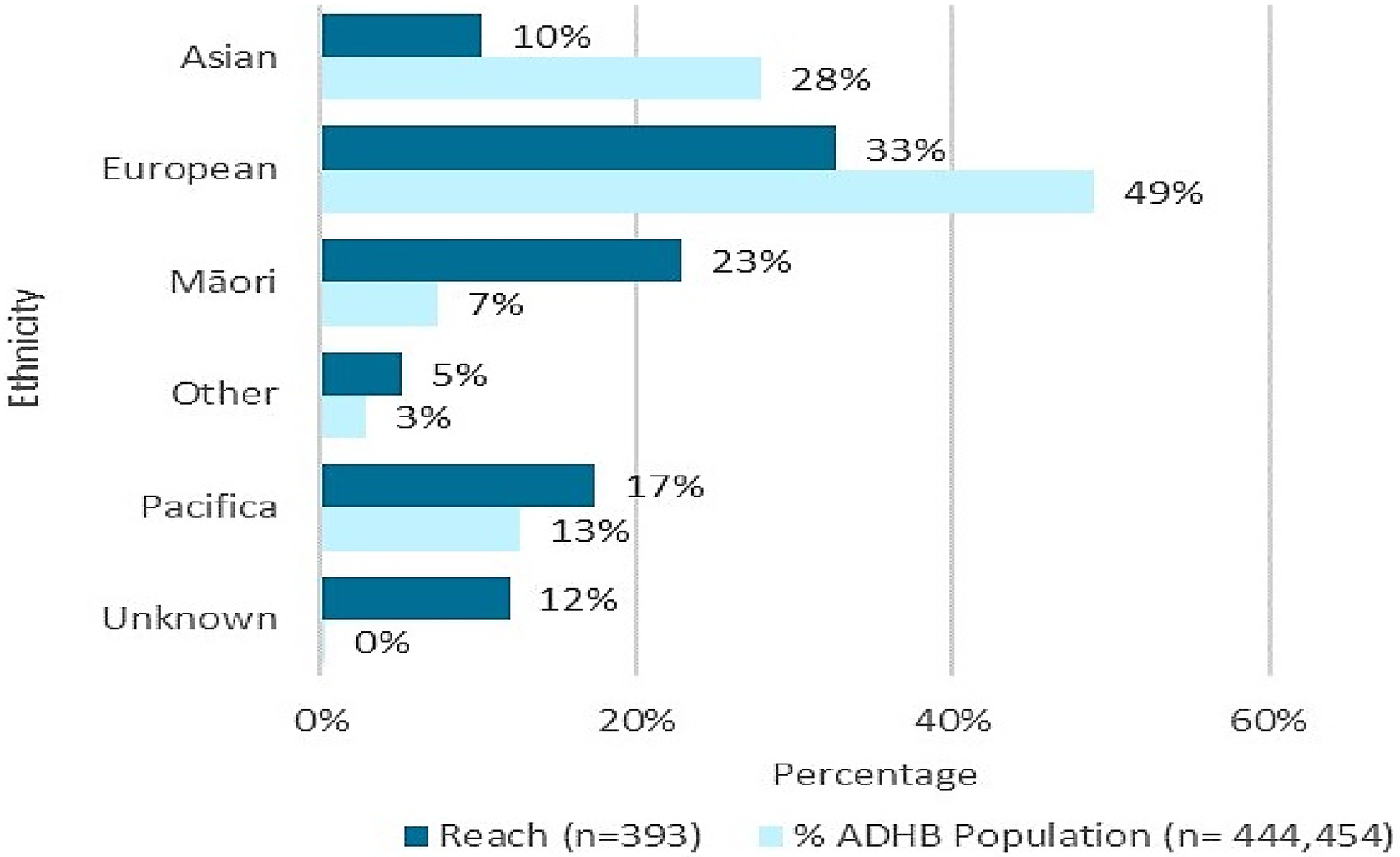
Charlotte is a young mum who struggles to cope with her sub-standard housing and wheezing baby and resorts to alcohol as a coping mechanism



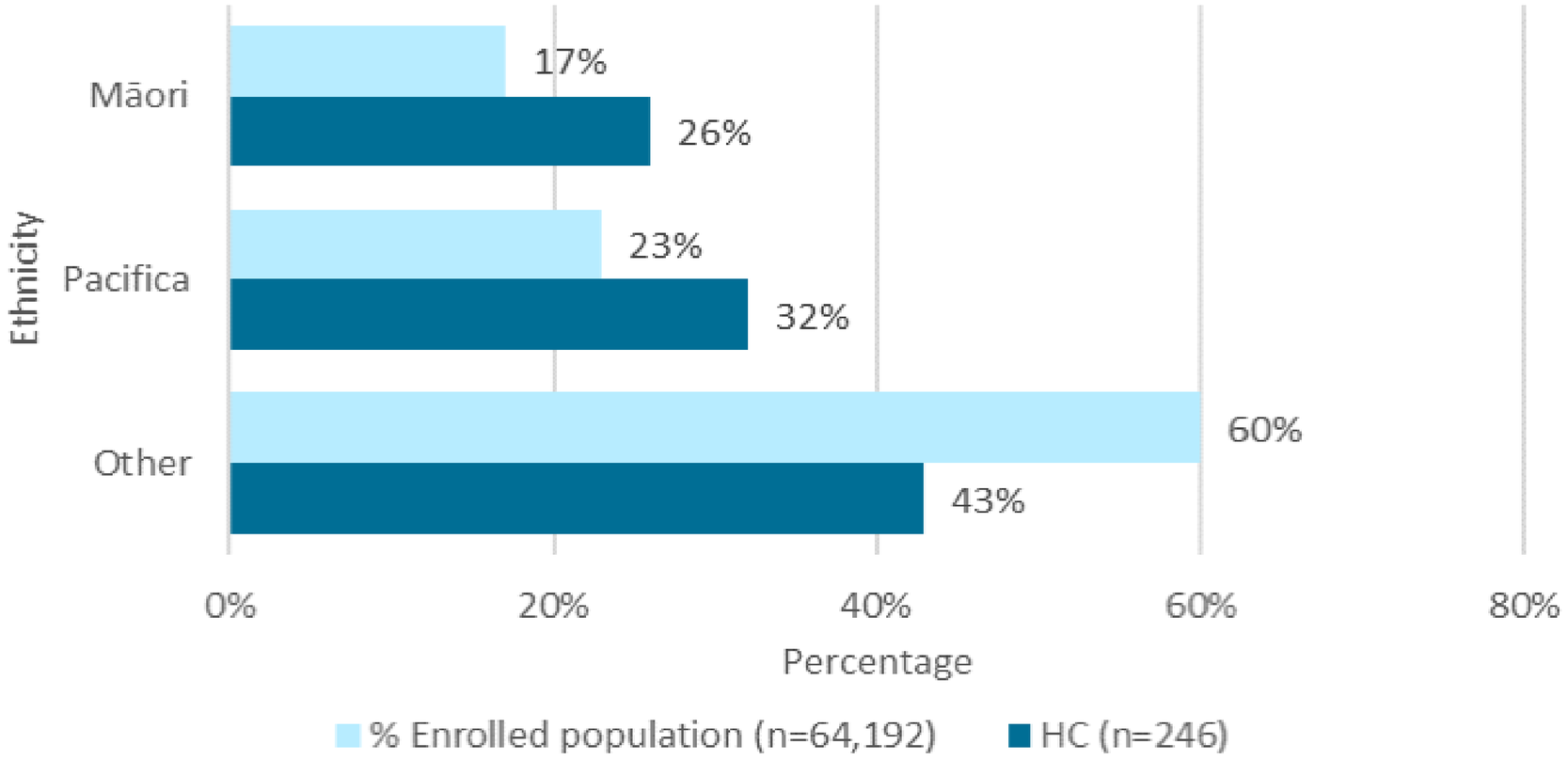
Synergia evaluation – positive outcomes

- **Access rates >90%,**
  - (compared to 30-50% under referral model).
- **Differential increased access**
  - Maori, Pacifika, and young adult.
- **Good clinical outcomes**
  - significant reduction symptom scores; greatest improvement in Maori.
- **Reduced prescribing of psychotropic medications**
  - Focus on prescribing only for severe persistent anxiety/depression
- **High level satisfaction levels with services**
  - "how useful was this service today" average score above 9/10.
- **Significant increase in productivity**
  - 500-600 new patient/FTE/yr (vs 200-250/yr under package of talking therapy model).

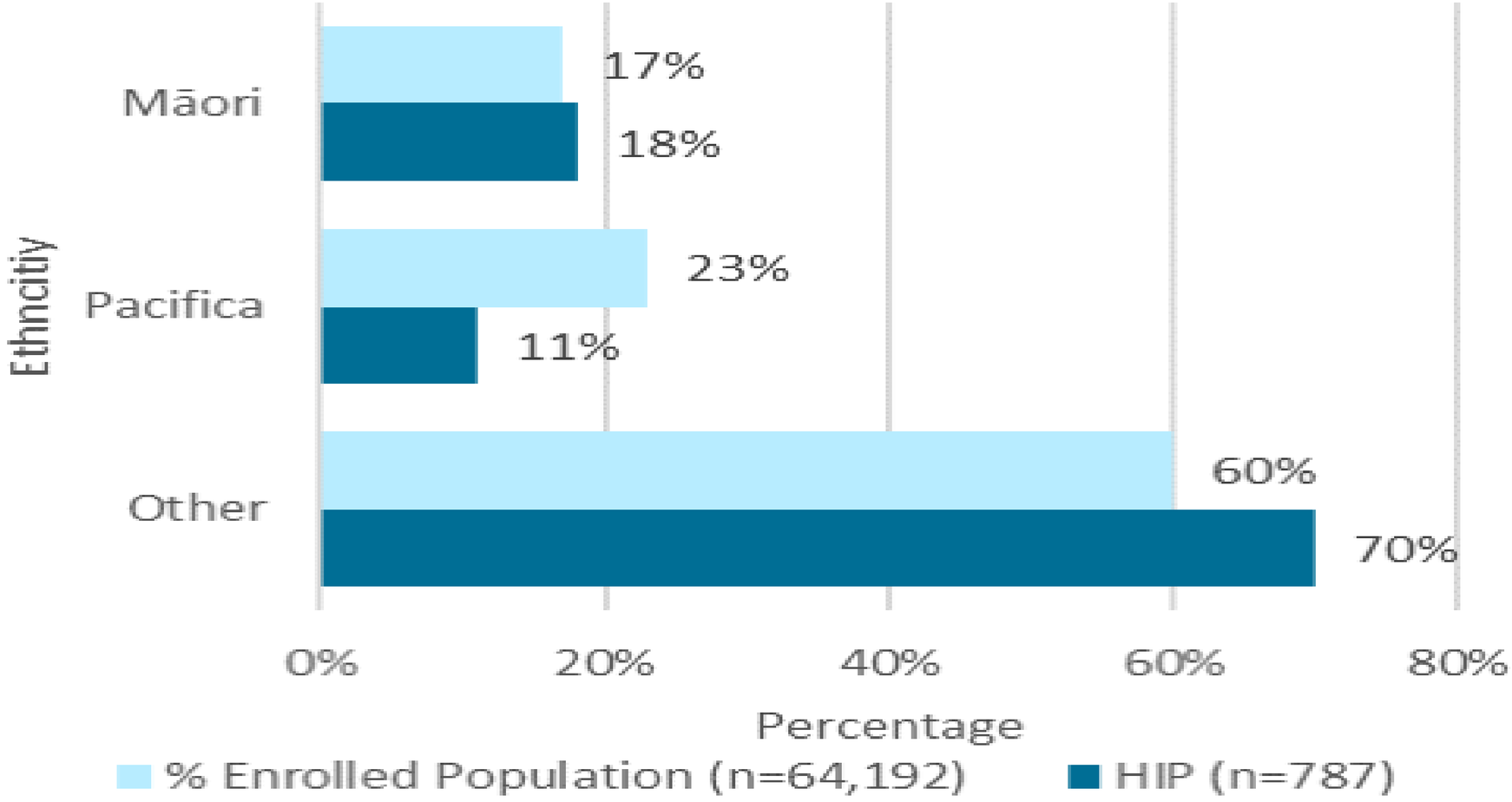
Awhi Ora reach by ethnicity



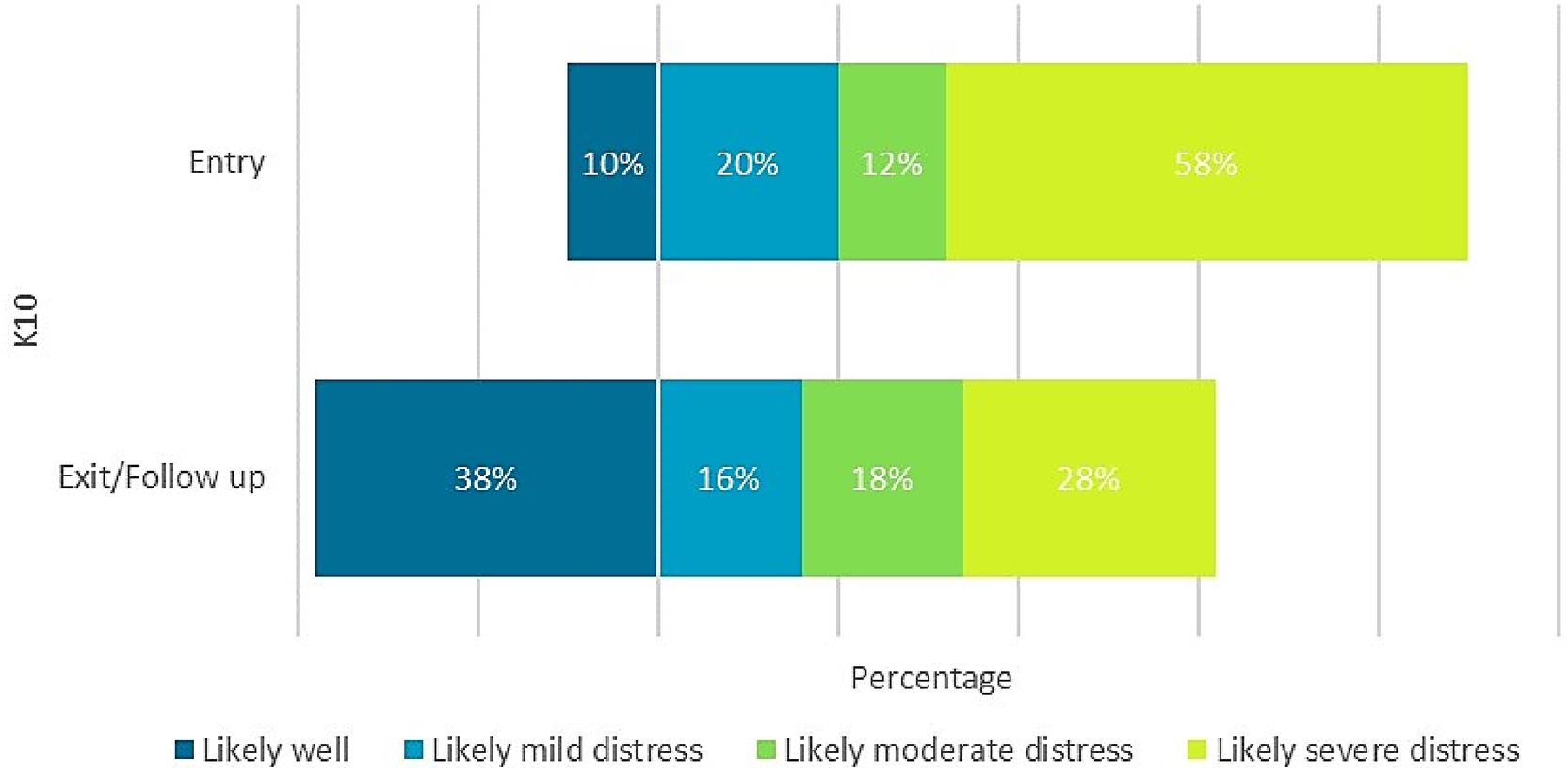
Health Coach reach by ethnicity



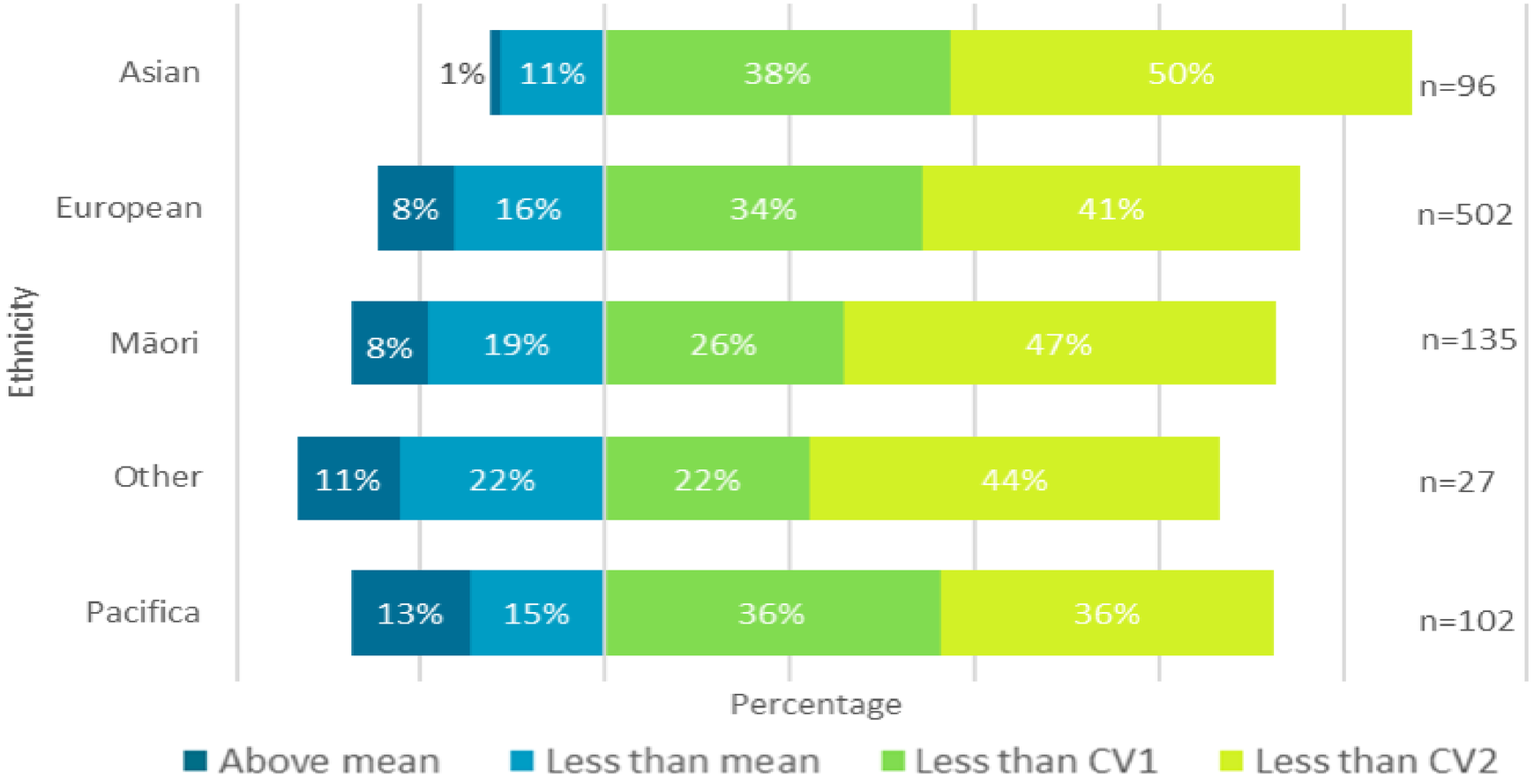
HIP reach by ethnicity



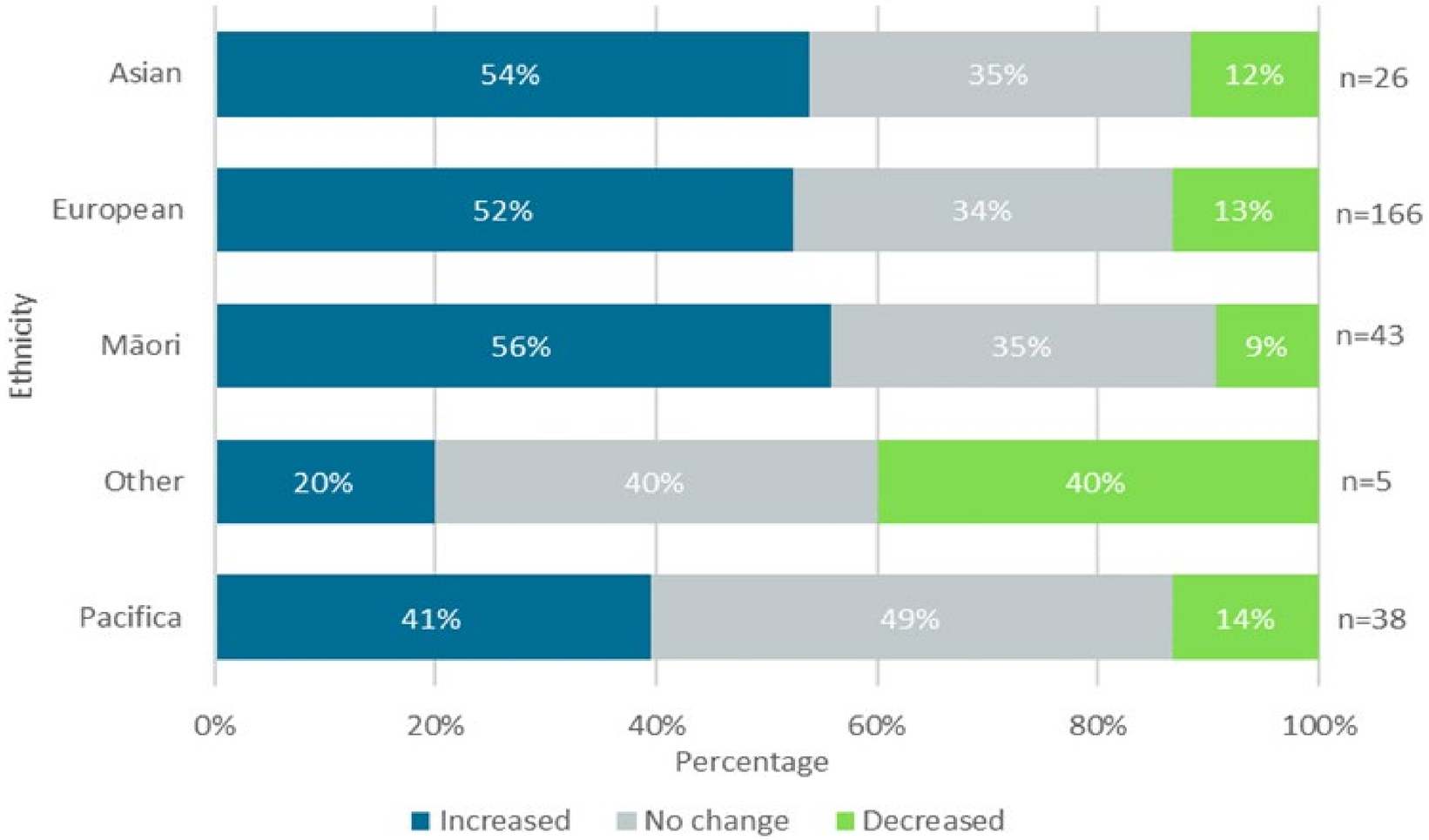
Awhi Ora Outcomes



HIP/HC Duke Health Profile entry scores by Ethnicity



HIP/HC Duke Health Profile Outcomes



NEW WAYS OF MEETING THE WIDER NEEDS OF PEOPLE PRESENTING IN PRIMARY CARE, IN METRO AUCKLAND:

part 2 of the journey 2013-2020 –

2 Enablers:

- Competent and capable GPs and PNs

-Close working relationships with secondary care

Enabler 1: Competent and Capable GPs and PNs

(Includes PN Credentialing Programme and significant GP education)

Wellness Support
Model of Care

Practice nurses and GPs working confidently with people towards their mental health and holistic well being goals.

COUNTIES MANUKAU HEALTH

	Person	Workforce
Kind Ngakau mahaki	I feel heard	The model is easy to use and allows flexibility
Clear Whanuihia te titiro	I know my options, what's next and have a back up plan	A wider team support me and my patients (including ILoC)
Continuous Paapaho te ara	My GP/nurse team keep in contact with me	I have continuous professional development opportunities to develop new skills
Effective Manahaere oranga	We are working towards my goals	I support more people to access care in ways meaningful to them

Give hope, follow up, involve the wider team

These principles were developed with the community following several cycles of consultation.

Wellness Support is effective for people

All the clients interviewed said they had benefited from Wellness Support.

- Reduction on their distress or symptoms
- Some described learning tools and strategies they could use to self mange, or had greater understanding and acceptance of their experience. Those who spoke about medication said it had been effective for them

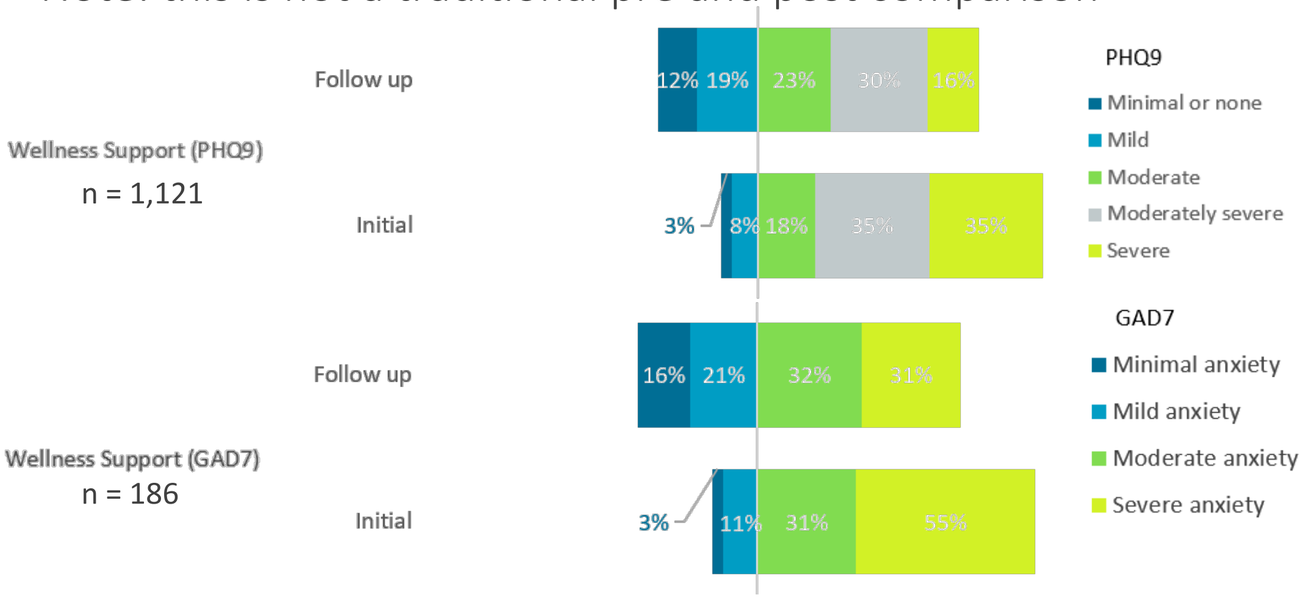
“I've come along way. ..feel I learnt lots of tools. I can use them to recover faster than before”- Client

“This experience has opened my eyes, that it is OK to have down days. ”- Client

“After therapy, I did find my feet…did stuff on my own. My whaanau could see I was becoming well.”- Client

Change in PHQ9 and GAD7 Scores

- Two in three people (66%) showed an improvement in their raw score between their initial consultation and the most recent on record
- Clinical improvement was rated by one in two (52%) with category change
- Note: this is not a traditional pre and post comparison



Repeat completion of these tools is not mandatory. Of the 1,695 enrolments that had 2 or more Wellness Support consults, 1,307 (77%) had a matched pair of clinical assessment scores.

Enabler 2: Close working relationships with Secondary Care

- Approaches tested include:
  - Psychiatrist advice phone line (the option most highly valued by GPs)
  - Primary Care Liaison MH Nurse and Psychiatrist roles, providing clinics in primary care
  - Integrated Locality MH Teams – subset of Community MH team, providing referral based consult-liaison service
- Currently all variably available across metro Auckland BUT all valued by GPs

Putting it in Context

- Historically primary MH programmes have had total national funding of $30million – 2% of the total MH&A budget - to meet 75% of moderate and severe MH&A need
- The Wellbeing Budget has dedicated $455million over 5 years – peaking at $187million in year 5 – with intent to develop 1600 new primary care based roles (BHC, Health Coach, NGO support), based in all GP clinics, to provide access to 325,000 people per year
- This will be an enormously challenging endeavour, with workforce being the single biggest challenge!

Key Messages

- The model pioneered by Te Tumu Waiora offers New Zealanders first class primary mental health and wellbeing care and support
- It is based on extensive co-design, testing and learning undertaken implementing international "best practice" over the past four years
- Key to the model is integration of 2 new roles into general practice teams – the Health Improvement Practitioner and Health Coach, along with ready access to NGO peer and community support
- Organisations already committed to implementing the model provide primary care services to more than half the NZ population
- We have established a Collaborative that will support those organisations (and any others wanting to join) to deliver locally tailored and nationally consistent services through shared learning and continuous improvement
- Our Collaborative will support the development of a world-leading primary mental health and wellbeing workforce and model of care

And that is why today, we will ensure every person in New Zealand will be able to access the support they need, when they need it, by rolling out a whole new workforce of trained mental health workers in doctors' clinics, Iwi health providers and other health services across the country. It is a new service targeted specifically at the mild to moderate mental health support that so many in the middle miss out on.

It is for all of us and it will be a game changer.

In total it will cost $455 million and take us a full five years to get the workforce we need to have this service running at full capacity, but I absolutely believe that when we do, this new layer of early care will transform mental health services in New Zealand.

Prime Minister Jacinda Ardern