



FIT FOR THE FUTURE: EVALUATING ENHANCED INTEGRATED PRACTICE TEAMS

A Report for the Ministry of Health

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This report has been written for the Auckland District Health Board and Waitemata District Health Board and their partners, and the Ministry of Health.

1. EXECUTIVE SUMMARY

In the 2017/18 financial year, the Ministry of Health put out a request for proposals to build on existing initiatives and support the development of an evidence base for interventions targeting people with mild to moderate mental health needs. Auckland and Waitemata District Health Boards (ADHB and WDHB) with their Primary Health Organisations (PHO) and Non-Governmental Organisations (NGO) partners responded successfully to the Fit for the Future (FffF) proposal. In September 2017, Synergia was commissioned to evaluate the interventions supported through the FffF funding in ADHB and WDHB, following a competitive tender process.

This report presents the findings from the evaluation of the interventions supported through the FffF funding primarily allocated in the ADHB region. Here funding was used to support development of enhanced integrated practice teams in practices in ADHB and WDHB, as well as for the expansion of Awhi Ora Supporting Wellbeing (Awhi Ora) in ADHB and its initial roll out in WDHB. This report presents the findings from the enhanced integrated practice teams, including Awhi Ora in the ADHB and WDHB regions.

Evaluation approach: The formative evaluation adopted a mixed methods design, drawing on service and outcome data, key stakeholder interviews, client feedback surveys and interviews, and a review of existing data and documentation relating to existing primary mental health interventions.

Implementation timeframe: Enhanced practice teams have seen the introduction of two new roles: a Health Improvement Practitioner (HIP; based on the behavioural health consultant model in the United States) and a Health Coach. These roles were introduced to practices from December 2017. In ADHB, Awhi Ora (NGO community support) continued a staged roll out that began in 2016. In WDHB initial implementation got off to a slow start from October 2017. This cross-organisational and emergent delivery model is still in its early stages of implementation. Though much has been achieved in this very short timeframe, the initiatives and their interconnectedness continue to evolve.

How much was done?

The enhanced integrated practice teams and Awhi Ora have:

- **reached the missing middle** through engaging people with a range of mental health needs who would otherwise have fallen through the cracks, as they were unlikely to engage with traditional psychological support services or meet the criteria for specialist support
- **provided immediate/rapid access to a range of person-centred support options.** People are seen the same day at the practice or within a week through Awhi Ora
- **facilitated equity of access for Māori, Pacifica and youth**, particularly through location at high-needs or youth-focused practices
- provided a **brief preventative response** that recognises and **responds to broader determinants** of ill health, including social and economic needs.

1.1 How well was it done?

Implementation is going well for something so new to primary care:

- The **change-management process is still underway**. Providers and clients were passionately supportive of this way of working; those close to service delivery told us it just made sense to be providing services in this way.
- **Practice team relationships are key to success**. This provides the interface that makes these roles work. **A consistent presence onsite** facilitates relationship building.
- **Complementary role strengths emerged quickly** with HIPs supporting those with higher levels of psychological distress, Health Coaches supporting physical health-related behaviour, and Awhi Ora responding to a range of psychosocial needs.
- Health Coaches and Awhi Ora provide a **culturally responsive connection** point for people accessing support.
- **High satisfaction and acceptability** from providers and clients.

"I don't know of any primary care programme that has hit the ground running and taken off so fast...this has just flown. There's a need and we all recognize the value of it. It makes our lives so much easier so why wouldn't we be flying with it?"
(GP)

1.2 Is anyone better off?

The evaluation provides a good level of evidence through which to understand the contribution of the enhanced practice teams to people with mild to moderate mental health needs. More specifically, the evaluation demonstrates the positive contribution that the enhanced practice teams make, and the value of continuing to support and further roll out their implementation.

Outcomes for people accessing services and supports:

- **improvements in mental health and wellbeing**
- **improvements in and towards the broader determinants** of wellbeing, such as housing, money matters and employment
- **immediate or fast access** to services and supports
- **improved access** for Māori, Pacifica and youth
- **access for people whose needs would have gone unmet.**

Benefits for people providing services and supports:

- **reducing the burden** on general practice teams
- giving general practice **staff confidence to 'have the conversation'** about mental health
- **able to access community support** for practice population via Awhi Ora

Practice and system outcomes:

- **better use of psychological support services** as reduced demand and wait times are emerging

- efficiencies are supporting GPs and PNs to work at **top of scope**
- emerging **reductions in prescribing** for antidepressants.

1.3 What does this mean for the missing middle?

The range of interventions that were expanded and supported by the FfF funding have provided an important and timely insight into the value of reaching the missing middle through:

- providing immediate access to services and supports for people in primary care
- providing services and supports that respond to the psychological, social and economic determinants of ill health and wellbeing without barriers to entry
- providing brief interventions and supports that help people at a point in time and enable them to move upwards on their wellbeing trajectory.

The evaluation also indicates that people with complex mental health needs can be managed within primary care, if it is equipped with the capacity and capability to do so. The findings also highlight the preventative nature of the support offered, as without it there is a real risk that these people's needs will continue to go unmet.

Ongoing improvements to initiatives: The improvements offered for consideration reflect the early phase of implementation and focus on the ongoing clarification, integration and functioning of the HIP and Health Coach roles and their fit and mix in difference practice contexts. Awhi Ora expansion and roll out beyond ADHB has highlighted scaling-up issues, which are being addressed. Enhanced pathways to support the integration of primary and secondary services will optimise the functioning of this flexible and collaborative response to mental health needs in primary care.

1.4 What's next for Fit for the Future?

To support primary mental health care in being fit for the future, the following recommendations are made:

- Extend the current enhanced integrated practice teams and provide additional funding to support the expansion of the HIP, Health Coach and Awhi Ora support workers to other high needs practices.
- Continue to target Māori, Pacifica, Asian and youth populations.
- Ensure practices that have HIP and Health Coach roles have an Awhi Ora support worker connected to them to optimise the value their role and expertise.
- Awhi Ora and the Health Coach roles are also important for supporting a culturally responsive approach for Māori and Pacifica, and it is important that this is considered in any future roll out.
- Place emphasis on whole of practice education to promote speedy and effective implementation.
- Review the role of Awhi Ora in engaging with youth through schools. This aspect of implementation did not work as intended due to the high level of administration. The WDHB evaluation highlights the value of connecting with youth-specific providers to increase the range of options available for young people, particularly those who might not access supports through general practice.

2. INTRODUCTION

In the 2017/18 financial year, the Ministry of Health put out a request for proposals for existing initiatives designed to support people with mild to moderate mental health needs. This funding sought to build on existing initiatives to support the development of an evidence base for interventions targeting people with mild to moderate mental health needs. This evidence base should guide decision making and investment to support the sector in becoming 'Fit for the Future' (FfF), as indicated by the title of the tender.

Auckland and Waitemata District Health Boards (ADHB and WDHB) and their partners successfully responded to this tender. Each DHB worked with its local Primary Healthcare Organisations (PHOs) and Non-Governmental Organisations (NGOs) to respond to the requirements of the Ministry, alongside support from Specialists in Secondary Mental Health Services.

The DHBs and their partners submitted an application that built on existing work, including:

- Awhi Ora Supporting Wellbeing (ADHB and NGOs)
- the ProCare Stepped Care model
- the East Tamaki Healthcare Health Coach model
- the Our Health in Mind Strategy (WDHB).

The FfF funding provided an opportunity to establish and evaluate enhanced integrated practice teams in practices across ADHB and WDHB. This included an expansion of Awhi Ora Supporting Wellbeing in ADHB, and its roll out in WDHB. WDHB also used the funding to support Business Case One of the Our Health in Mind strategy.

In September 2017, Synergia was commissioned to evaluate the interventions supported through the FfF funding in ADHB and WDHB, following a competitive tender process. This report presents the findings from the evaluation of the interventions supported through the FfF funding primarily allocated in the ADHB region. The enhanced integrated practice teams in WDHB and the roll out of Awhi Ora are also presented here to present a comprehensive evidence base.

The formative evaluation adopted a mixed methods design, drawing on service and outcome data, key stakeholder interviews, client feedback surveys and interviews, and a review of existing data and documentation relating to existing primary mental health interventions. Integrating insights across these data sources enabled the evaluation to provide robust feedback on the delivery and benefits of the enhanced integrated practice teams.

2.1 Structure of the report

This introduction is followed by an overview of the FfF funding and the enhanced integrated practices teams, which include Awhi Ora. Following this, a summary of the evaluation approach and methods is presented. The report then focuses on the key elements of the enhanced integrated practice teams that were implemented within the timeframe of the evaluation (Awhi Ora, Health Improvement Practitioners and Health Coaches). The results-based accountability framework is used to guide the results section through addressing the questions of how much? How well? And is anyone better off? The report also considers ideas for improvements and concludes with key considerations and recommendations.

This report is accompanied by an overview of the ADHB and WDHB FfF evaluation. A full evaluation report for the WDHB Our Health in Mind strategy, Business Case One is also a companion to this report.



3. THE FIT FOR THE FUTURE INITIATIVE

FfF has provided an opportunity for ADHB to work with its PHO and NGO partners to further respond to the needs of people with moderate mental health needs and strengthen the evidence base for their approach. This work builds on the initiatives and interventions of those partners and has enabled additional delivery of some and supported the early development of others.

Specifically, ADHB has used FfF funding to support:

- the co-design of a framework to guide development and delivery of a person-centred primary and community mental health model of care (Framework Document)
- the expansion of Awhi Ora, NGO-provided community support services
- new practice team roles of health improvement practitioner (HIP) and Health Coach
- Mental Health and Addictions Credentialing Programme for Primary Health Care Nurses in ADHB
- telehealth support.

People with moderate mental health needs are those who are unable to self-manage yet don't meet the criteria for secondary mental health services. Often referred to as 'the missing middle', these people have thoughts, feelings or act in ways that are detrimental to their health and wellbeing. This cohort is currently poorly served by a primary care sector that lacks capacity and capability to address the volume and complexity of biopsychosocial needs. This position is unsustainable, hence the need to be fit for the future and investment in understanding how we might do this from the Ministry and the sector.

3.1 Supporting existing interventions

Supporting the integration of services and supports across key players from the sector requires strong project management and governance processes. The initiatives supported through FfF funding have been overseen by a steering group of key stakeholders facilitated by the DHBs. These stakeholders also link FfF with related initiatives including the Our Health in Mind programme of work, existing primary mental health initiatives and the Tāmaki Wellbeing initiative.

The complexity of this network of initiatives and relationships cannot be underestimated. Many of the organisations represented are contributing from the perspective of their own organisational pilots and change programmes. FfF is not a discrete project or initiative in the traditional sense; there are many moving parts, each working towards an improved response for people with mild to moderate mental health needs.

The Framework Document, developed through the FfF funding, has provided a lens through which to view and evaluate the multifaceted activity across ADHB, and reaching into the WDHB region.

3.2 The Framework Document

In November 2017, the Framework Document was published. This was the culmination of a co-design initiative that involved people and providers developing a response to meeting the needs of people with mental health issues in primary care and the community.



A framework to guide the prototype of a person centred model of care that responds to mental health need in primary care and the community.

This framework includes principles of practice, the support landscape and some ideas to operationalise the principles of practice (concepts).

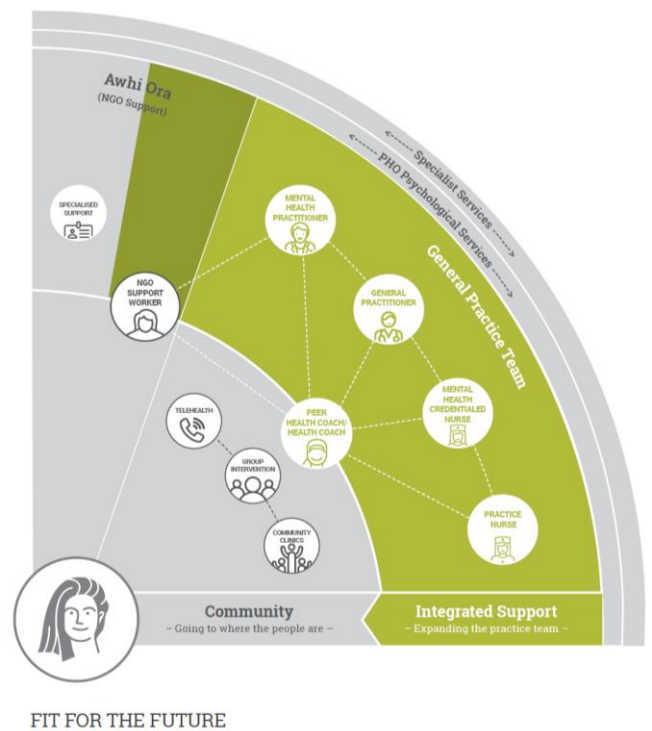
The co-design process provided insights that evolved into twelve “actionable principles of practice to guide the development of a person-centred service in primary care and community.”¹ These principles are:

- address needs before diagnosis
- normalise conversations about mental health
- address people’s holistic needs
- help people to help themselves
- connect for the whole journey
- one size doesn’t fit all
- provide timely support
- develop trusted relationships
- go to where people are
- be responsive to cultural needs and preferences
- be persistent
- recognise lived experience.

The Framework Document identified the people and places necessary in the support landscape. Three core aspects of this landscape are:

¹ Think Place (2017) Fit for the Future: A framework to guide the prototype of a person-centred primary and community mental health model of care (p.44)

- an enhanced general practice team; enhanced with new roles that work with each other and the existing practice team. The new roles identified are a mental health practitioner, peer Health Coach/ Health Coach and NGO support worker. These enhanced integrated general practice teams are referred to as Framework practices in this report
- 'walk alongside' community support (Awhi Ora) that is accessible from and beyond the GP practice and will support people with what matters to them
- reach into the community by providing points of access in homes and community settings beyond the practice as well as other modes of delivery such as telehealth.



This evaluation focuses on interventions that were delivered within the timeframe of the evaluation.

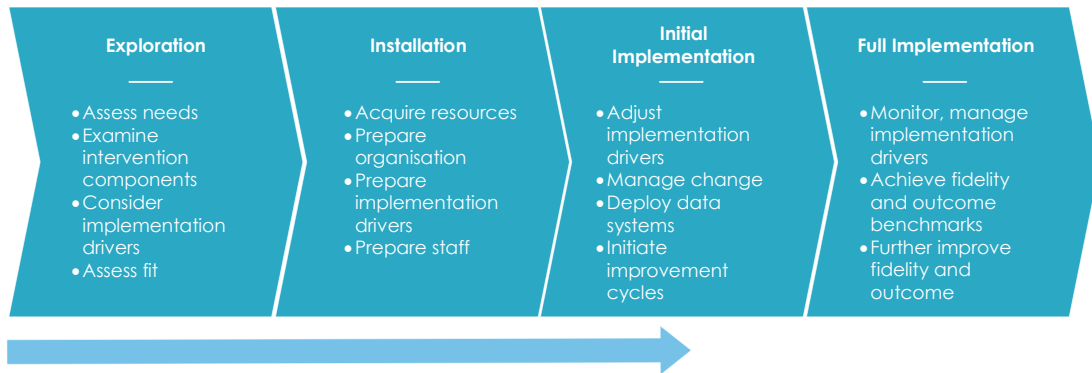
3.3 Implementation of the Framework Document

FtF was designed to build on existing interventions, and this has expedited the delivery of initiatives recognised under the FtF umbrella. It is important to recognise, however, that some of these initiatives were still in the early planning stages at the beginning of the FtF funding period or were not operating at scale. The introduction of new roles and relationships into general practice is a change process of real significance. The implementation science research literature² reminds us that implementation processes take time – greater time than the FtF period – with maturity occurring within a two to four-year period. This stage of implementation is considered when making evaluative

² Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., and Wallace, F. (2005). Implementation Research: A synthesis of the literature (FMHI #231). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network

judgements about the delivery and achievements of the enhanced integrated practice teams.

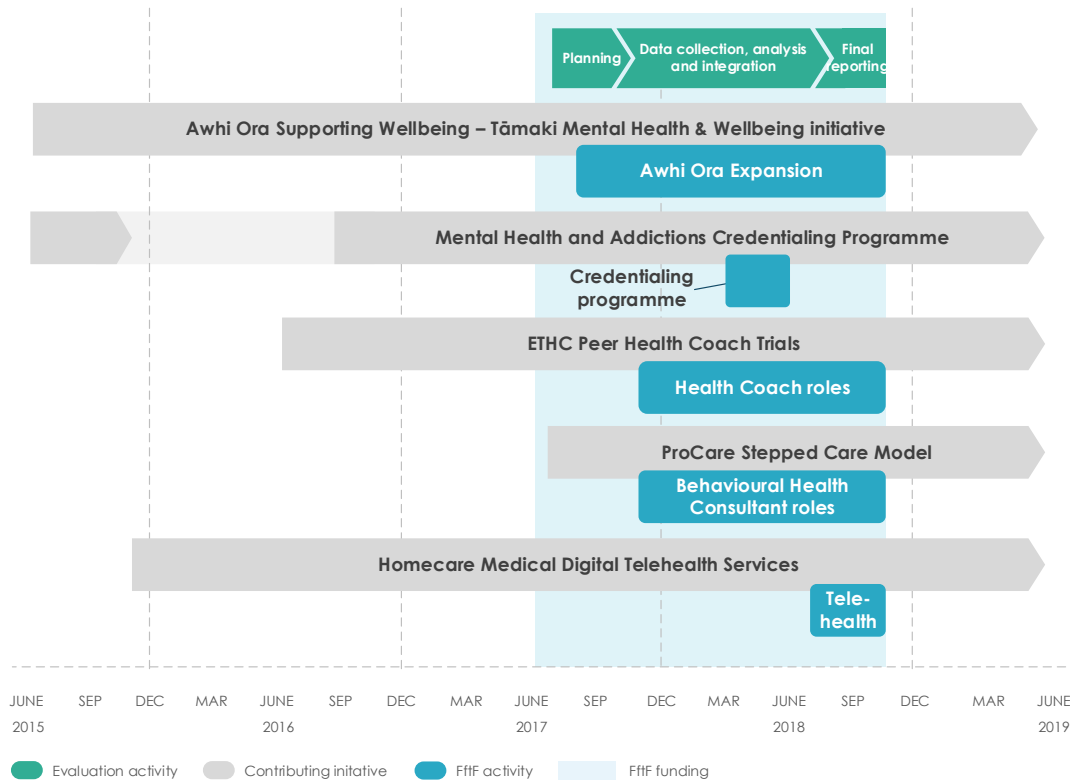
Figure 1: Stages of implementation



The following timeline illustrates these contributing components, the FfF funding and evaluation window. This demonstrates:

- The upscaling of Awhi Ora across the ADHB region and its roll out into WDHB. This is the most mature of the interventions delivered, although it has not been evaluated as a model of support or for its readiness for upscaling.
- The introduction of HIPs and/or Health Coaches to seven practices. This was supported by existing work at ProCare and East Tamaki Health Care (ETHC):
 - o Planning for ProCare's Stepped Care Model began in late 2017 and the PHO facilitated the very first training of HIPs in November 2018. This role and its function is a New Zealand first and this is in the early stages of implementation.
 - o ETHC ran its first pilot of Health Coaches in 2016 to support diabetes care. These roles are new to the Framework practices primary care teams and are at the initial implementation stage.
- The delivery of an additional Mental Health and Addictions Credentialing Programme.

Figure 2: FfF timeline



The evaluation of FfF in ADHB focuses predominantly on the enhanced practice teams, including Awhi Ora, as these are the aspects of the Framework that were being delivered within the timeframe of the evaluation. FfF has also supported a nurse credentialing programme and telehealth within this landscape. These aspects of the Framework Document are not a key focus of this evaluation as:

- Telehealth support started in July 2018 at ETHC's Glenn Innes practice. This service is to provide additional HIP-type support over the phone for three days a week between 4.30 and 8pm. By mid-August there had been no referrals to the service. Homecare Medical and the ETHC Wellness Support Team are currently working on strategies to increase uptake of the service.
- The nurse credentialing programme has previously been evaluated by Auckland University of Technology in 2016.³ The evaluation confirmed the quality and value of this training programme both in its delivery and achievement of learning objectives. There is little value to add by evaluating this programme again. This

³ Evaluation of Collaborative Mental Health and Addictions Credentialing Programme for Primary Health Care Nurses. Report prepared for Metro Auckland DHB and PHO Collaborative February 2016, Allan Wyllie

evaluation however, does seek to understand the current and potential contribution of credentialed nurses to the Framework.

- FfF has funded Comprehensive Care to run a fourth nurse credentialing programme. This was delivered over a shorter four-month period: March to June 2018. All 17 nurses who enrolled have completed the programme. Portfolios are currently being submitted for assessment.

The evaluation draws on interviews with credentialed nurses at some of the enhanced integrated practices to provide feedback on their potential fit and role within this wider Framework landscape, as well as on the factors that are important for supporting the use of the skills learned through the training programme.

3.4 Key points

- The FfF Framework document identifies principles and a support landscape for meeting the needs of people with moderate mental health needs in primary care and the community.
- FfF has provided funding to support a range of initiatives that were already in progress, though most were at the planning or early stages of implementation. None of the interventions can be described as mature.
- The evaluation focusses predominantly on Awhi Ora and the roles of HIP and Health Coaches in the enhanced integrated practice teams. Examples from WDHB are included in this report to strengthen the evidence base and insights from the evaluation.

4. ENHANCED INTEGRATED PRACTICE TEAMS

This section provides an overview of the FfF interventions identified in the support landscape by ADHB, WDHB and their partners. Awhi Ora, the HIP and the Health Coach roles are the main focus of this evaluation report, but other interventions, the Mental Health and Addictions Credentialing Programme and Telehealth are also outlined.

4.1 Awhi Ora Supporting Wellbeing

Awhi Ora provides access to community support to people experiencing life challenges or stress. Previously such support has only been available to people through secondary mental health services. Awhi Ora is designed to enable primary care practices and cross sector agencies to have a lead NGO they can introduce people to who would benefit from wellbeing or social support. Following an introduction, people are seen by a support worker. This may be in the GP clinic, their home or in the community. A plan to address the person's presenting need is developed with the support worker. Support is usually brief – typically weekly for up to three months – but varies according to need. People with multiple or more complex issues may require support for a longer period.

4.2 Health Improvement Practitioner and Health Coach

HIPs are registered health professionals who can work briefly with a high number of people (8+ per day) to provide targeted behavioural health support within primary care. Health Coaches are non-regulated workers who support people with health literacy and self-management relating to long term conditions. The warm handover, a face-to-face introduction that enables immediate or same day consultations, where possible, is an important dynamic of these roles within the practice team. Practical action and self-management plans are developed with people that focus on the wellbeing issues of concern to them and repeat consultations occur as and when required by the client.

4.3 Mental health and addictions nurse credentialing

Following a successful pilot in 2015, Comprehensive Care has been contracted by the three metro Auckland DHBs to lead and deliver a Collaborative Mental Health and Addictions Credentialing Programme for Primary Health Care Nurses across ADHB, WDHB and CMDHB.

The programme aims to enhance the competency and confidence of nurses in their everyday practice when supporting individuals and whānau impacted with moderate mental health and addiction issues. Successful participants are accredited by Te Ao Māramatanga New Zealand College of Mental Health Nurses (NZCMHN).

An evaluation of the inaugural training programme was published by Wylie and Associates in 2016⁴. The evaluation confirmed the quality and value of this training programme both in its implementation and in achievement of learning objectives. Overall, the programme was considered an effective and sustainable contribution to building mental health and addiction capacity in primary care.

The evaluation did not extend beyond the training programme timeframe, so provided only limited insight into the experiences and contribution of credentialed nurses back in their practices' teams. Still, the evaluation found that nurses with time to engage with patients reported the greatest benefit from the programme. Nurses without sufficient time and school nurses were less able to use their learning back in the workplace. The evaluation noted the need for ongoing support of credentialed nurses post training and acknowledged the value of longer term evaluation.

To date, 137 nurses including the FffF cohort have completed the credentialing programme.

4.3.1 Nurse credentialing for FffF

FffF has funded Comprehensive Care to run a fourth nurse credentialing programme. This was delivered over a shorter, four-month period: March to June 2018. All 17 nurses who enrolled have completed the programme. Portfolios are currently being submitted for assessment.

Programme survey feedback identifies successful outcomes in terms of mental health and addiction knowledge, understanding and confidence.

Consideration within the FffF evaluation

The credentialing programme is considered as a contribution to the support landscape, rather than being a key focus of the evaluation. This was a pragmatic decision, given the FffF cohort's training was completed just within the evaluation timeframe and an evaluation of the training period has only recently been completed by Wylie and Associates⁵.

Where possible, credentialed nurses (or those in training) were interviewed or asked about in interviews at Framework practices. Their feedback was consistent with the Wylie and Associates evaluation findings; they found the training to be relevant and valuable and were much more aware and confident about working with people with mental health and addiction issues. The ability to use these skills in practice was limited by time and expectations of service delivery (such as a schedule of smears or vaccinations). In one Framework practice the credentialed nurse had a clear contributing role and there

⁴ Evaluation of Collaborative Mental Health and Addictions Credentialing Programme for Primary Health Care Nurses. Report prepared for Metro Auckland DHB and PHO Collaborative February 2016, Allan Wylie MSoc Sci, Ph

were plans in some of the other Framework practices to make better use of their knowledge and skills.

4.4 Telephone support (telehealth)

An initial trial of telehealth support went live on 3 July 2018 at the ETHC Glen Innes practice. This service is to provide additional HIP-type support over the phone for three days a week between 4.30 and 8pm. This is the period between the onsite HIP finishing and the practice closing. This service is delivered by Homecare Medical.

By mid-August there had been no referrals to the service. Homecare Medical and the ETHC Wellness Support Team are currently working on strategies to increase uptake of the service. Given the stage of implementation, the telehealth component of the practice landscape is not included in this evaluation.

The value of delivering this type of intervention and its fit with other functions and roles is important to understand in the future. It has the potential to provide an accessible, cost-effective option instead of, or to compliment, other primary care support.



5. EVALUATING FIT FOR THE FUTURE

This section summarises the evaluation approach and methods used to evaluate the interventions supported through the FftF funding at ADHB.

5.1 Key evaluation questions

The evaluation sought to address the following key evaluation questions and purposes (Table 1):

Table 1 Key evaluation questions

| | |
|-------------------------------|---|
| How much? | <ul style="list-style-type: none">○ To identify the reach of the interventions delivered through FftF. |
| How well? | <ul style="list-style-type: none">○ To identify the delivery of the FftF interventions, including fidelity and adaptation.○ To identify barriers and enablers to delivery. |
| Is anyone better off? | <ul style="list-style-type: none">○ To evaluate the effectiveness of the delivery and outcomes of the FftF interventions for people supported by and providing the interventions, and the wider primary and community care system. |
| Future considerations: | <ul style="list-style-type: none">○ To integrate the evidence across each of the interventions to identify their contribution to supporting people with moderate mental health needs.○ To identify ideas for improving and modifying the specific interventions and ways of working.○ To inform future considerations relating to the sustainability and expansion of the FftF interventions. |

5.2 Evaluation approach

This evaluation adopted a formative approach guided by the results-based accountability framework⁶ and programme evaluation theory.^{7,8} This guided the evaluation to address the questions of how much, how well and is anyone better off? Programme theory also enabled the evaluation to move beyond these questions to understand the broader context within which the interventions were delivered.

⁶ Ryan, D. and Shea, S. (2012). Results based accountability: Guidelines and resources. Ministry of Social Development, New Zealand <http://www.familyservices.govt.nz/working-with-us/funding-and-contracting/results-based-accountability/resources/guidelines/introduction.html>

⁷ Funnell, S. (1997). Program Logic: An Adaptable Tool for Designing and Evaluating Programs. *Evaluation News and Comment* 6(1): 5–7

⁸ Donaldson, S. (2005). Using Program Theory-Driven Evaluation Science to Crack the Da Vinci Code. In M. C. Alkin and C. A. Christie (eds) *Theorists' Models in Action*, New Directions in Evaluation, 106: 65–84

Programme evaluation theory also supports the evaluation to provide rapid formative feedback.

The evaluation adopted a mixed methods design. This supported a comprehensive analysis of the delivery and successes of the FfF interventions. The specific data collection methods were:

1. an analysis of service data collected by general practice, NGOs and the DHB
2. a time series analysis of psychological distress using a validated tool with people receiving more intensive supports (pre and post; Awhi Ora Supporting Wellbeing)
3. a time series analysis of other validated outcome tools to assess mental health and functioning for people accessing services and supports for HIPs and Health Coaches (pre and post)
4. a survey and interviews with people using the FfF interventions
5. interviews with people providing the FfF interventions, including practice visits.

Further detail on the specific data collection methods and approaches are provided in relevant sections of this report. A brief overview is provided here.



5.2.1 Data collection methods and sources

Interviews with people and organisations providing services, key stakeholders and clients receiving support.

Table 2 identifies the count of people interviewed, by type. These include brief and longer, more formal interviews. In total, 109 people's views are represented in this evaluation.

Provider data relating to client profile, service delivery volumes and activities and client outcome measures.

Framework practices provided de-identified data for the period December 2017 to 13 July 2018. Outcome measurement data differed between providers and client cohorts, it included the Duke, the Patient Health Questionnaire 9 (PHQ9), Strengths and Difficulties Questionnaire, Partners in Health, and the Kessler Psychological Distress Scale (K10).

Awhi Ora providers in ADHB and the four with additional funding in WDHB provided de-identified data. There was an initial data set for testing, then quarterly data for the September 2017 to 30 June 2018 included in the evaluation. Outcome measure data consisted of the Kessler Psychological Distress Scale (K10).

NGO providers supported the administration of an Awhi Ora client feedback survey which was collated by Synergia.

5.3 Data integration and analysis

Each data source has been analysed using the method traditionally associated with that data source. For example, interview data was analysed thematically using a general inductive approach,¹⁰ and service data was analysed using descriptive statistics. To move beyond the findings of individual data sets, a mixed methods data integration framework was used to identify and understand the contribution of the different methods to the key evaluation questions.

Table 2 People interviewed⁹

| Category | Number of people |
|--------------------------|------------------|
| HIP clients | 7 |
| HC clients | 3 |
| Awhi Ora clients | 9 |
| Awhi Ora providers | 22 |
| Awhi Ora partners | 9 |
| HIPS and Health Coaches | 11 |
| Framework practice staff | 36 |
| PHO staff | 6 |
| DHB project staff | 6 |
| TOTAL | 109 |

⁹ This table counts the number of people interviewed by their involvement with FtfF. Some people were interviewed more than once at different stages of the evaluation but are only counted in this table once. Other people fit more than one category and so therefore are counted twice, for example a client of both Awhi Ora and a HIP. Some people were interviewed together and in this case are all counted separately.

¹⁰ Thomas, D. (2009). A general inductive approach for analysing qualitative data. *American Journal of Evaluation*, 27(2)

Mixed methods data integration and interpretation has been supported by ongoing engagement with stakeholders as well as two sensemaking workshops.

5.4 Ethics

The Health and Disability Ethics Committee confirmed that the study is out of scope for the requirement of ethnics committee review. The evaluation however, has been guided by the Aotearoa New Zealand Evaluation Association Standards.¹¹ Formal written consent and engagement with service providers occurred to ensure that clients invited to participate in interview could do so safely.

Limitations

The key limitations of this evaluation are:

- The impact of the evaluation timeframe on the window available to understand the FfF interventions. Some initiatives were still in their very early stages, so ongoing monitoring will be important for strengthening the insights from this report.
- The quality of data provided by Awhi Ora, and lack of systematic outcome measurement across initiatives challenged the ability to track all aspects of delivery and the level of outcome data available.
- The range of data-collection protocols and tools used has limited the direct comparison of intervention types. The Duke is particularly challenging, as it has cohort-specific analyses, which makes it difficult to conduct an analysis of effect sizes, for example.
- The collecting of a primary presenting condition by HIPs and Health Coaches has limited insight into co-morbidly, particularly the extent of alcohol and other drug use in this cohort.

¹¹ Evaluation standards for Aotearoa New Zealand.
<https://www.anzea.org.nz/evaluation/evaluation-standards/>

6. AWHI ORA IMPLEMENTATION: HOW MUCH?

The Tamaki Wellbeing project began in 2013, taking a community development approach to developing and delivering health and wellbeing services that meet the needs of local communities. From one of five workstreams, an initial mental health pilot began in April 2015 with three NGOs and two primary care practices. This 'walk alongside community support service' (Awhi Ora) was expanded to the seven NGO providers and thirteen practices from October 2016. FfF funding enabled further expansion to include 23 practices and some non-health sector partners.

Awhi Ora responds to a range of biopsychosocial needs for people experiencing life challenges to their wellbeing or experiencing stress in their lives. In keeping with its principles, there is deliberately no definition of stress or criteria for accessing support. Awhi Ora is not a clinical service.

Success is described as people having greater control over their lives and maximising their health and wellbeing.

6.1 Service specification

Providers have received variations to their existing contracts for community mental health services. These variations require providers to work on integration with primary care and deliver brief intervention approaches to health and social services navigation. This is to:

- support the wellbeing needs of people with primary mental health needs (over 18 unless specified otherwise)
- develop relationships across primary care, NGOs and health and social service providers that facilitate rapid introductions.

1.2 Awahi Ora role overview

Awahi Ora is summarised in the overview below. A more detailed description of the service is included in the appendix.

Awahi Ora-Supporting Wellbeing



BACKGROUND

- Tāmaki Mental Health and Wellbeing initiative piloted a walk alongside community support service in 2015. This became known as Awahi Ora, and ADHB expanded delivery in 2016 and again for Fit For the Future in 2017. Awahi Ora began in WDHB in October 2017



ROLE

- Awahi Ora support is person centred relational and collaborative
- Delivery is underpinned by 12 guiding Awahi Ora principles
- Awahi Ora providers are linked to a GP practice or other sector partner
- Awahi Ora providers form a network to collaboratively support people, learn and grow together



TARGET GROUP

- Awahi Ora is described as walk alongside support for people experiencing life challenges to their wellbeing or experiencing stress in their lives. There is no criteria for access
- Adults (over 18). One provider to target youth through a school
- Awahi Ora is not a clinical service



PRACTITIONER

- Community Support Workers from NGO providers of mental health community support contracts
- Equivalent or higher qualification than Level 4 Mental Health and Addiction Support Work
- In ADHB there are seven NGO providers involved
- In WDHB there are ten NGO providers involved



DELIVERY

- Following an introduction, people are seen by a Support Worker usually within five working days
- Support is provided mostly in the community or in people's homes
- Support is usually brief – typically weekly for up to three months – but varies according to need and the personal plan developed with each person
- Support includes practical and emotional support, navigation and connection to services and community resources



OUTCOME MEASURES

- For evaluation purposes, NGO providers are using Kessler 10 on entry and exit from services



SUCCESS

- People having greater control over their lives and maximising their health and wellbeing

Awahi Ora in ADHB now involves 24 practices: 13 from the existing Awahi Ora work and an additional 11 from the FfF expansion. This work was led and supported by seven NGOs, the ADHB project team and Awahi Ora Steering Group.

The seven NGOs providing Awahi Ora have been linked to the following primary care practices and social sector partners (Figure 4). Managers from each of the NGOs have worked with the FfF project manager as a working group to support delivery.

Figure 3: ADHB Awhi Ora NGO providers and associated practices

| AWHI ORA PROVIDERS | Kāhui tū Kaha | Emerge Aotearoa | Mind & Body | Mahitahi Trust | Pathways | Framework Trust | Vaka Tautua |
|-------------------------------------|---|--|--|---|--|---|--|
| AWHI ORA PRACTICES PRE EXPANSION | Panmure Medical Centre ProCare Orakei Auckland PHO | Calder Auckland PHO Mt Wellington ProCare Doctors Onehunga NHC | Glen Innes ETHC Mission Bay ProCare | Mt Wellington Family ProCare | University Health and Counselling Service ProCare Avondale Alliance+ Glen Innes ETHC | Grey Lynn ProCare Mt Roskill ETHC | Mt Smart ProCare Mt Wellington Integrated ProCare |
| | Avondale Family Doctors Auckland PHO | Avondale Health Centre Auckland PHO | Tamaki Family Health Centre NHC | Turuki ProCare Stoddard Rd TBC ProCare | Turuki ProCare | Sandringham Clinic ETHC Stoddard Road Clinic ETHC Mt Roskill Urgent Care ETHC | Langumalie Health Centre Alliance + Health Star Medical NHC |
| COMMUNITY PARTNERS | | Emergency Housing Selwyn College | | CORT Housing National Hauora Coalition ProCare Psychological Services | | | Fanua Ola & Langafonua |

● = Framework practice

NHC = National Hauora Coalition, ETHC = East Tamaki Health Care, CORT = Community of Refuge Trust

6.2 Awhi Ora working group

An Awhi Ora working group has begun developing a best practice guide to formalise and communicate expectations around delivery of service, promote quality process and support consistency of approach across providers. This was in its initial draft phase at the end of the evaluation period.

This group includes representation from ADHB and WDHB Awhi Ora providers as well as from DHB Planning, Funding and Outcomes. Learnings from the formative phase of the FffF evaluation and the acute need to support WDHB implementation are being addressed by this group.

6.3 Awhi Ora in WDHB

Awhi Ora was funded in WDHB from September 2017. This was part of the Our Health in Mind strategy (Business Case One) designed to increase access to NGO support hours across the district. The reach and experiences of WDHB Awhi Ora are included in this report as their learning and implementation journeys are intertwined.

Unlike the staged roll out in ADHB, implementation was intended to be at relatively large scale from day one. Insufficient coordination and communication between the DHB, all NGO providers and primary care practices resulted in a launch that was uncoordinated and confusing for NGOs and practices. Additional project management support was made available for WDHB Awhi Ora in March 2018, and a process of consolidation began. This process includes re-establishing links between practices and providers via PHOs and is still underway.

The NGO providers and their introduction partners are identified in Figure 5. Not all providers have formally identified partnerships and some of those identified are very new. There may be other partnerships in place that have not yet been recognised by the Awhi Ora network.

In WDHB there are other providers that are not included in Awhi Ora delivery.



Figure 4: WDHb Awhi Ora NGO providers and associated practices

| | Kāhui tū Kaha | Emerge Aotearoa | Mind & Body | Equip | Pathways | Walsh Trust | Vaka Tautua | Connect SR | Te Kotuku Ki Te Rangī | Te Whanau O Waipereira |
|---|-----------------------|-------------------------------|---------------------------------|---------------------------------|--------------------|----------------------------|-------------|-------------------------------------|-----------------------|------------------------|
| | Additional funding | Additional funding | | | Additional funding | Additional funding | | | | |
| AWHI ORA PRACTICES Partnerships established to June 2018 | Royal Heights Medical | Westview Medical Glen Eden | Glenfield White Cross GP Clinic | Glenfield White Cross GP Clinic | Health New Lynn | The Doctors Massey Medical | | Comprehensive Care PHO | | Wai Health |
| | Peninsula Medical | | Hobsonville Family Doctors | Hobsonville Family Doctors | Med Plus | Waitakere Union | | Glenfield Medical Centre | | Ranui Medical |
| | | | The Doctors New Lynn | | | The Doctors Red Beach | | Brown's Bay Family Doctors | | |
| | | | | | | Valley Road Medical Centre | | ProCare Psychological Services WDHb | | |
| | | | | | | Lincoln Road Medical | | | | |

● = Framework practices (ProCare)

7. AWHI ORA REACH: HOW MUCH?

This section describes the people accessing services and supports through Awhi Ora, including a presentation of their demographic profile, range of support needs and severity of distress they present with. Key sources of referrals (introductions) are also identified.

7.1 Who is accessing Awhi Ora?

Awhi Ora has provided access to community support for people who would not otherwise have been eligible for support. Awhi Ora providers have, in interview, confirmed that people accessing supports are predominantly those who have not been able to access support before. They are seeing people with distress that is linked to a range of biopsychosocial determinants of ill health, which can be reduced with timely and targeted support.

"We are short sharp and sweet - we go in and address the specific needs and this reduces anxiety and stress which works preventatively. We are task focused and short term."
(NGO provider)

Through interview, providers also referred to supporting people who had used secondary mental health services in the past, and associated community support services. This was not described as a group of significant size, but the support offered was necessary to keep people well and prevent decline.

One client we interviewed saw Awhi Ora as a way for him to access support and get connected to services on his own terms, without becoming involved with secondary mental health services:

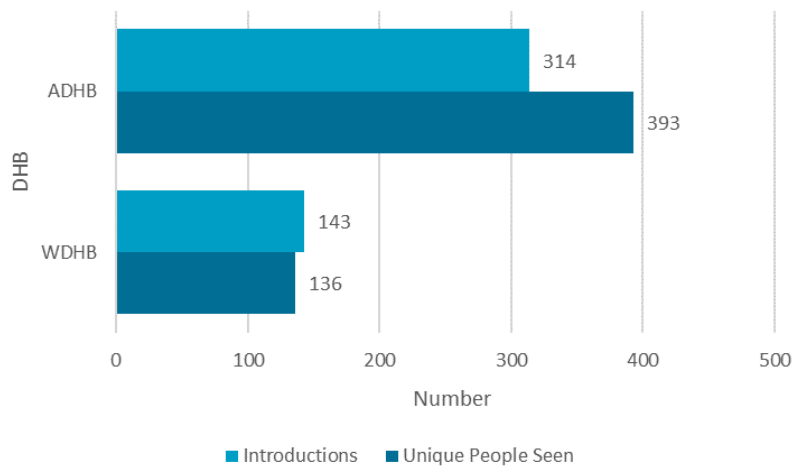
"I have been out of prison for 12 years, and out of mental health services for longer. I'm flying under the radar – not wanting them but needing them."
(Person accessing Awhi Ora support)

Though small, this may be an important cohort of clients for Awhi Ora to engage with and provide episodic support to, to maintain wellness. Currently this cohort is not identifiable at a system level; this may be a consideration of ongoing monitoring.

7.2 What is the reach of Awhi Ora?

In the FfF period, 457 introductions were made to Awhi Ora across ADHB and WDHB.

Figure 5: Introductions and Unique Individuals Seen by DHB



The 393 people engaged through Awhi Ora in the ADHB region included people introduced before FfF but who were still involved during the funded period.



457 new introductions across ADHB and WDHB



Conversion rate for Awhi Ora is around 8 in 10; for every 10 introductions, eight engage to the level of at least one face to face contact.

From our work with provider agencies, we know that not all introductions or one-off supports (such as navigation advice offered over the phone) are consistently entered into their client information systems. For that reason, the numbers presented here should be considered as indicative of a minimum of introduction numbers.



7.3 What is the demographic profile of people accessing Awhi Ora?

This section presents data relating to the demographic profile of people accessing Awhi Ora. Across WDHB and ADHB there is a consistent overall pattern of gender reach, with two thirds of people accessing Awhi Ora identifying as female.

Figure 6: Awhi Ora reach ADHB by ethnicity

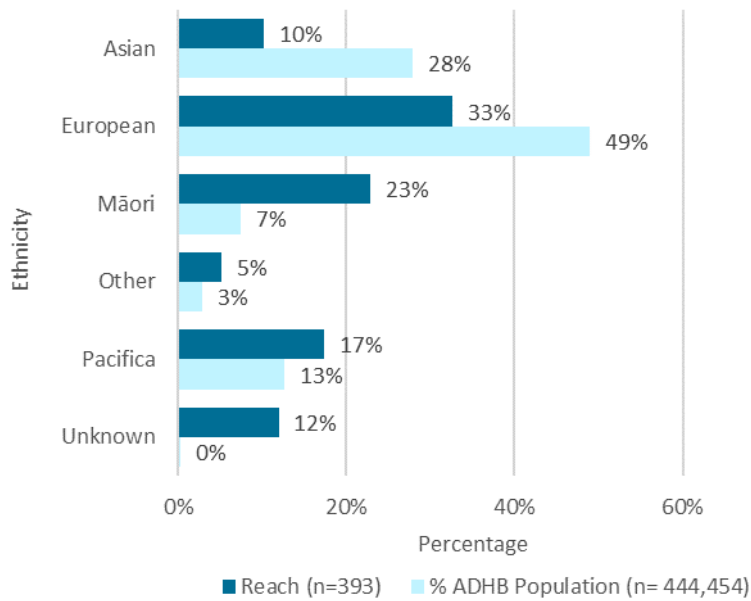
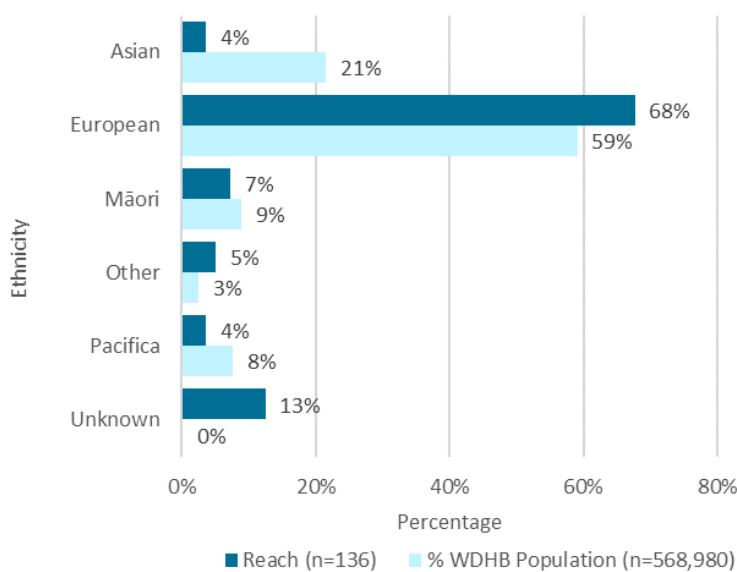
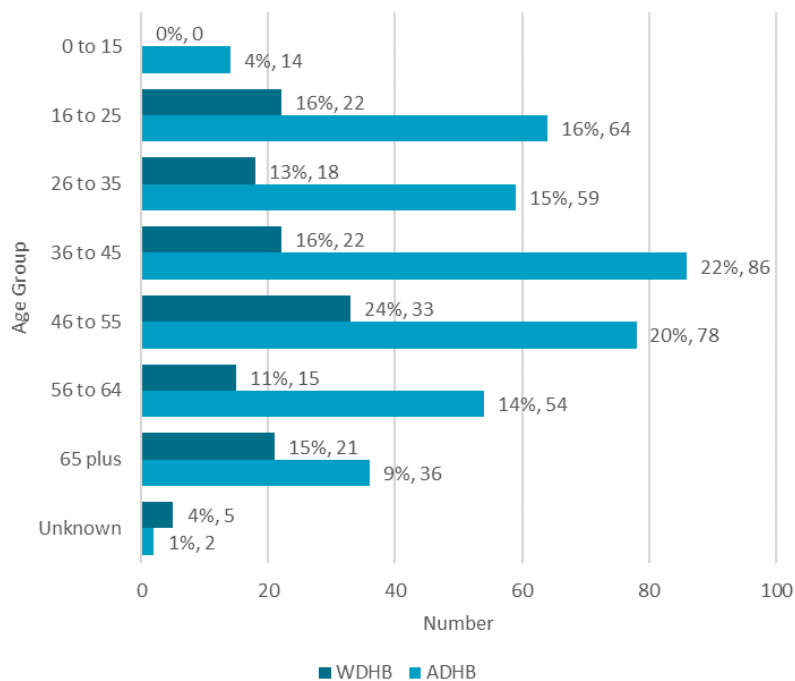


Figure 7: Awhi Ora reach WDHB by ethnicity



In ADHB, Māori and Pacifica had a higher representation (Māori by a factor of three), than would be expected based on their representation within the DHB-enrolled population. WDHB data represents a much newer and smaller volume of service delivery that doesn't include all potential providers or partners, so is indicative only at this stage.

Figure 8 Awhi Ora reach by DHB and age group



Awhi Ora has reached people across all age groups. Those aged 36-55 are more likely to be reached (42% of all reached in ADHB and 40% in WDHB).

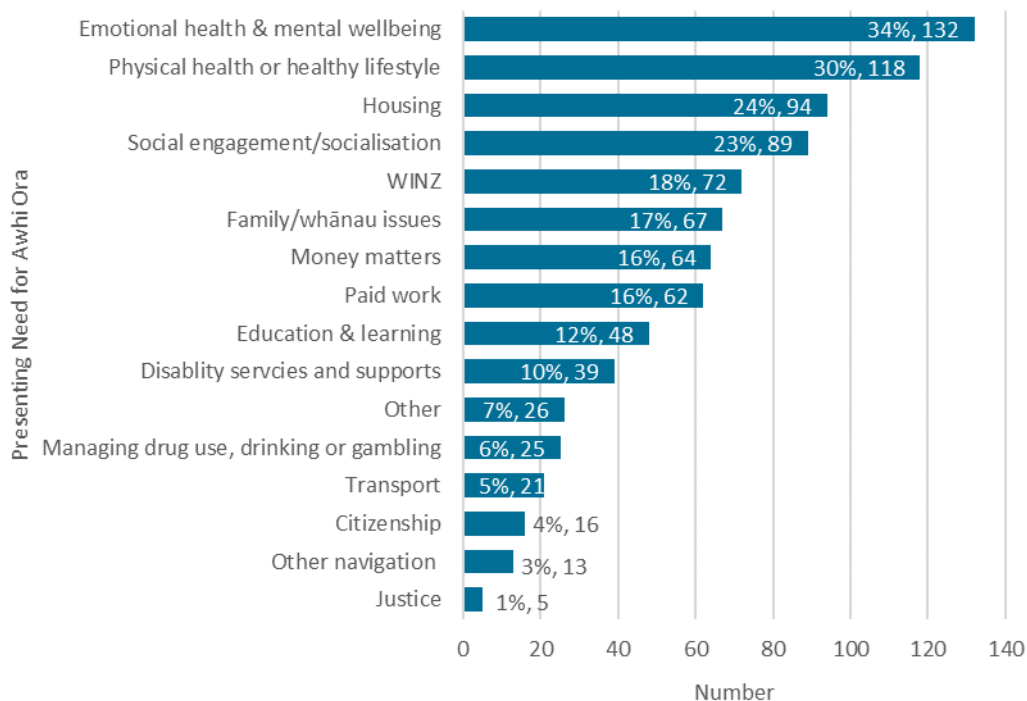
7.4 Awhi Ora client presenting needs profile

In discussion with Awhi Ora providers it was identified that the most reliable source of extractable information about peoples' support needs was the free text information entered against goals or activities in each client's record. By its very nature, this is not consistently entered. It was however a source of quantifiable information that was corroborated in our interviews with providers. This provides the most reliable insight into the support needs of people accessing Awhi Ora support, but limits the comparison of support needs with those presenting to HIP and Health Coaches.

Of the 572 active clients, 69% had goal and/or activity descriptions that identified support needs, and some people had more than one type of support need. For these 390 clients with information about presenting needs, a total of 1,174 presenting needs were identified (Figure 9).



Figure 9: Presenting needs for people accessing Awhi Ora services and supports



People who were working on their emotional health and mental wellbeing often referred to moods, anxiety and learning strategies to manage anxiety and panic. Physical health goals often related to diets and smoking. Socialisation or social engagement referred to navigation supports or connecting people to their community or planning to get out more to support their wellbeing. WINZ and money matters were also common goals or areas that people wanted support with.

7.4.1 Youth presenting needs

The needs of those aged under 26 followed a similar overall pattern, with emotional health and mental wellbeing the dominant need, followed by physical health-related issues. As may be expected with a younger population, housing issues featured less, and social engagement and socialisation featured more prominently.

7.5 Severity of distress

For the evaluation period, NGO providers were asked to use the Kessler Psychological Distress Scale (K10) at entry and exit or follow up for all clients. This would provide evidence of change in levels of distress, but also provide a profile of the severity of distress on entry. The use of an outcome tool was not without its challenges, and some NGOs felt that any outcome measurement, particularly the K10 for some, did not align well to the principles of Awhi Ora. This coupled with the time to communicate the value of the tool and embed it into the practice of support workers has resulted in variable uptake and use of the tool. It is interesting to note that the K10 was introduced as part of



the Awhi Ora roll out in WDHB, and the use of the tool has been more extensive in this region.

The K10 is a 10-item questionnaire intended to yield a global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent four-week period.¹² The questionnaire can be self-completed and contains items designed to assess levels of fatigue, nervousness, hopelessness, restlessness, depression, loss of energy, and worthlessness. The literature notes its wide use as a screening tool for common mental disorders, it has also been used as a primary outcome measure in several studies to track change in mean K10 scores.^{13,14,15,16} A summary of the properties of the K10 by these authors notes its strong psychometric properties, including its one-factor structure, strong reliability and validity, sensitivity to change, and value as a valid predictor of the common DSM-IV mental disorders.

When using the K10 as an outcome measure, the studies adapted the instrument to focus on the past two weeks or a time period that reflected the intervention being implemented with the target population. This adaptation is important for this evaluation, as a range of brief interventions will be available for people, so we will be asking them to reflect on the four weeks before their first contact (pre) and after they have received a specific intervention or support (post).

The results across both ADHB and WDHB are strikingly similar:

Only one in ten people with entry K10 scores were likely to be well, while two in three were experiencing severe psychological distress.

A clear relationship between K10 score and support needs was not observed.

¹² Kessler, R. C., Andrews, G., Colpe, L. J. et al. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine*, 32:959–956

¹³ Titov, N., Andrews, G., Robinson, E., Schwencke, G., Johnston, L., Solley, K., et al. (2009). Clinician-assisted internet-based treatment is effective for generalised anxiety disorder: a randomised controlled trial. *Australian and New Zealand Journal of Psychiatry*, 43(10):905–912

¹⁴ Perini, S. J., Titov, N., and Andrews, G. (2009). Clinician-assisted internet-based treatment is effective for depression: a randomised controlled trial. *Australian and New Zealand Journal of Psychiatry*, 43(6):571–578

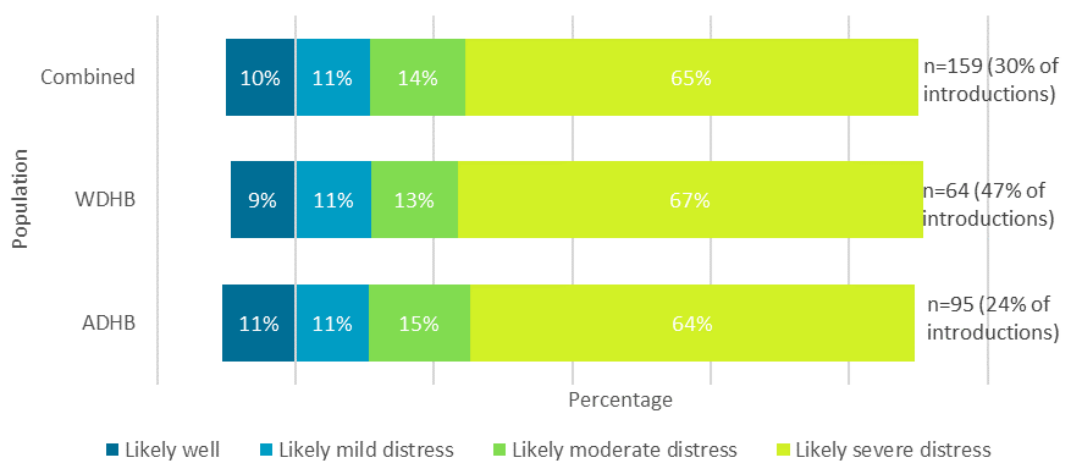
¹⁵ Sunderland M, et al. (2012) Investigating trajectories of change in psychological distress amongst patients with depression and generalised anxiety disorder treated with internet cognitive behavioural therapy. *Behaviour Research and Therapy*, 50(6):374–80

¹⁶ Murphy, M. J., Newby, J.M., Butow, P., Kirsten, L., Allison, K., Loughnan, S., Price, M. A., Shaw, J., Shepherd, H., Smith J. and Andrews, G. (2017). iCanADAPT Early protocol: randomised controlled trial (RCT) of clinician supervised transdiagnostic internet-delivered cognitive behaviour therapy (iCBT) for depression and/or anxiety in early stage cancer survivors -vs- treatment as usual. *BMC Cancer*, 17:193

The percentage of people who had completed at least one K10 increased slightly with age, from 29% of new youth introductions to 50% of new introductions for those 65 years and above. Individuals in the age range of 16 to 35 years showed a higher presenting severity (mean score of 34) than other age groups (mean score of 28).

The proportion of people having completed at least one K10 was highest within the Asian population (54%), and lowest for Pacifica (23%). Presenting severity did not appear to vary much between ethnicities.

Figure 10: Awhi Ora entry K10 scores



While this indicates Awhi Ora is reaching people in distress, it only represents 30% of people who have been introduced. Awhi Ora providers used their discretion in inviting people to complete the K10. This meant that:

- Support Workers did not use the K10 if they felt it would be a barrier to someone accessing support
- the K10 was often not used for people requiring straightforward community navigation, and it was considered to be inappropriate to ask someone's to rate their wellbeing.

This tells us that many of the people Awhi Ora supports are experiencing severe distress, but overall, the proportion of people in severe distress is likely to be lower.



7.6 Introduction source

The source of introductions is recorded by NGO providers. This data shows that 57% of introductions came from GPs (both identified and unidentified). Unfortunately, 27% of introductions did not have an introduction source identified. This, along with other inconsistent data entry practices, limits the use of this information.

In interview, ADHB providers talked about most introductions coming from their primary care introduction partners, a small number from other sector introduction partners and other agencies, and either non or very few from the Awhi Ora network. The low volume of introductions across the network is explored in section 8.6.2 of this report.

Only three introductions (0.5%) are listed as self-referral. This is potentially an under-representation, as during interview some providers were asking people to get their GP to generate and introduction, so the provider has the primary care link established and is provided with a NHI for record keeping. As marketing efforts ramp up, it will be important for providers to respond quickly and consistently to self-referral and not introduce additional steps and potential barriers to access for people who may be reluctant to or put off from visiting their general practice.

The 334 introductions in ADHB that had at least one face-to-face contact within the period, accounted for 0.08% of the ADHB-enrolled practice population.

7.7 Multiple episodes of support

There were 527 unique people active in the FfF period across ADHB and WDHB. From this we can see that

- 486 people had one introduction (85%)
- 37 people had 2 introductions (13%)
- 4 people had 3 introductions (2%).

We know some of these will represent transfers between organisations; this is difficult to distinguish from records, but from provider interviews we know it is a negligible amount. Awhi Ora is intended to be there for stressful points in people's lives, and therefore knowing there is something available if needed and the ease of reconnection are important. These results show people have reconnected when further support is required.

7.8 Key points

- Reaching those whose needs would have likely gone unmet.
- Reaching Māori and Pacifica effectively in ADHB region.
- Reaching those with needs relating to physical, social, economic and behavioural determinants of ill health.
- This data indicates that two thirds are likely to experience severe psychological distress (K10s only available for 30% of all introductions).
- Limitation of data quality for understanding introduction sources and wait times.

8. DELIVERY OF AWHI ORA: HOW WELL?

Following the formative evaluation feedback, providers have been improving the consistency of data entry, as there have been differing practices that challenge the ability to understand certain aspects of implementation, such as wait times. For example, different practices account for the fact that 18% of people had their first face-to-face visit prior to their 'start date', whereas, 58% were seen within a week of introduction. Through interviews with providers, partners and clients, there was a consistent picture emerging of people being seen within a week.

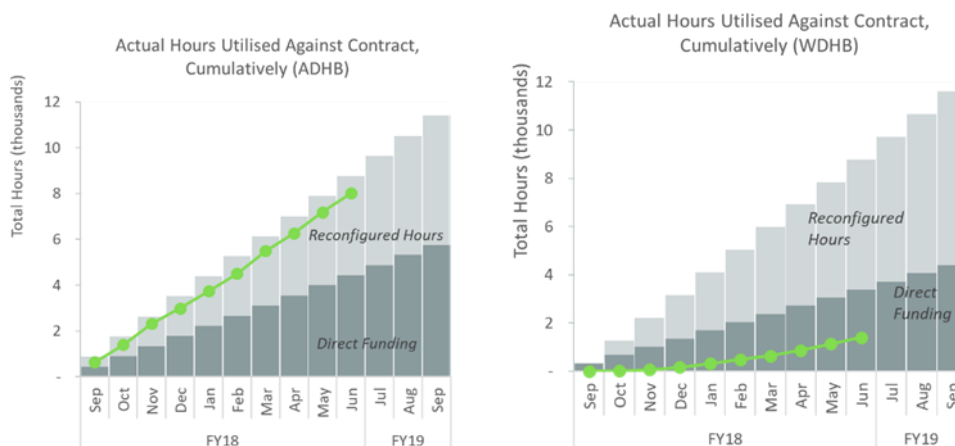
8.1 Delivery of Awhi Ora

In ADHB all seven NGOs were providing services, and across the district there was a steady overall pattern of delivery of just over 90% of total capacity (92.5% at June 2018; Figure 11).

Individual providers were delivering at different levels of capacity. At June 2018, five of the seven NGOs had capacity to provide more services. Two NGOs were aware they were at or over capacity and were planning to use the Awhi network to manage their resource. Over delivery can occur where there is lack of visibility in the provider organisation to distinguish Awhi Ora from other mental health community support contract activity. This reflects internal administration decisions or data base limitations. Awhi Ora is also not currently supported through a separate contract.

Mahitahi and Vaka Tatau were provided twice as much direct funding than mainstream NGOs to meet expected demand from Māori and Pacifica communities, respectively (1,274 hours over the funded period, compared to 643 hours). When service delivery hours were first explored for the evaluation (to December 2017) there was concern that these organisations were not being used by the network or their introduction partners. Service delivery hours have increased steadily for both these organisations since then.

Figure 11: Actual hours utilised against contract (ADHB and WDHB based NGOs)



8.1.1 WDHB delivery

In WDHB, the delivery of Awhi is still being established and at June 2018 sits at 16.7% of total capacity. Most of the service delivery is accounted for by two of the ten provider agencies: Pathways and Walsh. Pathways was already delivering Awhi Ora in ADHB and got off to a fast start based on pre-existing practice relationships in WDHB and the benefit of having the same senior manager across ADHB and WDHB. Walsh have created a particularly successful partnership with The Doctors in Red Beach, which has generated most of their Awhi Ora activity. This was supported by the Awhi Ora support worker being provided with onsite access to the practice and their patients, enhancing the integration of Awhi Ora within the practice.

By the end of June 2018, the four providers with direct funding were all delivering some Awhi Ora hours; the six remaining providers were just starting or preparing to start delivery.

Flexi-funding

ADHB providers appeared slow to associate the inclusion of flexi-funding with this contract variation. Only 6% of the total pool of funds tagged to additional Awhi Ora hours was claimed for the year ending 30 June.

8.1.2 Learning from the delivery of Awhi Ora

The implementation of Awhi Ora in the ADHB and WDHB regions highlights:

- The value of building up steadily from an existing base and network.
- The importance of quality project management to support the coordination of implementation.
- The need for clarity when expanding services to NGOs; the inclusion of all NGOs on the basis of using support hours caused confusion.
- This coupled with the lack of coordination put the principles and philosophy of Awhi Ora at risk in WDHB.
- Defining best practice is important for supporting scale. The notion of tight-loose-tight is helpful here for maintaining the course while enabling adaptations for local providers and context.

8.2 Delivery of support

This section combines the service delivery data from ADHB and WDHB to look at the patterns of Awhi Ora service delivery to clients. This is designed to support the evaluation in understanding how well Awhi Ora was reflecting its principles of brief services and supports.

Table 3: Awhi Ora engagement and service delivery

| | ADHB | WDHB |
|---------------------------|------|------|
| % Introductions converted | 82% | 73% |
| % Contact days with DNA | 13% | 22% |
| % Under 3 months duration | 68% | 82% |
| % Over 3 months duration | 32% | 18% |

Though not documented, there was a common understanding that episodes of support were usually less than three months. Over the course of the evaluation and during exploration at two previous timepoints there had been concern that a significant proportion (up to half the client group) was using ADHB Awhi Ora for more than three months. This was at variance with interview information and, it emerged, was partially the result of poor data entry, with some confusion between teams for Awhi Ora and those for longer term packages of care contracts. This data entry appears to be mostly resolved but highlights the benefit of providers setting up Awhi Ora clients on their information systems separately to other contract activity.



Seven in ten (68%) of ADHB and eight in ten WDHB people (82%) who have been exited this period have used the service for less than three months.

Of the 203 introductions that were still active at 30 June 2018, 29 (14%) have been with the service for over 365 days. Given the turnover of the service, this is a small cohort.

8.2.1 Episodes of support



For people using Awhi Ora for less than three months, a typical experience was to have two to eight contacts with the service, totalling four to nine and a half hours of support.

For those using the service for more than three months before discharge, a typical experience was to have seven to twenty contacts with the service, totalling 10.1 to 38.8 hours of support. These findings are illustrated in Figure 13 and Figure 13.

Figure 12: Contact patterns for people with Awhi Ora for less than three months

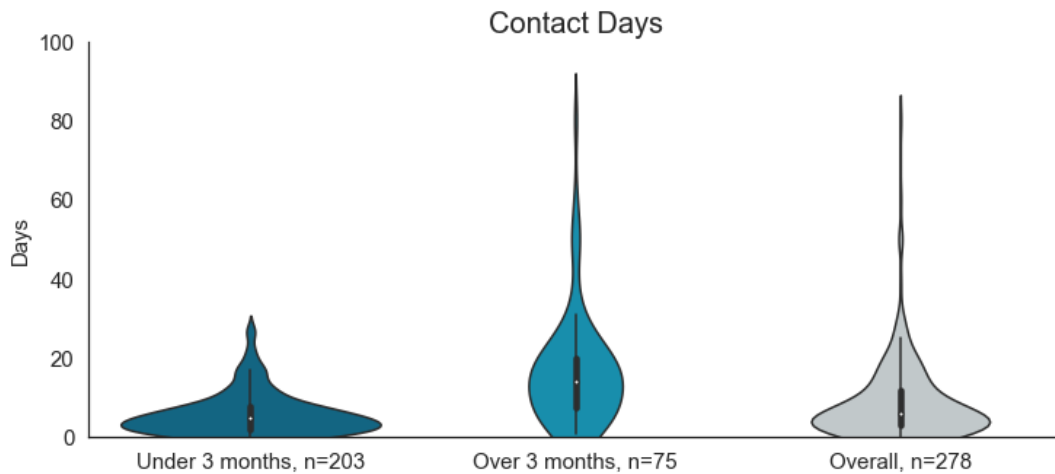
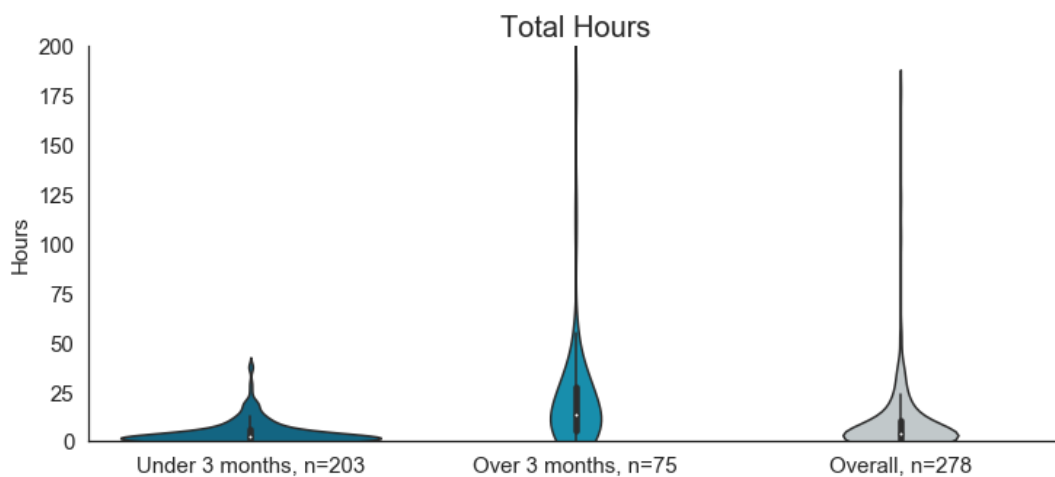


Figure 13: Contact patterns for people with Awhi Ora for more than three months



8.2.2 Do not attend rates

Contact days with DNA (Did Not Attend) accounted for 13% of ADHB activity and 22% of WDHB activity. Contact days are defined as unique days that an individual had contacts on. This is more accurate than counting 'activities', as activities can appear multiple times in the data, depending on how they have been coded. This level of DNA is low in comparison with other services and supports for people with mental health needs, such as psychological therapies. ETHC have shared programme data with the evaluation that shows only 52% of people referred for CBT made an appointment to attend and of that 52%, four in ten would not attend. (ETHC 16 November to August 2017).

8.2.3 Setting of delivery

The setting of service delivery activity is coded. When time spent is considered, we can see that most activity took place in the **community (55%) and in peoples' homes (29%)**. Community settings are public spaces – such as meeting somewhere to walk, in a café, the library or going with a person to an appointment. Indirect contact, such as phone



calls and texts made up 10% of activity time, with support on provider premises (4%) and other (2%) making up the difference.

Most providers would code services provided on GP premises as 'community' or 'other', but this delivery cannot be distinguished from the data alone. In interview, Awhi Ora providers referred to services being delivered in the community and in peoples' homes, with only a minority seen in GP practices. This highlights the challenges and time that is needed to support relationships with general practice.

8.2.4 Nature of delivery

The specific types of support provided to people cannot be easily identified with the current data system. The information is coded under broad categories with most people selecting 'client'. The range of other categories, however, does indicate the role of Awhi Ora in providing/accessing community support, individual assessment and planning, working with whānau and providing peer support. If this data system is designed to clarify the nature of delivery, it could be improved by focusing on a shorter list of options that better reflect the engagement with clients, to avoid 'client contact' being the most selected category.

8.3 Risk management

The minimal introduction information raised concerns in the FffF Steering Group regarding providers seeing people at home, particularly for the first visit. Providers had a range of approaches to identifying and managing risk, something they considered themselves competent and experienced at. This ranges from requests for risk and information forms to be completed by a GP (which some of whom have charged for) to simply meeting in a public place or doing a home visit to a new client in pairs. The Best Practice guideline will address the management of risk.

A Clinical Governance Report was provided in July 2018 following concerns with the clinical risks involved in Awhi Ora, which is a non-clinical service. Clinical risk is retained by the GP. The report proposed this should be made clearer to GPs, and that "standard clinical screening should continue to be provided by primary care as required." The report also highlighted and made recommendations about other risks:

- Privacy issues, as not all communication from GPs to NGOs was secure.
- Informed consent, as the introduction process is managed by NGOs with minimal client choice or consent. In the interviews the evaluation team completed, Awhi Ora clients said they were asked if they had a worker preference but were not provided with NGO choices.
- Lack of visibility around clinical governance.

Getting the right balance may not be easy; this is a non-clinical service supporting some highly distressed people. It is also a service that works because access is easy, and any additional process or paperwork requirement is a potential barrier to entry.

8.4 Navigation and connection

Navigating and connecting people to community services and supports is a key aspect of Awhi Ora. Support workers often provide advocacy and advice on how to navigate a

service, rather than just referring someone on to a service and support. The inconsistent data entry does not give the confidence needed to present the detailed numbers of links or connections on to other services. An analysis of the data entered and the case notes, however, has supported the evaluation in identifying the key areas that people are seeking navigation support and connection.

This highlights the importance of WINZ, Housing New Zealand, mental health services and supports, physical health services, advocacy support, and linkages to other NGOs. This link to other NGOs is promising and provides some support for the functioning of the Awhi Ora network.

Figure 14: Overview of key navigation and connections supports for people accessing Awhi Ora



8.5 Exit and where to next?

The range of exit codes or classifications available to providers through their standard contact set up has not been helpful in determining the circumstances of exit. Many of the categories are not mutually exclusive or are vague in their meaning (goals met versus ended routinely, for example). There is potential for definition agreement and standardisation of use of these existing codes within the Awhi Ora network to better illustrate the exit circumstances and onward journeys of people post Awhi Ora.

If providers have entered details of an ongoing referral on exit we can see formal ongoing connections. This is a free-text box, and of the 42 entries (41 for ADHB, one for WDHB) 24 appear to be for ongoing community mental health services support (11% of all exits). The rest are predominantly community programmes and social service agencies.

Without systematic and standardised data collection, the onward pathways of people using Awhi Ora are difficult to quantify.

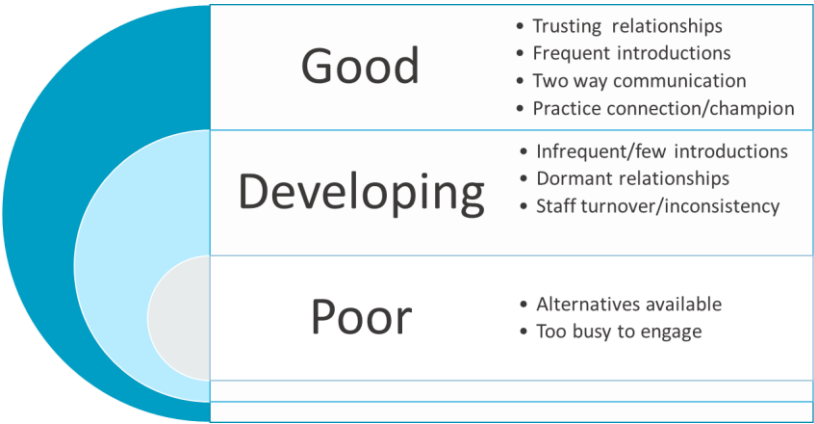
The Best Practice guidelines include a mandated three-month review and the identification of ongoing pathways for support for those with longer-term support needs. Some standardisation of use of existing exit codes and better recording of onward pathways will help identify the ongoing pathways for people accessing Awhi Ora. For most people, however, the brief intervention is sufficient, as people can also access Awhi Ora in the future if needed.

8.6 Working and integration with introduction partners

Relationships and integration with general practice teams is a key aspect of the Awhi Ora implementation. Relationships take time to establish, as does the level of trust and understanding to maximise the value of Awhi Ora services and supports for people with mental health needs.

The interviews found that variation exists in these relationships, with practice and NGO relationships ranging from good to developing or poor in both the ADHB and WDHB region. The interviews identified key characteristics of these different types of relationships or integration with the practice teams:

Figure 15: Features of Awhi Ora relationships



Just over half of relationships fall in the 'good' category, with most of the rest best described as 'developing'. There have only been a few relationships that didn't get going and one practice that disengaged, finding the lack of e-referral capacity a barrier for them. The relationships with general practice require ongoing investment, particularly as staff turnover can impact on existing relationships. This can see highly functioning relationships shift back to 'developing'. While relationships do take time to establish, when the integration and value of Awhi Ora with the needs of patients is realised, good strong relationships can be quickly established. For example, Red Beach in WDHB has the Awhi Ora support worker on site for two days a week, supporting the rapid establishment of a very effective relationship. This integration of the support worker into the practice team maximises the value of the skills and knowledge of the support



worker who is able to offer a range of services and supports for people with mental health needs presenting at general practice.

Relationships are supported by:

- feedback to general practice teams. This supports practice teams in understanding what Awhi Ora does, as well as the value it can bring for patients
- regular presence and/or engagement with practice team members.

There are overlaps to consider, however, particularly if people are unclear on Awhi Ora and what it might be able to contribute. For example, some practices have indicated that they do not need Awhi Ora due to their involvement with Whānau Ora. When Awhi Ora, HIPs and Health Coaches are working together, the potential overlap between these roles also needs navigating. They are complementary roles and work well when they support one another. Consideration just needs to be given to their integration and to the pathways of access for general practice teams.

Awhi Ora partners value the NGOs for their:

- mental health expertise and connections
- community knowledge and connections
- ability to navigate and align with other services and supports
- ability to support introductions to a broad range of services and support.

"Lifewise is about my day to day living and Emerge Aotearoa is about my mental health."
(Person accessing Awhi Ora support)

8.6.1 Understanding the integration and fit of Awhi Ora

The reasons for introducing people to Awhi Ora has varied depending on the options available to introduction partners and their perception of Awhi Ora's role and capability. This has been experienced by Awhi Ora providers and shared in interviews with providers and some introduction partners.

In the Framework practices (practices implementing the enhanced integrated practice teams), staff will refer people to the onsite HIP and Health Coaches for mental health and wellbeing issues, as well as broader social and physical health needs. In these practices, Awhi Ora will receive referrals for needs that fall outside that scope, such as housing, social engagement and practical support (such as advocacy) needed within the community. Support workers, however, can support people with a broad range of services and supports, and have considerable expertise in working with people with mental health and other needs.

Practices where relationships are strong are more likely to introduce people with a broad range of needs, including mental health support. These include people who experience anxiety or moods and emotions that make life difficult. Other primary care practices where the relationship is still developing can have a narrow understanding of Awhi Ora

support, perceiving it to be focused on just housing or financial support. This limits the number of people being introduced to Awhi Ora and its reach and value.

Support workers can also provide more extensive supports than the proposed one-off brief engagement provided through the HIPs and the Health Coaches. It is important, therefore, that all members of the enhanced integrated practice teams develop a good understanding of one another's roles, skills and expertise. This will help to ensure that people are offered the right level of services and supports for their needs.

8.6.2 Network functioning

Awhi Ora is underpinned by a network of high-trust relationships that have supported the very development of this approach. As a result, the principles of Awhi Ora align well to the NGOs and the ways in which they work. The shared learning sessions were highly valued by the NGOs. The formative evaluation feedback highlights the value of continuing to support these sessions, particularly as Best Practice guidelines are developed. This would provide an ideal avenue to reflect and refine their implementation.

One aspect of the network that could be improved is the internal introductions across NGO providers. While these were identified in the notes and some of the interviews, there is no consistent quantitative data to understand this aspect of the network. The analysis of capacity across the providers, however, did indicate that the original intention of providing people with Kaupapa Māori and Pacifica-specific options is not systematically happening. Some of the NGOs indicated that they would like more information on these services and supports to better offer them to Māori and Pacifica people accessing Awhi Ora.

8.7 Expanding to schools

Emerge Aotearoa's youth team provided Awhi Ora support through Selwyn College. The presenting needs of those youth (aged 14–18) were described as developmental, as much as mental health related, and were met with social skills development.

Engagement with schools was implemented as part of the Awhi Ora expansion. The formative evaluation and learning established within Awhi Ora highlighted:

- the high administrative burden of engaging with schools, including consent forms with young people and at times parents/carers
- the high potential for duplication due to existing work happening within schools, with Emerge Aotearoa withdrawing from providing services at one college, as another provider was already working there
- A lack of clear scope of the contribution of Awhi Ora in this space
- the importance of considering consent when engaging with people under the age of 16 within a school environment.

The aspect of the expansion warrants review, particularly in terms of understanding the potential contribution of Awhi Ora within this space. The work happening within the WDHB region with *HealthWEST* highlights the potential value of Awhi Ora connecting with youth-specific providers to boost their capacity. This would increase the support options

and availability for young people and remove the administrative burden of engaging with youth via schools.

8.8 Adaptations to intended implementation

Key adaptations to the intended implementation of the Awhi Ora expansion included:

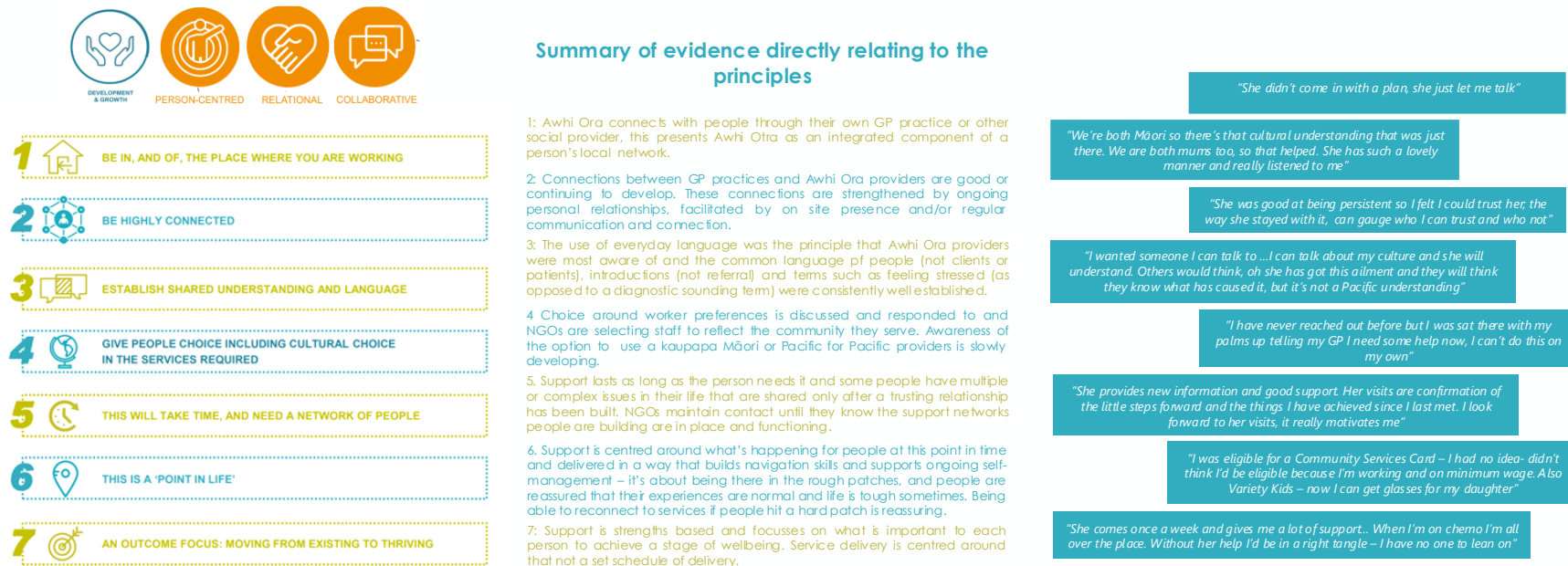
- securing additional project management support to facilitate relationships with PHOs and practices in WDHB
- responding to considerations relating to risk and governance as the project develops at scale
- working to ensure ethnic-specific options are systematically offered
- improving data collection processes and consistency, including outcome data.



8.9 Reflecting the principles of Awhi Ora

The interviews with people accessing and providing services and supports highlights the ways in which the principles of Awhi Ora are woven into practice. The alignment between the Awhi Ora principles and the philosophy of the NGOs supports this integration. Key quotes highlighted the influence of the Awhi Ora principles:

Figure 16: Reflecting the principles of Awhi Ora



The key barriers and enablers are reflected here in the aspects that are important for supporting successful implementation. Key enablers included:

- engaging primary care via its PHO relationship management team
- ensuring fit with enrolled population and NGO
- finding and keeping a presence in the team
- consistent feedback to GPs
- no entry criteria to support access and engagement
- skills and expertise of support workers
- knowledge and integration with broad range of community networks and supports.

Key barriers to success included:

- lack of marketing materials to support engagement and understanding of Awhi Ora
- turnover of staff (impacts on existing relationships)
- tension between community development roots and upscaling process or 'Best Practice'
- limited pathways on, such as packages of care and secondary service supports if needed
- understanding of risk and safety across practices and NGOs (potentially – resolved by clarification).

9. AWHI ORA: IS ANYONE BETTER OFF?

This section uses the available outcome data, client surveys and interviews, and provider interviews to address the question: Is anyone better off?

9.1 Effectiveness for people accessing Awhi Ora

Figure 17 identifies the feedback from the survey completed by a sample of people who have accessed services and supports from Awhi Ora. This survey was developed as part of the evaluation. It was designed to be completed by people at or near their last session. This can be challenging, as the last session can also be hard to predict, as this is not a specific treatment program. This makes it hard to complete an 'exit' survey. To boost the sample size for the evaluation, NGOs also invited people who had received at least two contacts to complete the survey in July 2018. The surveys were given out by the NGOs but returned through an envelope that can be sealed to support confidentiality.

The survey was completed by 67 people. We are not able to identify those surveys that were exits and those that were completed in July to support the evaluation, as the surveys are anonymous to encourage people to respond. **From the 67 respondents, 25% were Māori and 10% Pacifica.** This reflects the reach of Awhi Ora.

Survey respondents were all directly engaged with Awhi Ora and reflected similar engagement patterns to others involved in Awhi Ora. There was higher response from Māori and Pacifica.

- Almost all respondents worked on an issue with help from the support worker.
- Half were also given information to support their wellbeing needs.
- Around one on five were connected to support or referred on to other agencies.



97% of people agreed that Awhi Ora helped to make an important improvement in their life (n=67)

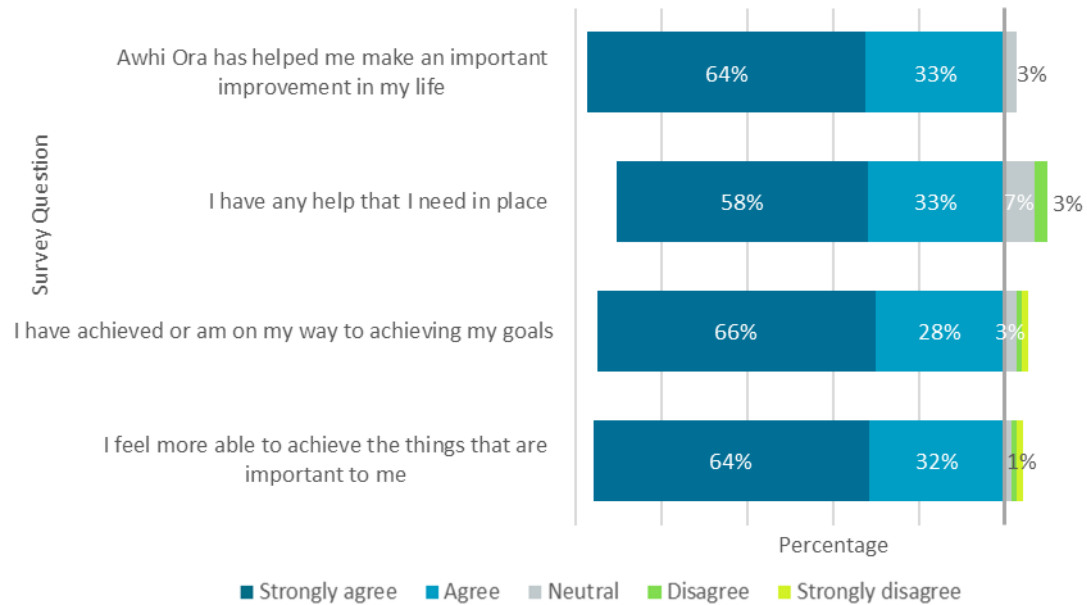


96% of people agreed that they were now more able to achieve things that were important to them (n=67)



94% of people agreed that Awhi Ora supported them to achieve or be on their way to achieving their goals (n=67)

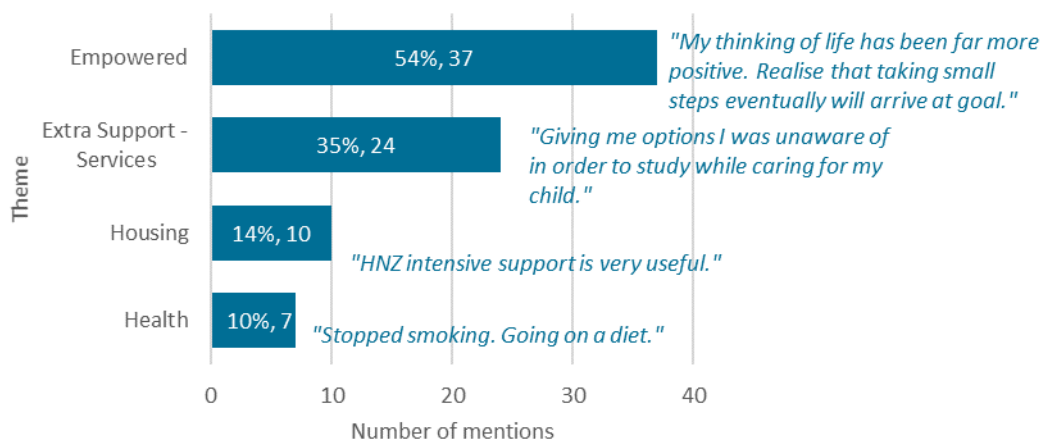
Figure 17: Feedback survey completed by people accessing Awahi Ora (n=67)



The survey also invited people to share their views and experiences of Awahi Ora, and the difference that the service made for them. All written feedback was very positive.

The survey responses identified the role of Awahi Ora in empowering people to make a positive improvement in their life. This was achieved through providing direct support and connecting people with a range of community, health and housing supports. Feedback was thematically analysed to identify key themes and the frequency that they were noted (Figure 18).

Figure 18: People’s feedback on Awahi Ora services and supports



Nineteen of the survey respondents made suggestions for improvement. The emerging theme was wanting more of this service to be available, or more support for themselves.

The effectiveness of Awhi Ora was a consistent and powerful theme in the interviews. A NZ European lady who had separated from a violent partner was only offered help from Women's Refuge if she moved into one of their refuge houses. She did not want to place her daughter in that environment and was unsure of where else she could get support. Her GP introduced her to Awhi Ora; her interview highlights the value of Awhi Ora:

"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 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 though 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)

Other benefits identified by people accessing services and supports were:

- psychological benefits such as managing social anxiety and feeling more confident
- practical benefits, predominantly housing but also transport and budgeting
- social and support connections
- timely access to support when little or no other options seemed to be available
- supporting people to engage and self-activate
- person-centric response and ability to focus on what is important to them.

The interviews also indicated that Awhi Ora were providing services and supports to people who would not access other services, and whose needs would have gone unmet.

9.1.1 Changes in levels of psychological distress

The K10 was used to track changes in people's psychological distress levels when accessing Awhi Ora and again on exit or at follow up. As with the feedback survey, it was challenging to get follow-up measures and so again people who had been engaged for at least two weeks were invited to complete the K10 as part of a review process in July 2018.

As noted earlier, the K10 was not the outcome tool of choice for some of the NGOs, and some felt that outcome measurement itself went against the no entry criteria or issues before diagnosis principles of Awhi Ora. Others, however, were already using this and/or other outcome tools for Awhi Ora. Many are using outcome measurement for their other contracts.

K10 matched pairs were made available for 30% of people accessing Awhi Ora in the FffF period.

When reviewing these findings, it is important to remember that people are provided with brief services and supports that are designed to enable them to make an improvement in their lives. Awhi Ora is not a specified treatment programme that is designed to fix people.

The chart below shows the changing distribution of ratings between entry and exit or follow up ratings by clinical category.

Figure 19: K10 matched pairs for people accessing Awhi Ora (n=50)

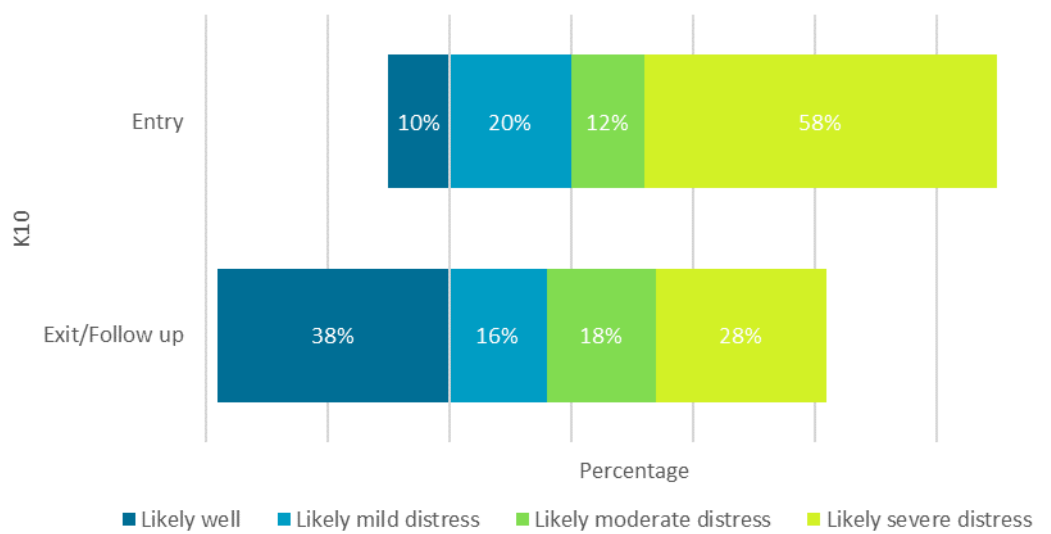
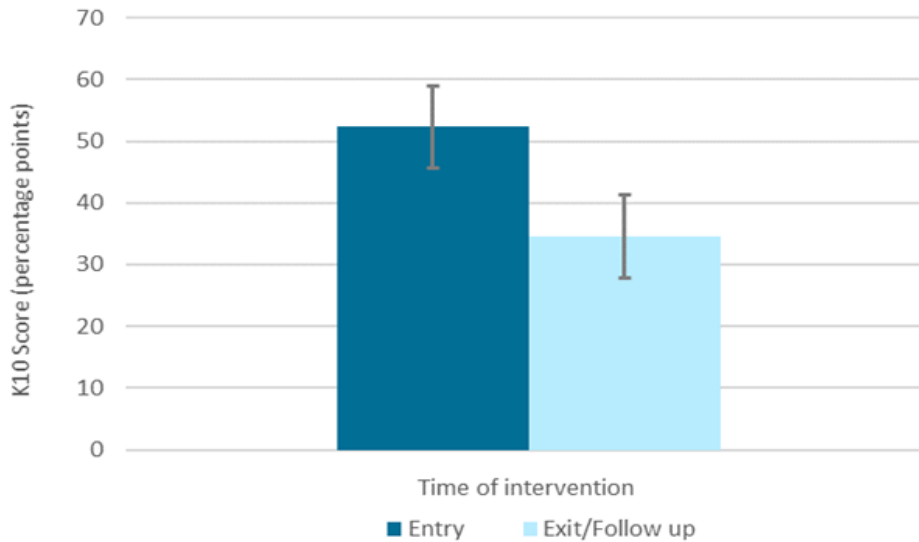


Figure 20 K10 matched pairs by percentage change



The K10 matched pairs showed an average of 52.3 percentage points (95% CI: 45.7 to 58.9) at entry (equivalent to a 30.9 K10 score) and an average of 34.5 percentage points (95% CI: 27.8 to 41.2) at exit/follow up (equivalent to a 23.8 K10 score).



70% of people showed a reduction in psychological distress

This change represents 35 people whose percentage change showed improvement (a reduction in psychological distress), 5 that remained unchanged and 10 people whose psychological distress increased. Overall, 70% showed an improvement, which compares well to the Primary Mental Health Initiatives (PMHI),¹⁷ which identified 80% people rating an improvement; however, in the PMHI Māori and Pacifica were not as well represented as they are in this data.

¹⁷Dowell AC, Garrett S, Collings S, McBain L, McKinlay E, Stanley J. 2009. Evaluation of the Primary Mental Health Initiatives: Summary report 2008. Wellington: University of Otago and Ministry of Health

9.1.2 Key points

The integration of the evidence from the feedback survey, outcome measurement and client interviews identified the following key points:

- Awhi Ora provides important support for people with high level of need.
- Social and housing outcomes are particularly important.
- Awhi Ora connects people to a wide range of health and community resources.
- Awhi Ora effectively supports people to make changes to support their wellbeing.
- 70% of people demonstrated an improvement in K10 scores within a brief timeframe.
- Awhi Ora provides timely preventative support for people whose needs would have likely gone unmet.
- Outcome measurement and survey feedback needs to be more systematic.

9.2 Effectiveness for those delivering support

The interviews identified the benefits of Awhi Ora for the NGOs and for organisations connecting people to support. For the NGOs, key benefits were:

- Strength and value of the Awhi Ora network.
- Ability to leverage and connect people through other contracts.
- Better engagement through the opportunity to be on site or through a named contact over a generic referral.
- Legitimacy of the service through engagement and introductions through general practice.
- Professional satisfaction from seeing the benefits and valued added for people within a short timeframe.
- Ability to provide people with support that is not challenged by traditional rostering approaches to client engagement (if a dedicated Awhi Ora worker).

"Awhi Ora – it's a game changer!"
(Awhi Ora provider)

"It's the way it should always have been. It just makes sense."
(Awhi Ora provider)

"A few times a client goes into their GP and it happens on the day I'm there, so I can introduce myself and make an appointment then or later. It's a lot less intimidating than getting a call from a stranger."
(Awhi Ora Provider)

For practice partners, key benefits included:

- Highly effective partner for supporting people with mental health needs when supported by a functioning and effective relationship.
- Valued the knowledge and ability for Awhi Ora to connect people with a wide range of supports that reached beyond the knowledge of the practice teams.
- Practical support available for people, that walks alongside them.

"In my lengthy experience as a GP it has been perhaps the best scheme in terms of provision of exactly what is required to make a real difference to community health outcomes for individuals, families and therefore the better health of the community."
(GP letter)

"In here we can only talk. Out there Awhi Ora can walk the talk."
(Practice Manager)

9.3 Effectiveness for the system

Evidence is emerging on the system-level benefits of Awhi Ora. Awhi Ora has contributed to system-level benefits at Orakei Health Services, where the practice has seen a decline in referrals to psychological services since the integration of Awhi Ora attributed to Awhi Ora by the practice staff.



Awhi Ora is supporting a decline in referrals to psychological support services at practices with a highly functioning Awhi Ora relationship/integration

Other practices with good Awhi Ora relationships and introduction patterns are also showing decline in referrals to psychological support services. This is an important finding that highlights the value and contribution of Awhi Ora to services and support for people with mental health needs.

10. IMPROVEMENTS OR NEXT STEPS FOR AWHI ORA

The evaluation identified the following improvements for Awhi Ora:

Engagement with introduction partners

- Improved integration with primary care practice teams is needed to consistently maximise the reach and benefits of Awhi Ora across the district.
- Marketing resources are needed to support engagement with introduction partners, particularly primary care, and to enhance their understanding of Awhi Ora
- HIP or Health Coach is a great connection point for Awhi Ora. A practice champion or key connection who is available to Awhi Ora is vital.
- Regular inclusion in team huddles or practice team meetings could also support engagement.

Supporting expansion and strengthening integration

- Review introduction partners to ensure that they are the most appropriate e.g. linking kaupapa Māori providers with practices with a high Māori population.
- Consideration of partnerships with youth specific services, such as *HealthWEST* may be a more efficient way of reaching youth than trying to engage through schools.
- Awhi Ora and primary care must partner to gain the value of Awhi Ora. Primary care practices must be committed and ready to work with an external partner. Communication is crucial to developing effective working relationships, and how the partnership is going to work should be established and monitored in the early stages.

Awhi Ora Network

- Clarify and support the functioning of the Awhi Ora network. This should include considerations to boost the networks' understanding of supports and services from kaupapa Māori and Pacifica organisations. This is important for ensuring that people can make an informed choice in terms of the support that they would like to access.

Data entry and quality, and outcome measurement

- Improve the consistency and quality of data entry. This includes recording all introductions and source of introductions and the consistent use of exit codes.
- Enhancements to data collection that would provide greater insight into reach and delivery include:
 - o having a presenting need drop down menu to support a more efficient and consistent analysis of needs,
 - o using delivery setting codes to identify service delivered in primary care practices,

- the ability to identify people who have used secondary mental health services within the cohort and also people who have multiple episodes of support.
- Ongoing monitoring and evaluation is essential to track and review delivery as intended as provision evolves and upscales.
- Agree options for outcome measurement and feedback surveys and ensure that these are consistently used. This might include a range of agreed tools rather than just one measure. Regardless of the tool the intended outcomes and the level of change that Awhi Ora is seeking to achieve should be agreed. This is important for managing expectations in relation to outcome measurement and the nature of this type of brief person-centric intervention.

11. THE FRAMEWORK PRACTICES

The 'Framework practices' refers to those practices that have been supported by the FfTF funding and investment from their PHOs to introduce new roles into their practice teams. This was designed to enhance and promote the integrated team approach to supporting wellbeing needs. Practices were selected to reach high-needs populations including Māori, Pacifica and youth. The new roles introduced at these practices are the HIPs and/or Health Coaches. All of the practices also had an Awhi Ora support worker.

A total of seven practices had a HIP and/or Health Coach role. Four of the practices received ADHB FfTF funding, two WDHB FfTF funding, and one is situated in CMDHB and is part of ProCare's Stepped Care model implementation, a parallel project that is a contributor to the FfTF initiative. We understand that the FfTF funding was also supported by additional investment from the PHOs, both financial and FTE. All seven practices are included in the evaluation scope, as collectively they provide better opportunities for understanding and learning than an analysis segregated by DHB.

11.1 Service specification

The ADHB service specification required providers to deliver and contribute to the ongoing development and evaluation of the primary mental health model of care in ADHB in alignment with other FfTF activities. Providers were funded for eight to eleven months (starting October 2017 for ETHC and ProCare and February 2018 for Auckland PHO) finishing on 30 September 2018. The service specification identified the need to participate in the FfTF steering group, the FfTF evaluation, change management support and provision of support that included:

- Awhi Ora Supporting Wellbeing providers were to start or continue to work with Awhi Ora and support coordination with its linked NGOs.
- Development of an extended general practice team to equip practices with the ability to answer the needs of people with moderate mental health needs. Where access is a barrier, there will be no co-payment access. This team development will include:
 - a mental health practitioner integrated in the general practice team (a registered health professional)
 - a Health Coach to support people to better understand their condition and support plan on an individual, whānau or group basis and proactively follow up with people. These can be peer roles
 - provision of a mental health-credentialed nurse (ETHC) or support and encouragement of nurses to become credentialed where relevant
 - inclusion of the telehealth service where relevant in the menu of support options for people.
- Some components to be delivered outside of the general practice setting in order to facilitate access for people who do not easily engage.
- Workforce development that identifies the need to use the HIP training, and ProCare's role in facilitating this training and providing it to up to four other practices.

11.2 Stage of implementation

Five of the seven Framework practices introduced these new roles into practice teams in December 2017, following training in November. These were Glen Innes, Mangere Health Centre, Health New Lynn, Peninsula Medical Centre and the University Health and Counselling Service. The four ProCare sites took until April before their data systems and process were functioning and considered reliable.

Orakei Health Services became a Framework practice in April 2018 with a part-time HIP only (following a second course of training in March).

Turuki (Panmure site) is a small kaupapa Māori practice that had planned to progress with a part-time Health Coach only. Implementation has been delayed at this site and the evaluation team has not completed any interviews there as the site was not ready to engage, and the Health Coach has only recently begun delivering regular services.

Data presented in this report relates to the 1 April to 13 July 2018 period, the most recent 15 weeks of delivery, unless stated otherwise. Orakei practice went live in April and the ProCare practices have been able to provide reliable data from this date. Turuki data has not been included in the analysis given the small volume and not yet established delivery of service.








It is important to remember that these roles have been in place a short time, they are still in the initial implementation stages, going through rapid learning cycles and improving and adapting to practice contexts and population needs.

Appendix five provides single practice one-page overviews showing practice profile, activity and outcome information.

Figure 21 provides a summary of the Framework practices and the FTE for the enhanced integrated practice teams.










Figure 21: Framework practice profiles








| | Practice | PHO | DHB | Practice Population | GP FTE | Nurse FTE | Mental Health & Addictions Credentialed Nurse | Health Improvement Practitioner FTE/count | Health Coach FTE/count | Ethnicity profile | NGO support |
|---|--|--------------|-----------|--|---------|-----------|---|---|------------------------|--|-------------------------------------|
|  | Peninsula Medical Centre | ProCare | Waitemata | 8700 | 6 FTE | 4 FTE | 1 Training | 0.7 FTE/1 + GP BHC | 0.3 FTE/1 | 55% European 17% Māori 17% Asian 9.5% Pacific 1.5% Other | Awhi Ora (Walsh Trust) |
|  | Health New Lynn | ProCare | Waitemata | 17895 | 10 FTE | 15.1 FTE | 2 1 Training | 1.3 FTE/2 | 0.5 FTE/1 | 67.5% European 13% Māori 10% Asian 7.5% Pacific 2% Other | Awhi Ora (Pathways) |
|  | University Health and Counselling Service | ProCare | Auckland | 9590 (including 3000 international students) | 7.2 FTE | 0.8 FTE | 2 3 Training | 0.8 FTE/1 | 0.5 FTE/1 | 54% European 31% Asian 8% Māori 4% Pacific Island 3% Other | Awhi Ora (Pathways) |
|  | Mangere Health Centre | ProCare | Counties | 11985 | 6.8 FTE | 7.4 FTE | 1 Training | 1 FTE/1 | 0.8 FTE/2 | 51% Pacific 25% Māori 14% European 9% Asian 1% Other | Via Integrated Locality Team (ILoC) |
|  | Turuki Health Care | ProCare | Auckland | 1800 | 1.5 FTE | 2 FTE | 1 Training | 0.2 FTE/1 | 0.5 FTE/1 | 30% refugees | Awhi Ora (Pathways and Mahitahi) |
|  | Orakei Health Services | Auckland PHO | Auckland | 4500 | 2.5 FTE | 3 FTE | 1 | 0.2 FTE/1 | | 44% European 29% Māori 27% other | Awhi Ora (Kāhui tū Kaha) |
|  | Glen Innes | ETHC | Auckland | 14522 | 8 FTE | 6 FTE | | 1 FTE/3 | 1 FTE/3 | 43% Pacific 23% Other 16% Maori 9% European 9% Asian | Awhi Ora (Pathways and Mind&Body) |

11.3 Role overviews

The HIP and Health Coach roles are summarised below and explained in more detail in the appendix.

| | |
|---|--|
|  | <p>BACKGROUND</p> <ul style="list-style-type: none"> Model developed by Mountainview Consulting Group, a US consultancy. Developed in response to the high prevalence of psychosocial health issues presenting to primary care Mountainview Consulting provided training to HIPs and practice teams as the role is new to Framework practices |
|  | <p>ROLE</p> <ul style="list-style-type: none"> HIPs work briefly with a high number of people, see all ages and behavioural issues, and provide behavioural health support within primary care Shorter consults (30 minutes) and fewer sessions than traditional therapy Works as an integrated team member to build practice capability and capacity including development of practice pathways and group interventions |
|  | <p>TARGET GROUP</p> <ul style="list-style-type: none"> People in primary care with psychosocial issues impacting on their wellbeing Do not need diagnosis Individuals, whānau or groups |
|  | <p>PRACTITIONER</p> <ul style="list-style-type: none"> Registered mental health professionals with primary or secondary experience Trained in brief psychological therapies, includes FACT (Focussed Commitment and Acceptance Therapy) |
|  | <p>DELIVERY</p> <ul style="list-style-type: none"> Based in primary care clinics, face-to-face consultation, seen quickly – same day ideally Return only as needed Contextual and functional analysis concentrates on what's happening now and what can be done Behaviourally-based plan for self-management is developed |
|  | <p>OUTCOME MEASURES</p> <ul style="list-style-type: none"> The Duke Health Profile (Duke) is a 17-item health profile measure, used to identify a range of function and dysfunction across three wellbeing domains – physical, mental and social Auckland PHO practice uses Kessler10, ProCare using Strengths and Difficulties Questionnaire with young people |
|  | <p>SUCCESS</p> <ul style="list-style-type: none"> Effects small changes in wellbeing for many people Supports efficiency of GPs and whole practice capability |

Health Coach Role

| | |
|---|---|
|  | <p>BACKGROUND</p> <ul style="list-style-type: none"> ETHC has been delivering HC training based on the University of California Centre for Excellence in Primary Care model since 2015 ProCare staff attended ETHC and Counties Manukau Health Coach training |
|  | <p>ROLE</p> <ul style="list-style-type: none"> Health Coaching helps people build knowledge, skills and confidence to manage their health conditions The role uses evidence-based practices to support clients to self-manage condition, bridge gap between client and doctor, navigate health system and offer client emotional support Be the client's first point of contact if they have questions |
|  | <p>TARGET GROUP</p> <ul style="list-style-type: none"> People with low health literacy and chronic conditions People with co-morbidity, psychosocial issues who need support to engage with primary care and other support services and manage their wellbeing |
|  | <p>PRACTITIONER</p> <ul style="list-style-type: none"> People who are health literate, have usually held social/health worker, navigator or kaiawhina roles Can be peer roles - people with lived experience of mental health or living with chronic conditions Health Coaches may be selected also for their cultural expertise and /or language skills |
|  | <p>DELIVERY</p> <ul style="list-style-type: none"> Based in primary care clinics and work as an integrated member of the practice team, consults to people in the practice Deliver self-management and other wellbeing groups in the community and use a range of evidence-based approaches to have motivating conversations and engage people in health behaviour change Sees people who are referred or proactively identifies client group within the practice |
|  | <p>OUTCOME MEASURES</p> <ul style="list-style-type: none"> ProCare use Partners in Health – a tool that measures patient activation and have recently begun using Duke The Duke Health Profile (Duke) is a 17-item health profile measure, used to identify a range of function and dysfunction across three wellbeing domains – physical, mental and social Health Coaches at ETHC have been using PHQ9 (used as screening tool in the practice) |
|  | <p>SUCCESS</p> <ul style="list-style-type: none"> Increased patient activation, self-management and health literacy. Better chronic condition management |

12. THE REACH OF HIP AND HEALTH COACH: HOW MUCH?

This section describes the people accessing services and supports through HIPs and Health Coaches, including a presentation of their demographic profile, range of support needs and severity of distress they present with. Onward referrals are also identified.

12.1 Who is accessing support from HIPs?

The HIP is a generalist role, although the level of demand at the practices has seen HIPs predominantly support clients with moderate mental health and wellbeing issues. These are issues that impact on someone's life and may present risk. The HIPs are also seeing people who have accessed secondary services in the past and people who were described as having high needs relating to mental health but not meeting the criteria for secondary mental health services. The feedback from the interviews also suggests that the HIPs are also reaching people that may have been referred to but never engaged with psychological support services:

"They are really high needs people... high risk mental health, AOD and social issues, and only the odd person with sleep and anxiety issues. These are people who in the past had heaps of referrals to [Psychological Support Services] but never made it to engagement."
(HIP)

"A young man... he's 19... He functions but he's got a trauma background but not enough to meet criteria for ACC or anything. He's got issues with his anger and his emotional regulation. He's doing some skills work with me and he's working really effectively. He would not meet criteria for secondary services, and yet he is terrified about punching his girlfriend, he cuts his legs when he doesn't manage his distress, but otherwise functions really well."
(HIP)

In some practices the role is more generalist than in others, and a greater proportion of people present with mental health-related issues, such as undiagnosed symptoms, headaches, neck and back pain and poor sleep. The Health Coaches indicated that these people were also likely to be experiencing low-grade depression, which is not unusual for people with pain.

12.2 What is the reach of the HIPs?



1545 referrals to HIPs across seven practices during the FfF evaluation period. There have been 872 since April as the role becomes increasingly integrated into the team.



92% conversion rate for HIPs: this is high and very encouraging

Of the 872 referrals, 787 have been converted (90%). However, as the most recent referrals may not have had the opportunity to be converted, the conversion rate has been calculated for referrals received between 1 April and 30 June 2018 only). Conversions

represent the percentage of people referred for support that make it as far as engaging with the support service. This is an important indicator of access and equality of access, as many people are hard for the practice to reach, decline services after waiting too long or simply do not attend. The 92% conversion rate for HIPs (1 April to 30 June 2018) is encouraging because:

- five of the six practices have conversion rates above 90%
- conversion is reasonably consistent across ethnic groups (Māori 94%, Pacifica 93% and NZ European 91%)
- male and female clients have equal rates of conversion
- conversion is reasonably consistent across the age ranges with those under 16 and over 65 slightly more likely to convert.

12.3 What is the demographic profile of people accessing HIP support?

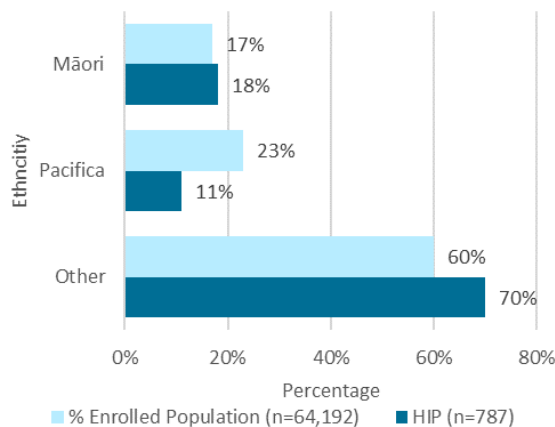
The following profile information is based on the 872 converted referrals (787 unique people) who accessed HIP.

HIPs were aware that the service was being offered and accepted by Māori and Pacifica, and those who were engaging had not sought or accessed services before. Figure 22 identifies the reach for different ethnic groups. This is compared to the enrolled population of the practices and demonstrates that Māori accessed service at a slightly higher rate. The same was not true for Pacifica.

In the Glen Innes practice this was particularly noticeable to the team (16% of their enrolled population are Māori and 30% of the people seen by HIP were Māori). They responded by bringing a Māori Health Coach onto the site to provide additional culturally responsive support.

Orakei Health Services has 29% of its enrolled population identifying as Māori, the highest of all the Framework practices and 44% of the people seen by HIP were Māori (Figure 22)

Figure 22: HIP reach by ethnicity



Across the Framework practices, one male accessed HIP support for every two females. Of the 784 converted referrals, 544 (69%) were female and 240 (30%) were male. Gender

was unknown for three referrals. We do not have practice consultation data to further interpret this trend, for HIPs or Health Coaches.

HIPs were reaching people across the life course. Reaching younger people (under 24) has been particularly effective because of the inclusion of the University of Auckland practice. Without the university, the other practices were still seeing people across all ages, particularly the 16–55 age range.

Youth aged 16–25 accounted for 29% of all people accessing HIPs, however only make up 21% of the enrolled practice population (Figure 23).

Only a small number of people under 16 have been seen by a HIP. HIPs said few had been referred overall. Additionally, some were seen with a parent (and the parent possibly recorded as the client). In ETHC, the option to refer to the Youth and Adolescent Service for youth specialist support may contribute to lower numbers of referrals for people aged under 16 years.

The university provides a unique opportunity to reach younger people. This provides them with an opportunity to access skills and techniques that they can draw on throughout their life. This demonstrates the preventative nature of the roles.

"If I can get someone into a normal sleep/wake cycle again and get them off an addictive sleeping pill, that's actually huge. And the other thing is these people are young, so they know this stuff now for the rest of their life. Whereas sometimes I'm treating 50-year olds, I'm like that's 30 years of this really terrible routine you've had, we could have intervened 20 years ago and your life trajectory would've been different. Now these young [people in their 20s], they know this forever, and so that's a really satisfying thing. It's empowering."
(HIP)

Figure 23: HIP reach for youth

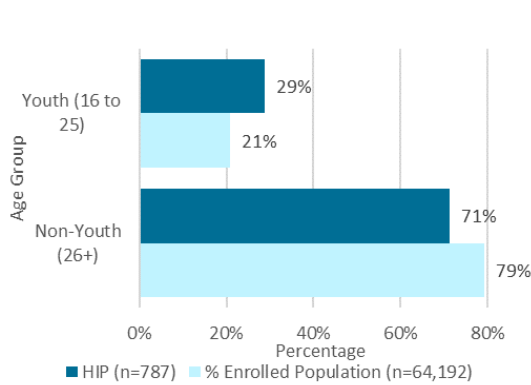
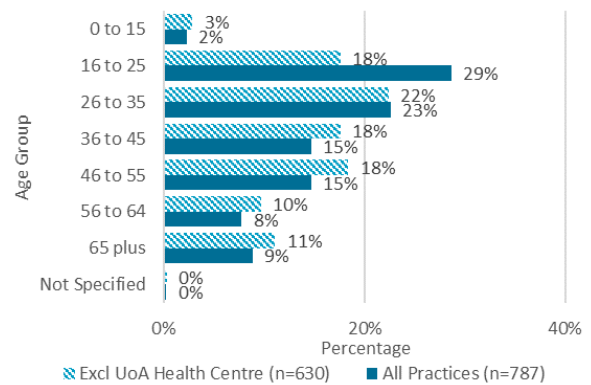


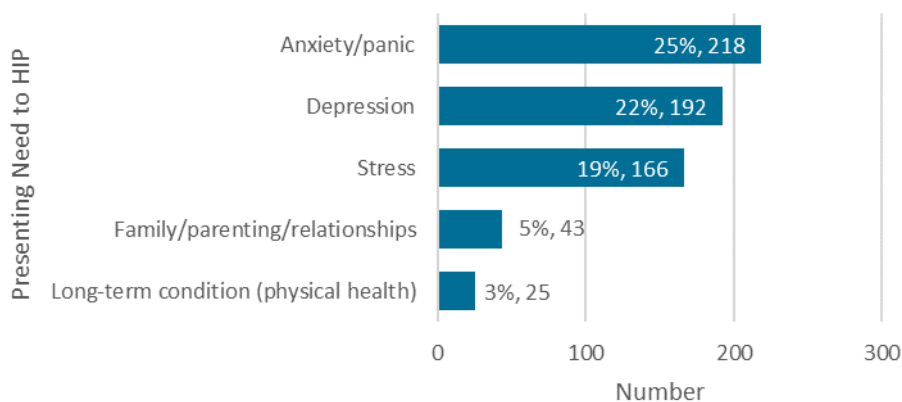
Figure 24: HIP reach by age group



12.4 Presenting needs profile for people engaging with HIPs

Across the practices, the top reasons for support identified by HIPs were anxiety, depression and stress (Figure 25). These descriptions are chosen by HIPs from a list of 27 conditions that all HIPs and Health Coaches use.

Figure 25: Top presenting client needs for HIP (n=872)



This pattern is reasonably consistent across all practices except Glen Innes. Glen Innes has selected a broader range of descriptions and has identified four people with traumatic stress, but none with stress as the primary presenting condition. The practice summaries also provide a useful insight into the presenting conditions across the different practice contexts and locations.

This is the first time data has been compared across all the practices, and there may be opportunities to confirm consistent use of descriptions (across HIP and Health Coaches). The option to choose multiple presentation reasons would be more reflective of this cohort, known to have co-morbidities and psychosocial needs. Alcohol and other drugs accounted for only 1.8% of all primary presenting reasons – much lower than expected – and this in particular highlights the shortcomings of collecting a primary presenting reason only.

12.5 Distress and functioning for people presenting to HIPs

The Framework practices used a range of tools to screen for symptoms of wellbeing and distress. They are presented here to demonstrate the level of distress and functioning of people engaging with the HIPs. Tools used by the HIPs included:

- The Duke Health Profile (Duke)
- Kessler Psychological Distress Scale (K10)
- The Patient Health Questionnaire – 9 (PHQ-9)
- The Strengths and Difficulties Questionnaire (SDQ)

The Duke is a 17-item health profile measure, used to identify a range of function and dysfunction across three wellbeing domains – physical, mental and social. These can be calculated to provide a total or domain health score. The tool was developed by the Department of Community and Family Medicine, Duke University, North Carolina, in 1989. Cut offs are statistically rather than clinically defined, and are based on reference values linked to each person's age range and gender. Critical value below 1 (CV1) represents a rating more than one standard deviation from the mean; critical value 2 (CV2) represents a value greater than two standard deviations from the mean.

The K10 is a 10-item questionnaire intended to yield a global measure of psychological distress based on questions about anxiety and depressive symptoms that a person has

experienced in the most recent four-week period.¹⁸ The questionnaire can be self-completed and contains items designed to assess levels of fatigue, nervousness, hopelessness, restlessness, depression, loss of energy, and worthlessness. The literature notes its wide use as a screening tool for common mental disorders, it has also been used as a primary outcome measure in several studies to track change in mean K10 scores.^{19,20,21,22} A summary of the properties of the K10 by these authors notes its strong psychometric properties, including its one factor structure, strong reliability and validity, sensitivity to change, and value as a valid predictor of the common DSM-IV mental disorders.

The PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression. The PHQ-9 incorporates DSM-IV depression diagnostic criteria with other leading major depressive symptoms into a brief self-report tool.

The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire for youth up to age 17 that has 20 items that relate to difficulties (emotional, conduct, hyperactivity/inattention and peer relationships), plus five that relate to prosocial behaviours (strengths). It is used internationally for clinical assessments, research and evaluation and some normative data is available for comparative purposes²³.

Scores for the Duke, K10 or PHQ-9 for people presenting to HIPs

The Duke, K10 or PHQ-9 was recorded on entry for 65% of all HIP clients (n=891). This represents all outcome measures on record from December 2017 when delivery began. To support sensemaking across the range of tools, the colour coding in Figure 26 highlights those who were likely to be experiencing mild, moderate and severe levels of distress or mental health needs at the time of the screening/assessment. This demonstrates the high level of distress or low functioning for people engaging with HIPs.

¹⁸ Kessler, R. C., Andrews, G., Colpe, L. J. et al. (2002). Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine*, 32:959–956

¹⁹ Titov, N., Andrews, G., Robinson, E., Schwencke, G., Johnston, L., Solley, K., et al. (2009). Clinician-assisted internet-based treatment is effective for generalised anxiety disorder: a randomised controlled trial. *Australian and New Zealand Journal of Psychiatry*, 43(10):905–912.

²⁰ Perini, S. J., Titov, N., and Andrews, G. (2009). Clinician-assisted internet-based treatment is effective for depression: a randomised controlled trial. *Australian and New Zealand Journal of Psychiatry*, 43(6):571–578

²¹ Sunderland M, et al. (2012) Investigating trajectories of change in psychological distress amongst patients with depression and generalised anxiety disorder treated with internet cognitive behavioural therapy. *Behaviour Research and Therapy*, 50(6):374–80

²² Murphy, M. J., Newby, J.M., Butow, P., Kirsten, L., Allison, K., Loughnan, S., Price, M. A., Shaw, J., Shepherd, H., Smith J. and Andrews, G. (2017). iCanADAPT Early protocol: randomised controlled trial (RCT) of clinician supervised transdiagnostic internet-delivered cognitive behaviour therapy (iCBT) for depression and/or anxiety in early stage cancer survivors -vs- treatment as usual. *BMC Cancer*, 17:193

²³ <http://www.sdqinfo.com/>

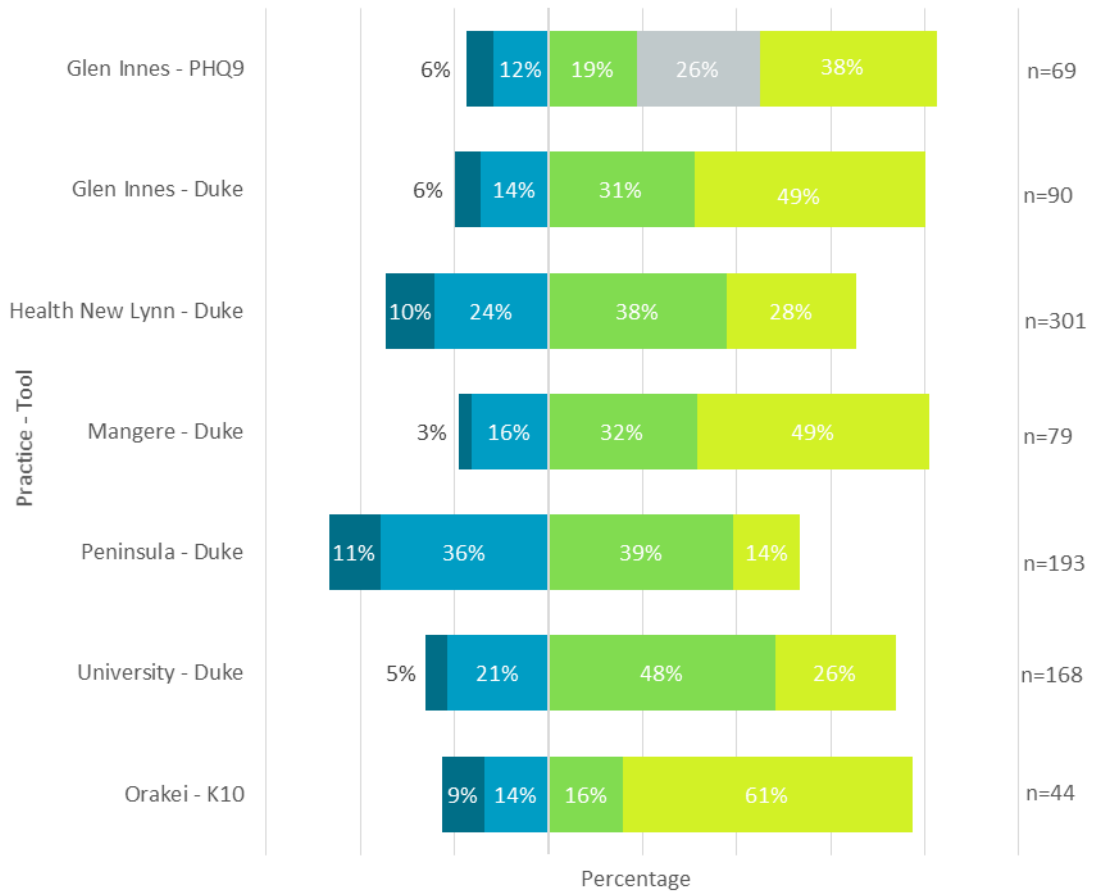
The assessments also demonstrate some variation in terms of need across the practices, such as the higher levels of functioning for people engaging in Peninsula. This was associated with the different practice contexts when review in a shared sensemaking session with sector experts. These differences also highlight some useful considerations in terms of the level of FTE or resource that might need to be provided to respond to these differing needs.


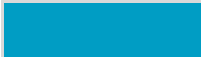



For example, Glen Innes, Orakei and Mangere practices have around four in five people rating as moderate or higher degree of distress or dysfunction. Orakei numbers are lower overall but present a particularly distressed cohort of people with one in six falling into the category of greatest dysfunction.

Glen Innes is described by its staff as servicing a high-needs community, and early into implementation it was realised that those seeking HIP support had significant needs. Around half those who had presented by March 2018 were flagged for suicide ideation, either through GAD9 or consultation. The demands and level of need in this practice alerted Framework practices to the potential for HIP burnout, which is discussed later in the report.



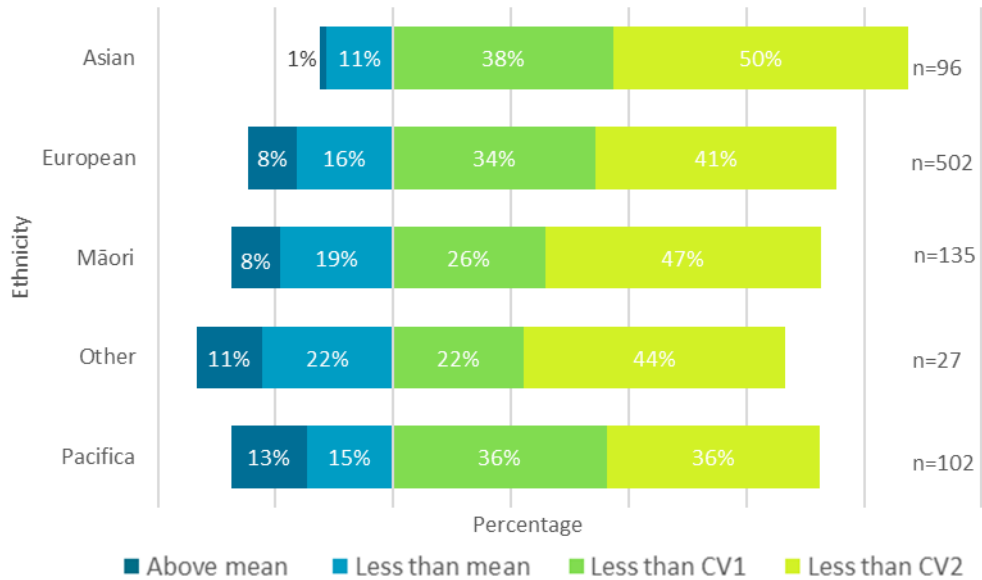
Figure 26: Level of distress and functioning: people presenting to HIPs (n=968)



| | Duke | K10 | PHQ9 |
|---|------------------------|----------------------------------|-------------------|
|  | Above mean | Likely to be well | Minimal |
|  | Below mean | Likely to have mild distress | Mild |
|  | Below critical value 1 | Likely to have moderate distress | Moderate |
|  | - | - | Moderately Severe |
|  | Below critical value 2 | Likely to have severe distress | Severe |

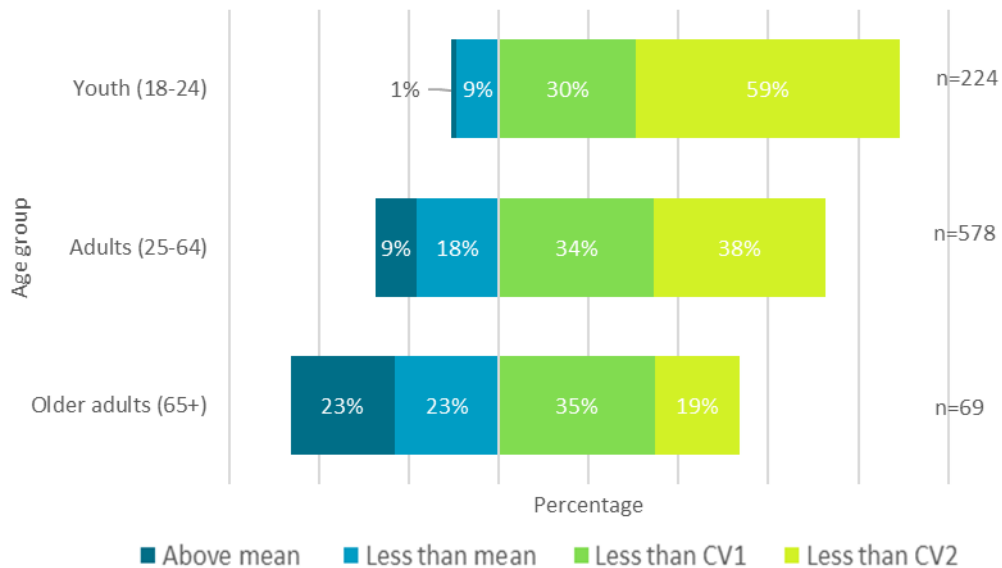
When the Duke ratings are compared by ethnicity, those identifying as Asian have higher level of psychological distress on entry, compared to the other ethnic groups.

Figure 27 Duke entry profiles by Ethnicity (n=862)



When the Duke ratings are compared by age, youth have higher levels of psychological distress on entry, compared to the other age groups.

Figure 28 Duke entry profiles by age group (n=862)



When reviewing the Duke ratings for mental health items only, the data shows that three in four people present as CV1 or CV2 below the mean, i.e. have distress at a level of



concern. This is the same proportion of people with a K10 score that indicates moderate or severe distress (77%) seen by the Orakei practice (n=44).

The reference scores for the Duke challenge a comparison of mean scores and effect sizes.

Youth SDQ ratings on entry

Three ProCare practices provided entry SDQ data, for a total of 24 youth. Results showed high levels of difficulty with 19 of the 24 youth rating very high difficulty (79%), four rating high difficulty (17%) and one rating slightly raised levels of difficulty (4%).

12.6 Who is accessing support from Health Coaches?

All practices except Orakei had a Health Coach. Health Coaches have summarised the key presenting needs of clients as relating to healthy lifestyles. This most commonly includes diet, chronic care management and exercise. These presenting conditions were often impacting on people's lives and contributing to mild anxiety and depression. Health Coaches have also seen people for psychosocial issues, such as parenting, relationship and anxiety issues.

"The GP introduced me as I'd tried Green Prescription and needed more support with weight loss and nutrition. I'm pre-diabetic and wanted to avoid diabetes, but had got discouraged."
(Person accessing support from a Health Coach)

"The role is much the same as a Navigator except in the practice; smoking, weight loss, and healthy eating is a big focus."
(Health Coach)

"I'm seeing a lot of 50 plus women about their weight but it's really more about their life stage and emotional issues."
(Health Coach)

12.7 What is the reach of Health Coaches?



421 referrals to Health Coaches across seven practices, 308 since April 2018.



85% conversion rate for Health Coaches; this is high and very encouraging.

While the HIPs are receiving far more referrals, it is important to remember that the Health Coaches have a smaller FTE across the practices and are also be more likely to spend additional time with people, particularly if this supports them in being responsive to people's cultural needs. The conversion rate of 85% of referrals received (1 April to 30 June 2018) is promising because:

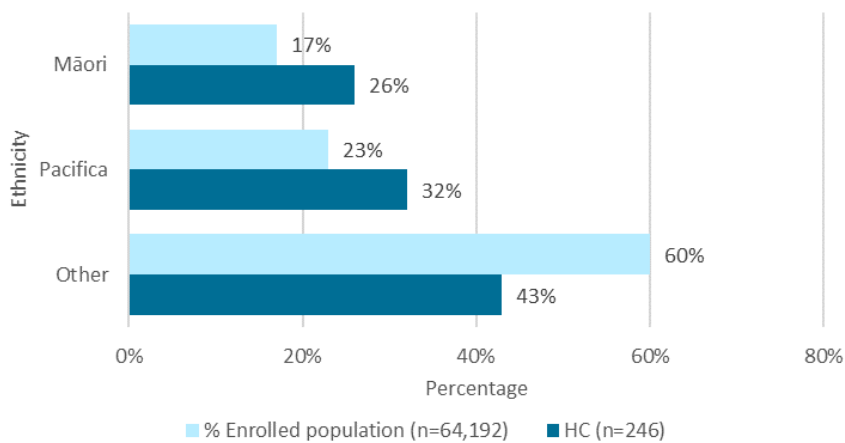
- four of the five practices have conversation rates above 80%

- NZ Europeans were more likely to convert than other ethnicities, although rates are still high for Māori and Pacifica (Māori 82%, Pacifica 82% and NZ European 89% converted)
- male clients were slightly more likely to convert than female clients (88% compared to 84%)
- conversion rates were very consistent across the age ranges.

12.8 What is the demographic profile of people accessing Health Coach support?

The following profile information is based on the 246 converted referrals since 1 April 2018. This demonstrates that Health Coaches were reaching a high proportion of Māori and Pacifica people. Māori and Pacifica make up 58% of Health Coach clients, and only 40% of the enrolled population (Figure 29). This aligns to the cultural expertise and knowledge of these roles.

Figure 29: Health Coach reach by ethnicity

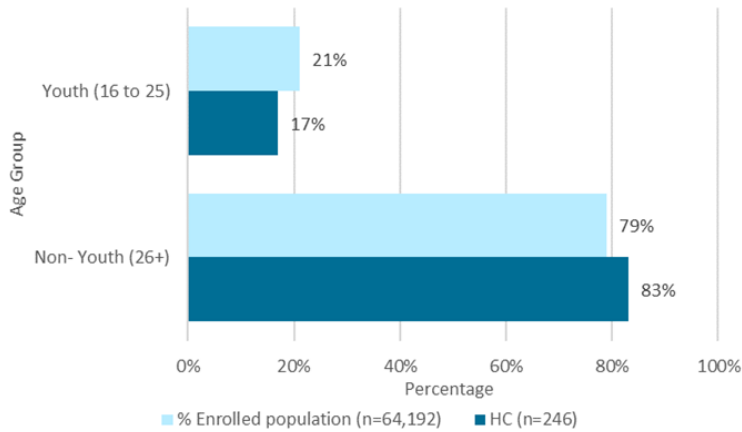


Health Coaches saw more women than men (65% compared to 35% respectively). Men in this group were much more likely than women to have long-term conditions (physical health) than women.

Health Coaches provide support with issues predominantly associated with physical health. This may make them more acceptable to men. Within this framing, Health Coaches also provide opportunities to prevent and discuss underlying or associated mental health issues. This highlights the role and value of Health Coaches, particularly given the lower reach to males through HIPs and Awhi Ora in this evaluation data.

Health Coaches are reaching more non-youth than youth compared to the enrolled practice population. When looking at practices excluding the university, Health Coaches are supporting people across the adult age range and this is weighted towards those aged 46 and older. People in these age groups are more likely to have chronic, long-term health conditions.

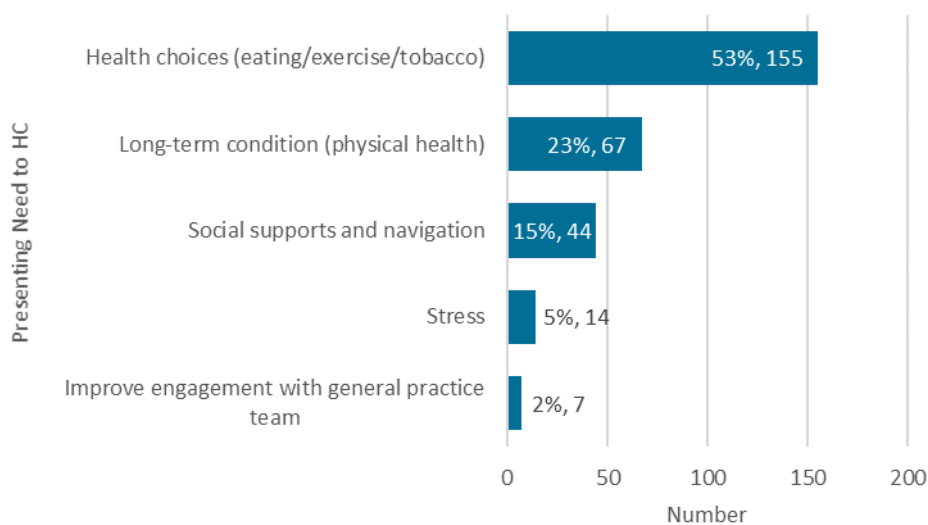
Figure 30: Health Coach reach by age



12.9 Presenting needs profile for people engaged with Health Coaches

The primary presenting reasons recorded for Health Coach clients are predominantly related to lifestyle choices and long-term conditions. This data aligns with the interview feedback. Health Coaches have been introduced to, and proactively engaged with, practice populations with diabetes and cerebral vascular disease (CVD). Social support and navigation was the most frequent presenting need at the university practice and Peninsula Medical Centre. At the university site, this was a recognised cohort of students that may be new to Auckland or New Zealand, experiencing isolation and needing connecting socially.

Figure 31 Presenting needs profile for people introduced to Health Coaches (n=293)



12.10 Distress and functioning for people presenting to Health Coaches

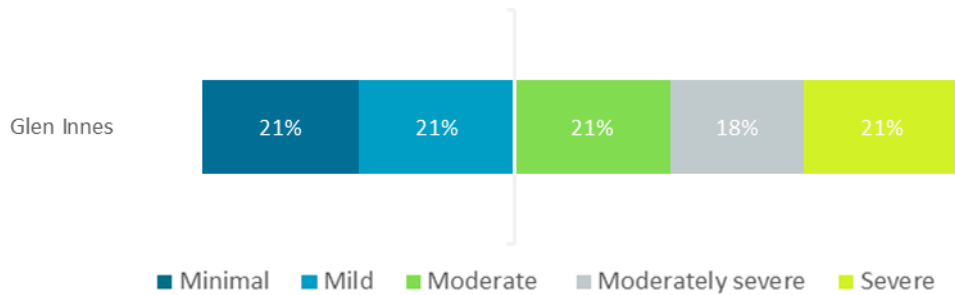
ETHC used the PHQ-9 to screen people engaging with Health Coaches. This was the same tool that the HIPs at ETHC used.

ETHC's Glen Innes practice uses PHQ-9 as a screening tool for HIPs and Health Coaches. On entry, 72% of all Health Coach clients at Glen Innes had a PHQ9 score recorded (n=34).

At Glenn Innes, 58% of people seen by the Health Coach had moderate to severe needs, this compared to 82% for the HIP (n=34; Figure 32).

In Glen Innes, people seeing the HIP were more likely to have a PHQ9 rating indicating severe distress than those seeing the Health Coach (38% compared to 21%).

Figure 32: PHQ-9 scores for people engaging with Health Coaches at ETHC practice (n=32)



The comparison of PHQ-9 scores across Health Coaches and HIPs at this practice suggests that people are being introduced to the right role. This illustrates the value of a consistent measure across roles.

Health Coaches at ProCare practices used Partners in Health (PIH). PIH measures patient activation and is designed for people with long-term conditions. Clients rate 12 questions on a scale of one to eight; eight indicates a high (positive) level of activation.

Across the four ProCare practices, the mean PIH score for people engaging with Health Coaches was 5.94. This indicates a relatively high degree of activation and suggests these are people ready to engage with a Health Coach and a behaviourally-based plan.

Figure 33: PIH scores for people engaging with Health Coaches at ProCare practices (n=67)

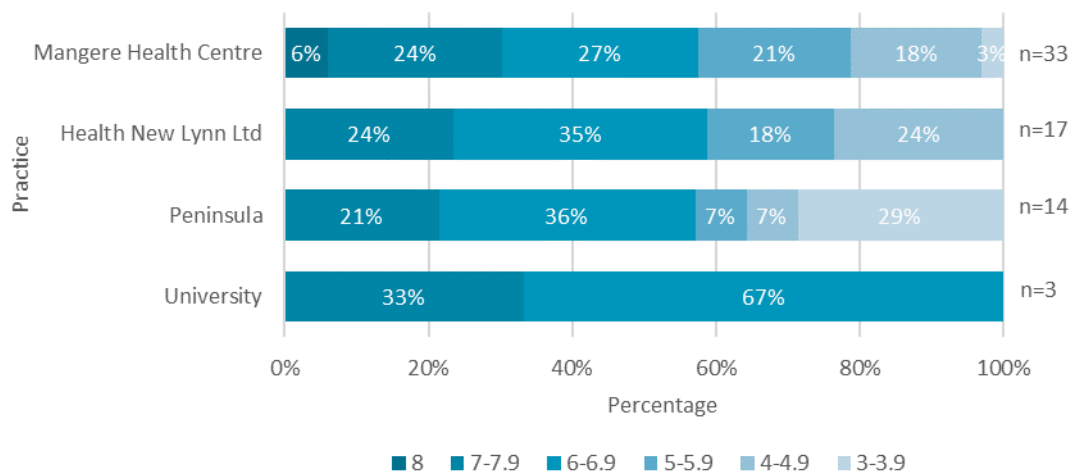


Table 4 PIH by question (n=80)

| Question | Mean | Median |
|--|------|--------|
| 1. Knowledge of the condition | 5.9 | 6.0 |
| 2. Knowledge of treatment | 5.5 | 6.0 |
| 3. Ability to take medication | 5.4 | 6.0 |
| 4. Ability to share in decisions | 6.1 | 7.0 |
| 5. Ability to deal with health professionals | 5.2 | 5.0 |
| 6. Ability to attend appointments | 5.9 | 7.0 |
| 7. Ability to monitor and record | 5.9 | 7.0 |
| 8. Ability to manage symptoms | 6.9 | 7.0 |
| 9. Ability to manage the physical impact | 6.8 | 7.0 |
| 10. Ability to manage the emotional impact | 6.9 | 7.0 |
| 11. Ability to manage the social impact | 5.6 | 6.0 |
| 12. Progress towards a healthy lifestyle | 6.2 | 6.5 |

There were no notable differences in PIH ratings of patient activation across the different ethnic groups.

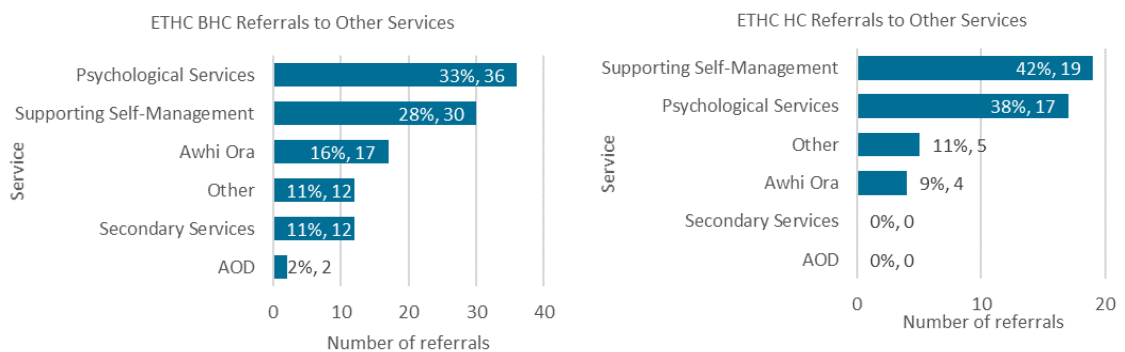
These measures were being trialled through the initial implementation of the Health Coach roles. During the sensemaking session with key stakeholders, it was noted that this tool is not as useful for patients who do not have a long-term condition, and Health Coaches in ProCare will begin to also use the Duke. This would support comparison across the roles and the people that they are reaching.

12.11 Onward introductions

The HIP and Health Coach roles play an important role in terms of connecting people with other support services. There are very different patterns of onward introductions emerging from ETHC (which is a single practice) and ProCare (data represents four practices). This data was not available from Auckland PHO.

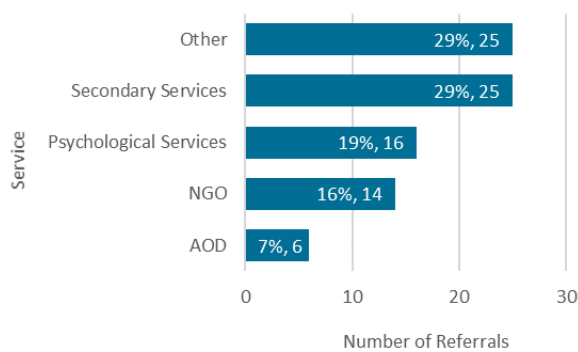
In ETHC, 56% HIP clients (70 people) and 61% of HC clients (28 people) were referred to other services (Figure 34). Health Coach clients were mainly referred to supporting self-management services, while HIP clients were mainly introduced people to psychological services.

Figure 34: Introductions to other services for ETHC HIPs (n=109) and Health Coaches (n=45)



In ProCare, 8% (86 people) of ProCare HIP clients were referred to other services. Of these referrals, 29% were to secondary services. No ProCare Health Coach clients were referred to external services.

Figure 35: Introductions to other services for ProCare HIPs (n=86)



Collectively, HIPs referred 37 people to secondary mental health services. This is a small number when the volumes of people seen, and their presenting severity is considered. Clinicians were aware that criteria for entry to secondary services was high and said only those likely to make the criteria were referred.

"There's a huge unmet need, it's massive. There's so many people who would not get into secondary services...I've done triage intake jobs and I know they wouldn't get into secondary services. But the need is there, and I'm really enjoying that part of the role, getting access to people who wouldn't meet that criteria."
(HIP)

ProCare has referred relatively few people to NGO support (Awahi Ora in ADHB and WDHB, via ILoC in CMDHB) as these relationships were only getting established in these practices from around May or June 2018. ETHC's Glen Innes practice, by contrast, has had a relationship with Awahi Ora since the very first pilot in 2015. This is reflected in the introductions to Awahi Ora and demonstrates the value of this type of support for people engaging with HIPs.

12.12 Key points: How much?

- HIPs and Health Coaches provide an immediate gateway to support in primary care.
- Supporting those who would not be reached or engaged through other services; reaching the 'missing middle'. People experiencing mild, moderate and severe mental health needs, with the latter not meeting the criteria for support from secondary services.
- High conversation rates for both roles across all ethnic groups. Overall 92% conversion rate for HIPs 85% for Health coaches.
- HIP support those with higher levels of need/distress. Health Coach supporting people with health-related behaviours and LTCs, often associated with anxiety and depression. Health Coaches are providing culturally appropriate or relevant support and providing support to more men than HIPs and Awhi Ora.
- Youth being reached predominantly through University practice, although there is good reach across all age groups for both roles.
- Effective reach for primary care prevention work (primary, secondary and tertiary levels of prevention).

13. DELIVERY OF HIP AND HEALTH COACH SUPPORT: HOW WELL?

This section summarises key aspects of the change-management practices that have supported integration of the HIP and Health Coach roles into general practice. The views and experiences of staff are used to support this. This is followed by an overview of the nature of service delivery to people accessing supports. The evidence is drawn from service delivery data, client feedback and feedback from interviews with clients, HIP, Health Coaches and other practice and PHO staff.

This evidence enables us to respond to the question, how well have these new roles have been implemented? In doing so, it is again timely to remind ourselves that these roles have been in place for around six months; less in Orakei. Implementation science suggests that two to four years is a reasonable timeframe for new practices to become settled and mature. This section therefore reflects the implementation timeline and the initial settling in phase for what is a fundamental change to the way mental health needs are responded to in primary care. Within this context, the ability for the roles to become well integrated and a functioning part of the team and offer high value for patients and staff demonstrates its value:

"I don't know of any primary care programme that has hit the ground running and taken off so fast...this has just flown. There's a need and we all recognize the value of it. It makes our lives so much easier so why wouldn't we be flying with it?"
(GP)

13.1 How well has the HIP role been delivered?

The HIP model is described in the role overview (see Section 11.3) and this has formed the basis of practice. HIPs interviewed shared some common experiences about transferring this model from learning to practice. Key themes related to:

- learning and unlearning

- managing a schedule with half of the available appointments left un-rostered
- using the Duke
- consultation format and time
- supervision and support.

| | |
|---|---|
| <ul style="list-style-type: none"> • Learning and unlearning | <p>The week of training provided by Mountainview in November 2017 was the start of a journey that required HIPs to unlearn and let go of old ways of practicing, as well as learning and applying new ways. One HIP described this as 'shifting gears'.</p> <p>It's a shift that has been embraced as HIPs were incredibly passionate about the role and were convinced it was the right way to meet mental health needs in primary care.</p> <p>HIPs with specialist mental health backgrounds found themselves upskilling with physical health knowledge, while those with a broader health base, such as health psychologists, felt they were well prepared for the role. Specialist mental health knowledge was valued by the practice team, especially when GPs were required to manage risk.</p> |
| <p><i>"It's a radical departure from providing mental health care or counselling and therapy. If I'd told myself six months earlier I would have questioned my sanity and professional ethics - the idea that I could see patients not seen before, not read any notes and within 30 minutes I would have done a psychometric assessment, assessed their needs and provided a meaningful clinical intervention that the patient will benefit from and find helpful - I wouldn't have believed it possible. But it is possible because this is based on some sound psychological theory... that makes me feel safe."</i> (HIP)</p> | |
| <ul style="list-style-type: none"> • Time management | <p>An unscheduled roster is unusual for practitioners. HIPs are now much more relaxed about trying to fill their day and are confident warm handovers will occur.</p> <p>Completing administration tasks in front of clients during sessions caused initial discomfort for some of the HIPs. Some are still completing notes at the end of the day. In session administration was becoming more routinised.</p> |
| <ul style="list-style-type: none"> • Using the Duke (functioning assessment used by all practices except Orakei) | <p>HIPs were becoming more comfortable with Duke over the months, with some surprised at how easy and useful they were finding it now. Most found they could get it completed within a few minutes.</p> <p>People that did repeat measures liked to see what had changed for them, and there was always something positive to observe and build on.</p> <p>Duke was harder to complete with people when they were very distressed and with 'talkers' who took a long time to go through the questions. There was recognition that starting the consult with Duke, or any tool, was not culturally appropriate for Māori or Pacifica.</p> |
| <p><i>"The first thing we do is do a questionnaire, and I would never do that with a Māori patient. I would just not do that, because it's all about whakawhanaungatanga, and relationship building. And if you go right, let's do this [Duke]... that doesn't actually fit so you do have to adapt it, and that's fine. There's no way [the trainer] can know that, because she's not from here. So, I think that it could've been probably adapted better to the New Zealand context."</i> (HIP)</p> | |
| <ul style="list-style-type: none"> • Consultation format and time | <p>Format for consultation is followed with some flexibility for cultural and basic human responsiveness, for example, establishing connection with a Māori client or simply listening to someone who is highly distressed and not able to engage in a structured consultation.</p> <p>HIPs all referred to people who had been highly distressed or ready to share their trauma history for the first time and were aware of the need to 'avoid the therapy bait' there were times this seemed appropriate.</p> <p>Overall, HIPs were adhering to the consult format and finding the structure really useful. These few examples suggest that HIPs are responding to the needs of the people they see and responding appropriately, even if that occasionally means a deviation from the prescribed model.</p> |
| <ul style="list-style-type: none"> • Professional supervision and support | <p>The high needs and acute distress of people referred to the HIP flagged the potential for HIP burnout quite early in implementation.</p> <p>Structured supervision became established across all the practices. Support from PHO teams, supervisors and Health Coach colleagues was very much appreciated.</p> <p>At a shared learning session in April, HIPs were reminded that the GP retains clinical responsibility for patients and the two roles should work closely together. For future practices, supervision and support structures needs to be part of early planning so it is quickly in place.</p> |

Overall, the HIP role has been well supported and initial engagement and implementation at practices is going well. The role is highly valued by general practice teams and clients who have shared their views and experiences for this evaluation.

13.2 How well was the Health Coach role delivered?

For those in Health Coach roles, these first months have been about introducing a familiar role into a new setting rather than learning a new role or very different way of working. In addition to one nurse, ProCare has transferred Community Health Navigators from its centralized teams that support practices. An interviewee described the role as much the same, except based in the practice. ETHC Health Coaches all had experience in the role but being based in the Glen Innes practice was new to them.

The Health Coaches are not health professionals, and the ETHC Health Coaches were peers. This can make it harder for some health professionals to understand the role and its important contribution. When discussing the integration of their roles, key themes included:

- language skills and cultural expertise
- knowledge of cultural models of wellbeing
- responsiveness and ability to relate to clients
- delivering education and self-management.

| | |
|---|--|
| <ul style="list-style-type: none"> • Language and cultural expertise | <p>Language skills and cultural expertise enabled Health Coaches to be more relatable to Māori and Pacifica people in particular. These skills were used explicitly to make those connections, build trust and support change.</p> <p>A non-Pacifica person, for example, might give standard dietary advice to all people, without understanding the cultural significance of eating certain foods and rituals around providing and sharing of food in that culture. For advice to be effective it has to be targeted.</p> <p>One success story involved a church elder who successfully lost weight and managed his Diabetes. He went on to run self-management classes and encourage other church members with healthier eating and exercise.</p> |
| <p><i>"I give them validation. I meet them where they are at and focus on what they are doing right."</i> (Health Coach)</p> <p><i>"I tell them on the phone I am Pacific... I understand the cultural pressures."</i> (Health Coach)</p> | |
| <ul style="list-style-type: none"> • Knowledge of cultural models of wellbeing | <p>This knowledge and expertise is an important aspect of the Health Coach role:</p> <p>A young professional Māori woman needed support with a cultural issue that had been causing her distress for some time. The Health Coach described the consultation as whakanoa, a process of letting go and becoming free from negative energy or extensions of tapu.</p> <p>The whaiora told her story while weeping and being encouraged to unburden herself through the distress. Communication throughout was in te reo. This process brought about whakatau – a settled state where the whaiora was at peace with herself. Whakatau was marked by a return to speaking in English and leaving together for some kai and a cup of tea – a traditional way to mark the completion of the process. This took around an hour and a half.</p> <p>The whaiora came back for a second session and was ready to engage in developing a behaviourally based plan to further support her wellbeing. The whaiora called the Health Coach whāea throughout, mother or aunty, a term in this context conveys closeness and respect.</p> |
| <ul style="list-style-type: none"> • Responsiveness and ability to relate to clients | <p>The ability for Health Coaches to be responsive and relatable was highly valued. In Glen Innes, a Māori Health Coach was introduced to the team because of the high number of Māori. They see clients as well as working alongside the HIP and other Health Coaches. Offering karakia, speaking te reo and having community and marae connections are valued aspects of her support; her presence alone has been described as 'settling' for clients.</p> |
| <ul style="list-style-type: none"> • Delivering education and self-management | <p>Health Coaches were providing group education and self-management sessions. This aligns to their focus on long term conditions and health related behaviours.</p> |

13.3 Change management in practices

The introduction of HIPs and Health Coaches into practices to work as integrated team members has and continues to be a significant learning experience. Overall, this is going very well, and a lot has been achieved in this relatively short time. Each practice has had its unique approaches and experiences but there were many common themes relating to this change process:

- practice and staff readiness
- relationships
- making the space work
- understanding the roles
- warm handovers work best
- integrating into the team
- feedback.

Practice and staff readiness: Practice staff attendance at the Mountainview training supported the wider practice team members to understand the HIP role, and to a lesser extent, the Health Coach role. **The training was recommended as vital to preparation for other practices considering this role.** Staff and practice readiness was enhanced if people had **previous experience of and/or readiness for working with a mental health practitioner**, particularly if they had a consultative style.

As with any change, there are earlier adopters. During interview, HIPs identified that some GPs and nurses were more likely to refer than others, and there were still some that had not yet referred. This suggests the referral volumes may not yet have reached their peak, as late adopters are not yet engaged.

Relationships: Change management is about people, and it was the trusting personal and professional relationships that have supported the successful implementation of these roles. These **relationships – enabled by a consistent presence on site – cannot be underestimated as they moderate and mediate every facet of service delivery.**

Practices are busy spaces and many staff are used to representatives from external organisations holding sessions on site, but nothing has been as effective for them as having these roles on site, every day. **Presence, it seems, is key** as this has been easier where there are full-time roles and where the practice team is stable and there are not key or frequent staff changes. This doesn't mean people in part-time roles can't build effective relationships; it simply takes longer, and relationships are more vulnerable to team changes.

Personality also comes in to play here – **promoting yourself and your (new) role in primary care is more than just a professional process.** HIPs and Health Coaches who are confident, articulate and comfortable creating space for a new role in the primary care team have found it easier to forge relationships.

Making the space work: Consult rooms and space in general are often tight in primary care, as vacant floor space is a waste of resource. Wherever possible, HIPs and Health Coaches were placed in consult rooms adjacent to the GPs and in areas close to the hub of the practice. This supports the visibility of the roles, as **these roles should be present and engaging** not tucked away in consult rooms at the back of the practice. This placement also supports HIPs and Health Coaches to observe and understand the natural rhythm of the practice.

One HIP observed that GPs in adjacent rooms were the earliest and most frequent referrers; others were moving around to different consult rooms for pragmatic and strategic reasons. **Being in the heart of the practice is highly symbolic and enables HIPs and Health Coaches to present as a normal part of primary care rather than a mental health service.** Not all HIPs and Health Coaches had optimal spaces all the time. For practices considering these roles, the availability of working space is a pragmatic but first consideration.

Understanding the roles: HIPs have become integrated into practices very quickly. This role fills a void that practices recognised and responded to with relative ease. Though the role is a generalist (similar to a GP), they are seen as the person in the practice with mental health expertise and used accordingly. This expertise has been easier for people to grasp than the nature of their consultation. GPs are still referring to HIPs as 'the

counsellor' or 'psychotherapist' and in some cases, encouraging people to complete a series of sessions – like therapy – which is not how the model works. These are not significant issues but an indicator of the early stage of settling in.

HIPs have been the main focus of implementation, and practices staff indicated that they were not as well prepared for the Health Coach role. The introduction of two new roles also required some navigation.

"The HIP has a more circumscribed role – mental health – we get that. Health Coach is more about wider behavioural change so it's taken a little while to work out what we refer and what we (as a GP and PN) do ourselves."
(GP)

By June, Health Coaches that we interviewed were 'turning a corner' and finding their niche in practices. This has been enabled by the promotion of specific skills of Health Coaches (such as parenting or nutrition) and identifying a role for them with groups of patients (such as those with diabetes).

The Health Coach is working in a space that is not clearly defined and that can overlap with other practice roles, particularly aspects of the nurse role. ETHC's experience with this role placed them at an advantage, but even in this practice the Health Coaches are working hard to establish themselves. The introduction of a role strongly associated with lifestyle choices and long-term conditions as part of a mental health initiative, and at the same time as a HIP, has contributed to this role taking longer to establish and it will continue to benefit from proactive integration.

The HIP and Health Coach (where co-located and their shifts overlap) are working well as a teamlet within the practice. This is helping them to define the boundaries and overlap of roles, promote each other's roles in the practice and with patients as well as providing collegial and moral support.

Warm handovers work best: Over this initial implementation period there has been some learning for HIPs, particularly about the importance of having alternate half hour appointments left free for warm handovers or same-day bookings. To make best use of their time and accommodate practice team members, most resorted to, or tolerated, the booking up of their schedules. This led to booked-up schedules that resulted in high DNA rates. In some ways it is counterintuitive, but practice teams are now understanding that leaving alternate consultations free really does enable them to make best use of HIP time and allow them to receive many new referrals as warm handovers – face-to-face referrals for people seen immediately or the same day.

"Yesterday I took two people to the HIP who wouldn't have come back [if offered appointments]. I can walk down with them and give her a history in a minute or two with the patient there with us - the patient sits there nodding. They have a history already and don't have to go through all that. I can say, these are the immediate things we'd like your help with."
(GP)

"I think I'd gone to see my doctor, and he'd said about this [anxiety], we've got like this service now at this clinic, where you can see this lady, [name]. And then, I said, "oh that sounds great", and so he said, "I think she actually has a place like now, like in half an hour or something". So I actually went to see her, the day I went there to get some help, or get some advice or something. That was really good, I just went straight in there and had my first session."
(HIP client)

Integrating into the team: These new roles are becoming integrated with wider practice teams through formal and informal mechanisms. Formal mechanisms include team meetings, professional development sessions, case reviews and morning huddles. Systematic review of rostered patients or groups of patients (such as those at CVD risk) identified patients who may benefit from an introduction.

Team work is also supported by informal exchange – and simply being present in the lunch room, available for a chat or simply leaving the door open between consultations, facilitates the relationship building facilities teamwork.

Within the practices, there are emerging roles for Health Coaches to be the main referral and contact point with Awhi Ora and HIPs as the contact with secondary mental health services. Awhi Ora is getting established at some practices, but even where it has been in place for some time, the conduit of the Health Coach will be beneficial to both parties.

Feedback: Having shared information systems supports communication between practice team members and HIPs and Health Coaches but **face-to-face feedback is more desirable and of higher value**. Providing feedback enables HIPs and Health Coaches to create professional trust, build relationships, promote their role and educate colleagues. Patients giving feedback to GPs about how helpful they found sessions has been very powerful and helped build trust and encourage further referrals.

13.4 Delivery of support from HIPs and Health Coaches

This section presents the service delivery data from ETHC, ProCare and Auckland PHO to look at the patterns of service delivery to clients. This is designed to support the evaluation in understanding how well the Framework practices are reflecting the key principles and intended implementation. Practice specific information is included in Appendix five.

13.4.1 HIP and Health Coach consultation patterns

The tables below present information on the wait time for consults and the pattern of follow up consultations that is emerging.

Table 5: Consult patterns for HIP and Health Coach

| | HIP | HC |
|--|---------------|---------------|
| Initial consult | n=721* | n=234* |
| Initial consults seen same day | 55% | 69% |
| Initial consults seen within 5 working days | 88% | 92% |
| Initial consults seen after 5 working days | 12% | 8% |

*Converted referrals with complete data

Access to both HIPs and Health Coaches is rapid, with a high proportion of same-day referrals (55% and 69% respectively) with most people seen within 5 working days (88% and 92% respectively). This compares very favourably with wait times for traditional referral based psychological support. ProCare have shared data that shows between 12% and 18% of people referred get a first consultation with psychological services within 5 working days in this same period.



Health Coaches: 69% seen same day and 92% seen within 5 days



HIPs: 55% seen same day and 88% seen within 5 days

With both roles there is no expectation that a set number of consultations will be completed nor is there a requirement to return on a regular basis. The table below shows the frequency of consultation patterns emerging. The timeframe this data is collected over (1 April to 13 July 2018) naturally limits the window for follow up consultations to occur for both roles, so this may look different over a longer period of time.

Table 6 HIP and Health Coach consultation frequency

| | HIP | HC |
|---------------------------------------|---------------|---------------|
| Converted referrals | n=716* | n=234* |
| Referrals with one consult | 68% | 80% |
| Referrals with 2 to 3 consults | 28% | 18% |
| Referrals with 4+ consults | 4% | 3% |

*Converted referrals 1 April to 30 June 2018 with complete data

The HIP model expects that consultations will be completed in 30 minutes or less. Data from Auckland PHO and ProCare practices from December 2017 onwards show that

- 79% of HIP consultations are 30 minutes or less (n=1799)
- 69% of Health Coach consultations are 30 minutes or less (n=383)

13.4.2 Who is declining support or not engaging?

GPs stated that few people declined the offer of support. Decline was recognised as a 'red flag', telling them that this person is not ready or sufficiently engaged to benefit. Following a decline, the offer is 'left on the table' and revisited later.

Support is about behavioural change and requires people to be active participants in improving their own wellbeing. Those who just want a medical certificate for benefit eligibility, or a pill to make it better, need more encouragement to accept this new approach:

"They come wanting something tangible and work will be needed to change their mindset – the HIP or Health Coach can't do something to, or for, them - they have to be engaged in their own health."

(Practice Manager)

For those more used to traditional programmes of scheduled psychological support, the high proportion of warm handovers and the high proportion of single consultations with HIPs may be a concern. Such patterns could be interpreted as people steered towards support in the moment, only to never return, and therefore a weakness of the model. There will be some people for whom this has not worked well, but feedback quite consistently supports the idea that a single consultation can be effective:

"She showed me this technique, it was strange. I can't believe it works but it does. She told me to close my eyes and imagine what my depression looked like. I told her it looked like a big black hole or cloud, and only a bit of light made it through. She asked me what I'd like to call it (interviewee had an incredulous expression on her face and started laughing). I gave it a name and she told me to talk to it in a normal voice and acknowledge it was there giving me bad thoughts and feelings. I put my hands up to my head and took the depression out of my head and held it on my lap. We talked and then I put it in my heart. I was so surprised, it sounds a bit silly but it works, and I have kept practicing. It's the best thing I have done."

(HIP client)

Few declined the offer of support and clients interviewed said they felt there was nothing to lose when offered a HIP or Health Coach consultation. The session ratings show that consultations are helpful and that people have positive experiences of them (see next section). People accessing services and supports also shared positive feedback to their GP. This noted the value of a single visit. This confirms that, for some, the process of identifying key issues and developing a strategy is all that is required for progress to be facilitated towards improved wellbeing.

13.5 Feedback from people accessing support from HIPs and Health Coaches

The PHOs all asked for session feedback and collected at first and follow-up consultations, though not consistently. Feedback was gathered in different ways:

- ProCare and Auckland PHO asked people to rate **session helpfulness** on a scale of 1–10.
- ProCare asked people to rate **confidence in carrying out their plans** on a scale of 1–10.
- ETHC and Auckland PHO asked people to rate four questions about their experience on a scale of 1–5. These were questions about **achieving things that are important** to them, **knowing about support available**, **making improvements** and **feeling understood**. They also provided the comments people had made in terms of improvement. This is the same approach used by Awhi Ora.

Feedback is presented for HIPs and then Health Coaches, with the ratings reformed into negative, neutral and positive ratings to support sensemaking across the different tools

used to collect client feedback (Figure 36). This data is all on records from the beginning of delivery (December 2017).

Figure 36: Feedback from people accessing support from HIPs and Health Coaches

| Rating | Negative ratings | | | | Neutral rating | | Positive ratings | | | |
|--|-------------------|---|----------|---|----------------------------|---|------------------|---|----------------|----|
| 1-10 scale | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Strongly agree to strongly disagree 5-point scale | Strongly disagree | | Disagree | | Neither agree nor disagree | | Agree | | Strongly agree | |

Figure 37 Client Feedback – HIP (number of sessions rated=3,528)

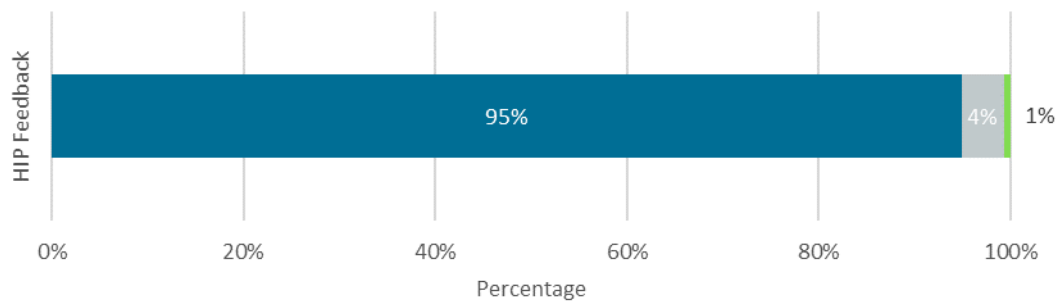
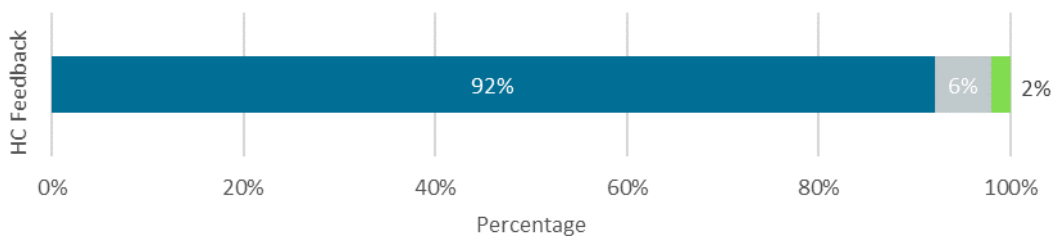


Figure 38 Client Feedback – Health Coach (number of sessions rated=540)



Overall, the ratings are highly positive. Indeed, 95% of HIP sessions rated positively for helpfulness, and almost one in five sessions were rated 10 out of 10. This positive feedback across all the different questions aligns with the positive feedback we got during interviews with clients and the feedback GPs had heard from their own patients.



92% of Health Coach and 95% of HIP consultations have been rated positively by clients

Survey feedback from HIP and Health Coach clients

People who shared feedback on the HIP and Health Coaches were generally very complimentary. Key themes included the value of the support, a sense of being listened to, links to other services and supports, and a sense of a plan of where to next.

"I felt really listened to. I was made aware of help available to me like counsellors etc. Great bunch of people down there."
(HIP Client)

"He gave me a boost of confidence, set me on the right path. It was an awesome chat."
(Health Coach client)

Although not a strong theme, there were three comments related to preferring to speak people of the same culture for greater comfort and understanding. Some comments even specifically named the Health Coach at the practice. This is important feedback and highlights the value of the cultural skills and expertise within these roles. It also supports the value of the HIP and Health Coaches working together, which is going well at a number of practices.

13.6 Key points: How well?

Overall, the implementation of these roles has gone very well and provides some valuable learning for other practices seeking to adopt these roles. Key aspects that demonstrate the success of implementation include the following:

- Integration into the general practice team, supported by the high value of these roles to general practice, although some late adopters are yet to come on board.
- Practice roles and pathways for referrals and management of specific conditions emerging. The integration of Awhi Ora in these is still developing at some practices, but provides value when fully utilised such as at the ETHC and Auckland PHO practices.
- HIP role requires the learning and unlearning of ways of working. This might not fit everyone's ways of working and requires some adjustment.
- Health Coaches are highly valued for their cultural knowledge and expertise. This ensures that cultural models of health and ways of knowing are available to respond to the appropriate clients.
- Support and supervision are an important aspect of successful implementation. This is important for reducing burn out.
- Warm handovers support access and engagement. They are highly beneficial for people accessing and referring to the HIP and Health Coach.
- Flexibility of the HIP and Health Coaches schedule is important. This is supported by not having a full day scheduled and also being able to spend more than half an hour with someone if they are in crisis or if more time is needed to provide a culturally appropriate response.
- General practice staff and people accessing services and supports are highly satisfied with the HIP and Health Coaches.

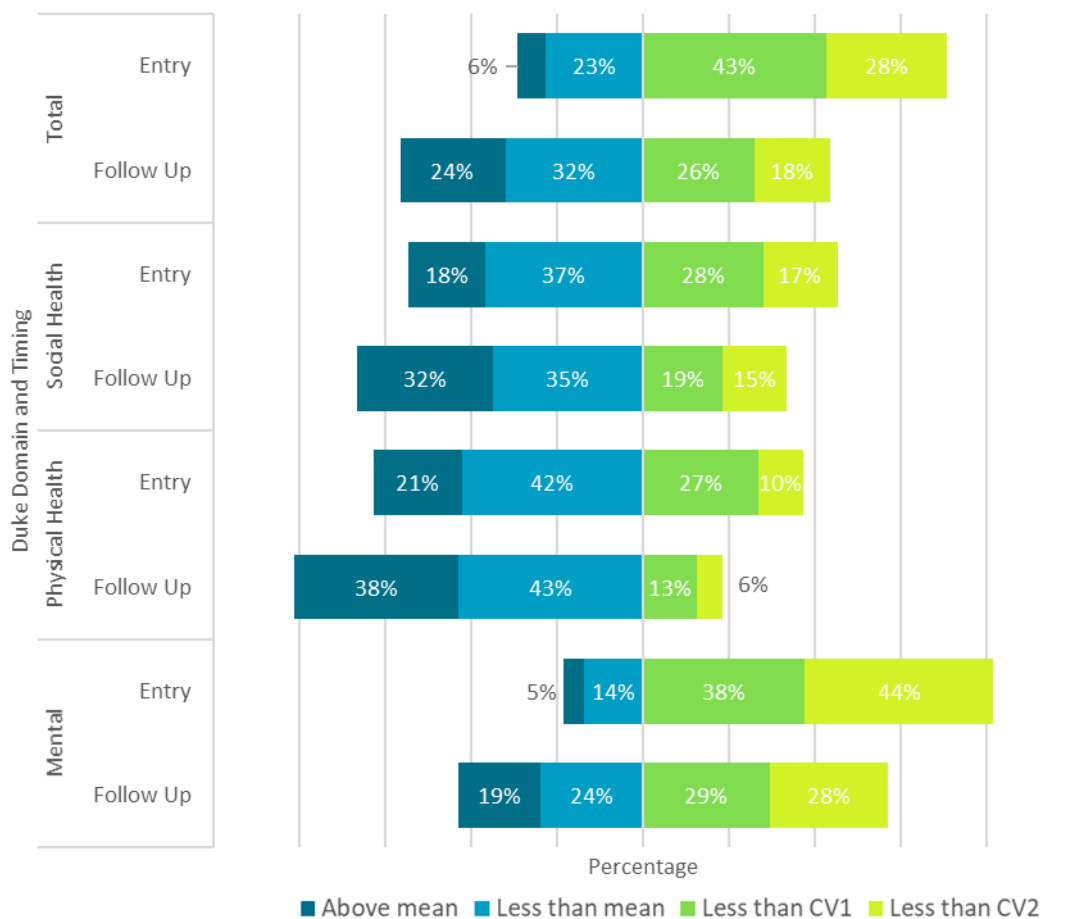
15. HIPs AND HEALTH COACHES: IS ANYONE BETTER OFF?

This section uses the available outcome data, client surveys and interviews, and provider interviews to address the question: Is anyone better off? Practice specific information is included in Appendix five.

15.1 Effectiveness for people accessing HIPs and Health Coaches

The evaluation evidence highlights the contribution of the HIP and Health Coach roles in improving people's functioning. Figure 38 identifies the changes in entry and follow-up Duke scores for all practices using this measure. The graph identifies the distribution for total Duke scores, and for each of the domains. This highlights the improvement in people's functioning following their engagement with a HIP.

Figure 39 Change in Duke score by domain (n=278)



To further understand this change, an analysis has been completed to identify changes in:



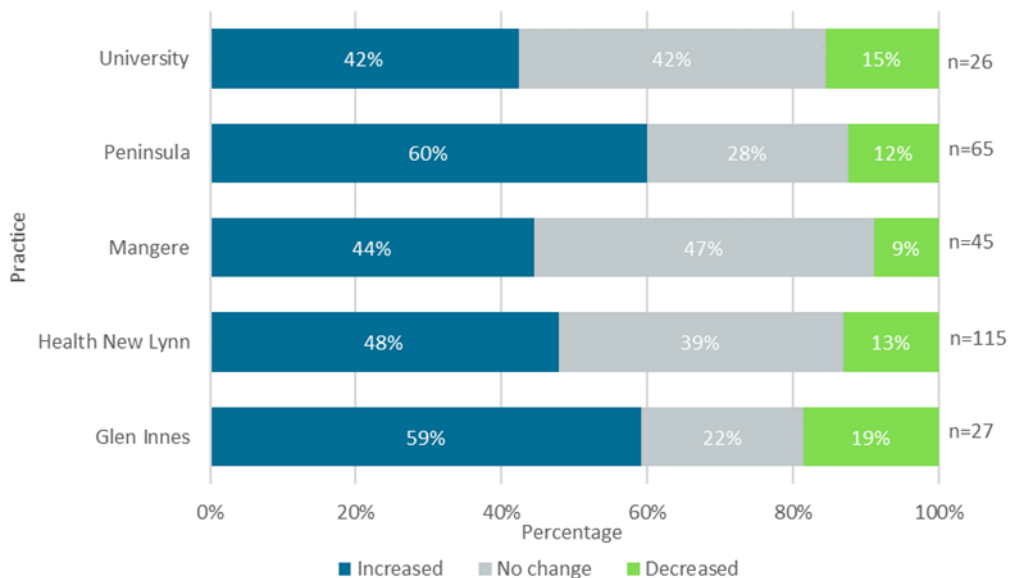
- Duke category (above mean, between mean and CV1, between CV1 and CV2, below CV2)
- total Duke score (this is the totalled domain score based on reference scores and comparison to the mean)
- raw score (changes in the raw score without links to the reference scores and mean comparisons).

These analyses were completed to compare differences across practices, ethnic groups and age groups. Comparing changes in these measures is designed to support the evaluation in identifying the level of change achieved. The Duke is a complex tool to score and interpret, particularly at aggregate levels, and this may limit its usefulness in practices on an ongoing basis.

Category change at individual level shows that half the people seen experienced a positive change in their Duke category (51%), such as shifting from the moderate category to the mild category. A further 36% made no change and 13% moved to a category that represented a decrease in their wellbeing (n=278)

The trend for improvement in Duke categories was reflected at almost all the practices using Duke as a measure (Figure 40). When reviewing this data, it is important to note that support from the HIP is a brief intervention designed to support people to make some changes to enhance their wellbeing. It is not a traditional pre and post measurement following a specified treatment programme where we expect people have been 'fixed'.

Figure 40 Change in Duke category by practice n=278



These improvements were broadly consistent across ethnic groups and age groups (Appendix Four). Given the smaller sample size for youth and 'other ethnicities', ongoing monitoring of improvements is recommended.

15.1.1 Duke raw score comparisons

Analysing by category alone does not reflect more subtle patterns of change that occur within the data. The Duke data has been reanalysed looking at changes in raw scores overall and by ethnicity and age group.

Ratings of people without complete age and gender information have been included in the raw score analysis, lifting the sample size from 278 to 287.

This way of analysing the information demonstrates that around **seven in ten people across all practices experienced a positive wellbeing change in their total Duke score (71%)**, almost a quarter (22%) had a decrease in wellbeing and one in ten (11%) had no change in their raw score. Furthermore, when wellbeing ratings improved they did so by around 19 points, whereas the decreases in wellbeing were smaller, around 12 points (mean scores, n=287). Due to the nature of the Duke and its use of statistical cut-offs for categories, it is not known how clinically significant a 19-point increase is for an individual compared to a 12-point decrease.



71% of people showed an increase in wellbeing (Duke raw scores)

When considering raw scores, the level of change for those whose score increased or decreased is similar for all Asian, European, Māori and Pacific populations (Appendix Four). However, a smaller proportion of Pacifica increased their scores, so while it may be as effective when it works, it is less likely to work for Pacifica.

15.1.2 Insights from people accessing services and supports

Interviews with people who had seen a HIP of Health Coach identified the value of the ease of access, having someone to talk to, and the personalised and practical nature of support. This made them feel supported and motivated to make changes.

Ease of access: People voiced relief at being able to access support so quickly and easily in their general practice. There was no charge for the services. This ease of access was especially important to people who had seen the HIP; several had tried to connect with support before and had experienced a range of barriers, most commonly being passed from one place to another, having to wait too long for support and finding the available options prohibitively expensive. Their access to the HIP was the antithesis of previous experiences and there was a deep sense of gratitude that this was support was available.

"I've been seeing ...a private psychotherapist. And you know, that was sort of too much for me. My Dad was helping me out, but its ...kind of crazy, and you know, missing work plus paying that much a week was kind of making my mental health worse, you know. I actually, I do find the way [the HIP] works, to be superior, for me, to what this guy did."
(HIP client)

Having someone to talk to: This was a strong theme, suggesting that even those who are engaged with primary care have not been given an opportunity to really talk about

what is bothering them. The normalization of issues and the non-judgmental approach from HIPS who have 'seen everything' was valued.

Personalised practical focus: The response people experienced was highly personalised to their needs, preferences and context. One client we interviewed had been suicidal in the past, something that she said was related to her physical health and a condition that had taken years to diagnose. Following her recent redundancy, she was again struggling with her physical and mental wellbeing and was feeling more able to cope because she had been able to talk to someone about what was going on and the HIP had acknowledged her emotions and given her permission to follow a plan of self-care she badly needed.

Another client was introduced to a phone app that helped her track her food and exercise that was "right up my street, as she loved technology. Clients we spoke to appreciate the bespoke nature of support offered and the practical action focus that meant they knew what to do. This is corroborated by the high ratings related to the confidence to carry out their plans (97% of ProCare HIP and HC clients rated as 7 or higher on a 1–10 scale, n=1270).

"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)

"I have been to [groups] – you graduate and that's it. This is more helpful, its just about me... they really care and I like that."
(Health Coach client)

Health Coaches, HIPs and clients all talked about the **reviewing progress**, encouraging positive change and acknowledging times when 'standing still' was an achievement in itself, considering all that was happening. The very structured HIP sessions worked well for people, especially those who came back for a follow up session.

Health Coaches were highly relatable, and this made people feel comfortable with them, able to work at a realistic pace and achieve small but significant changes. One client, for example, felt Green Prescription did not work for her. Staff were young and sporty and just did not understand what it was like for her. She also sustained injuries as she began to exercise. With the Health Coach, this client used some of the same material and resources and gained a better understanding of what to do and how to exercise safely, and was beginning to make progress.

"I was nervous, she put me at ease. It was easy to talk about everything. Life, family, money; I put it all on the table."
(HC client)

15.2 Better off? Effectiveness for those in primary care

BHCs have relished the challenge of this new way of working and feel this is an effective way to support people, makes effective use of their skillsets and is best use for the time available for consults. Doing the same amount of work in half the time to traditional

therapy and counselling roles was a common reflection. Concerns for individuals in the role regarding burnout have been responded to with support and supervision.

Practice teams have responded positively to these new roles and benefits they have identified include:

- **time saved in consultations**, as GPs and PNs can refer on to BHC or Health Coach for those longer conversations that are required. This was obviously a source of relief as clients were getting connected to the right support, and it also reduced the stress for GPs of running late on their schedule
- **confidence** to have conversations about mental health now GPs and nurses have someone within the practice they can refer people to. High confidence in the HIP and Health Coaches' ability to support people well, builds this confidence
- **a broader range of options, beyond prescribing**. Previously GPs were restricted to referrals for psychological support or prescriptions for people presenting with mental health issues. HIP is seen as an immediate and effective response. GPs are under less pressure to prescribe simply because there is another option that may suit their patient better
- **efficiencies through new practice pathways** that include identification of routine referral to HIPs, regarding depression for example, or to Health Coaches, regarding diabetes. Such pathways direct patients through the most appropriate pathway for their needs and enables practice to routinely optimise efficiencies that enable GPs and nurses to work at top of scope.

"Nurses don't ask if people are stressed - and doctors don't either- because if you ask that question you must do something about it, and that's going to blow my whole day."
(GP and nurse)

"Nurses have always done healthy lifestyle info, so now they can let that go and do meds and insulin and the Health coach can do the healthy eating. They can see more diabetics as consults are quicker, then they go to see the Health Coach."
(nurse)

- **a potential for credentialed nurses** to contribute to practice teams, which has been highlighted by these new roles and teamwork processes. There are plans in a couple of the practices for HIPs and credentialed nurses to work closely together; one of the ideas is for nurses to complete follow up consultations.

15.3 Effectiveness for the system

In this relative short timeframe system benefits are emerging. This includes:

- **relational network within primary care** teams that extends (via Awhi Ora) into the community. Once enhanced with stronger links with secondary care it will provide a network of support across the community, primary and secondary sectors that make connecting with and navigation across support easy, whatever the point of entry

- **an indicator of reductions in prescribing**, as indicated by individual GPs during the interviews and initial trends from prescribing data at the Glenn Innes practice. When tracking this data, focusing on antidepressants is most helpful. As the model is still reaching across the practice teams, an analysis by practice level is not helpful. GP-specific analyses are the most insightful at this stage.
 - o There has been a 9.8% drop in the number of SSRI prescriptions in this practice, when the January–March 2017 period is compared with that of 2018. This is promising and will require ongoing monitoring across more practice sites to confirm the relationship with HIP provision.

"My SSRI prescriptions have dropped quite considerably since having a HIP available. Because I know I can get a person seen, most days straight away or within a couple of days, that does change what I do if I know a patient is pretty unwell. The old PPS referral was minimum two weeks. I have to manage those two weeks. I can talk about self-help, refer to websites - and I do - we talk about the menu of opportunities. Some people are happy with that and willing to wait, but I'm wanting to do something for them now. If I don't have the HIP here I'm more likely to use an anti-depressant, if appropriate of course."
(GP)

- **better use of psychological services.** In Framework practices, people with mental health related support needs are receiving timely support in the practice. This is reducing practice referrals to psychological services. ETHC and ProCare data combined shows a 45% reduction in referrals (191 fewer) compared with the same six-month period the previous year. This reduction varies considerably between practices (16% to 82% reduction). In interview, clinicians felt those referred to psychological services were likely to engage and benefit.

15.4 Improvements or next steps for HIPs and Health Coaches

These roles have been in place for less than a year, so key improvements relate to the **implementation process** and the ongoing cycles of learning and improvement that are occurring.

- Continue to develop the scope of the roles so their potential is reached in terms of population health gain; identifying needs in practices and developing pathways and delivering group interventions as appropriate. This may help Health Coaches to further define their niche in the practice and their contribution to mental health support.
- Continue to integrate the roles with the practice team functions and roles, particularly the credentialed nurse role, as initial integration is promising.
- Explore the opportunity for capacity and capability building with programs, such as Health Care Home and Planned Proactive Care.
- Encourage engagement of late adopters in practices as there are still practice team members who have not made any referrals.

Adapting and developing the model in New Zealand

- HIP model adaptations to the New Zealand context can be explored now this initial learning phase has occurred. Structure, tools and techniques may be adapted to incorporate te ao Māori or Pacifica world views.
- Continue to build support for the new workforce. Explore the potential for ongoing peer support and shared learning for the organizations and people in these roles, as well as the level of supervision and support that these roles need.

Improve information by collecting data on more than one presenting need will further support the increasing evidence base in relation to the mental health and addiction support needs of people in primary care, and what works for them.

Outcome tool consistency will support whole sector learning. The use of common tools across organisations (and where feasible, roles), agreed protocols for collecting follow up outcome measures and agreement on the most useful level of analysis will also support future evaluation efforts. This is important for both HIP and Health Coach roles. The utility of the tools for people providing and accessing supports should continue to be understood. While the Duke was recommended, its analysis based on highly specific mean categories from a US population in particular warrants exploration and value in terms of utility and relevance to a New Zealand population.

16. OVERVIEW OF KEY FINDINGS

The FffF funding provided a valuable opportunity to support the expansion of existing interventions and develop the evidence base for interventions targeting people with mild to moderate mental health needs. This section summarises the evidence into an overview of key findings related to the enhanced integrated practice teams.

16.1 How much was done?

In terms of the enhanced integrated practice teams, the evaluation evidence found that Awhi Ora, the HIP and the Health Coach roles:

- ✓ **reach the missing middle** - people with complex mental health needs who are not eligible for secondary services and would not be referred to and/or would not access existing referral based psychology services.
- ✓ **reach people with a range of mental health needs** relating to physical, social, economic and behavioural determinants of ill health. This is evidenced through the use of validated assessment tools and insights from people accessing services and supports, and insights from health professionals and providers
- ✓ **Available much more rapidly than traditional referral based psychological services** and have reduced demand for those services and enabled people with more intensive needs to access interventions while they wait to access referral-based services
- ✓ **provide immediate/rapid access to a range of person-driven support options.** This is supported by the focus on a person-centric approach that enables the person to identify the areas of their wellbeing that they need to address. The brief rapid response also encourages and supports this self-activation
- ✓ **facilitate equity of access for Māori, Pacifica and youth,** particularly through location at high-needs or youth-focused practices. The cultural competence of the Health Coaches and some Awhi Ora Support Workers supports access and engagement for Māori and Pacifica. This is supported by an analysis of access rates by enrolled practice and DHB populations
- ✓ **provide a brief preventative response** that also encourages a more holistic response to supporting wellbeing than psychological support services in isolation. This is supported by recognising the broader determinants of ill health, including social and economic needs, such as support with housing

When reviewing these findings, it is important to consider the stage of implementation. The HIP and Health Coach roles were introduced into most practices in December 2017. These positive findings should continue to be monitored. Achieving this level of reach at this stage of implementation also demonstrates the void these supports have filled in primary care and the value of providing a gateway to immediate support where there are no barriers to entry.

16.2 How well was it done?

The evaluation evidence indicates that the HIP and Health Coach roles and Awhi Ora were well implemented overall, and in this short time are reaching a degree of practice integration that SAMHSA would recognize as approaching or achieving a fully integrated practice.²⁴ As an external partner, integration for Awhi Ora is more of a challenge, particularly establishing effective two-way communication. Despite this, there are some very strong relationships evident and work is underway to strengthen or review those that need development.

Integrating HIP, Health Coach and Awhi Ora roles with existing practice roles and systems is not without its challenges and is supported by a change-management process that is not complete. This identified key aspects of the enhanced integrated practice teams that are important for supporting success:

²⁴ SAMHSA-HRSA (2013). A standard framework for levels of integrated healthcare. SAMHSAHRSA: Washington, USA

Aspects of the integrated practice teams that support success

| | |
|--|--|
| <ul style="list-style-type: none"> • No entry criteria • Warm handover and immediate/fast access to support | <p>No entry criteria makes it easy for people to be introduced to services and supports.</p> <p>Warm handover is achieved when the HIP, Health Coach or Awhi Ora are at the practice. This approach was extremely valued by clients and practice staff. Warm handover was more consistently achieved through the HIP and Health Coach roles due to being located at the practice. Leaving every other booking free in the schedules of HIPs and Health Coaches facilitates immediate access. Awhi Ora sees most people within five working days.</p> |
| <ul style="list-style-type: none"> • Person-centric support | <p>The services and supports provided are determined by client-driven goals. These focus on the immediate or key things that need to be addressed to support their wellbeing. <i>One size does not fit all.</i></p> |
| <ul style="list-style-type: none"> • Presence at the practice • Feedback to GPs | <p>Presence within the practice builds relationships with existing practice staff. These relationships support integration with existing services enabling mental health services and supports to become part of the primary care landscape. This aspect is more challenging for Awhi Ora, as many practices do not have physical space to accommodate them seeing people on site. The HIP and Health Coach roles are emerging as gateways for people to access Awhi Ora supports.</p> <p>Feedback to GPs is important for building trust and also provides an opportunity to build capability.</p> |
| <ul style="list-style-type: none"> • Awhi Ora community networks and connections • Value of HIP, Health Coach and Awhi Ora Support Worker skill sets | <p>The community networks and connections of the Awhi Ora support moved beyond general practice to connect people to a broad range of services and supports. These are important for also addressing the social and economic determinants of mental health.</p> <p>Workforce and cost considerations can easily lead to the consideration of one role or choices about which roles should be implemented and where. Evidence in this space is emergent at this very initial stage of implementation. The evaluation, however, does indicate that:</p> <ul style="list-style-type: none"> - BHC support those with higher levels of need/distress - HC supporting with health-related behaviours and LTCs, and providing culturally appropriate or relevant support - Awhi Ora Support Workers can provide support across for a range of psychosocial needs. |
| <ul style="list-style-type: none"> • Adaptive workforce | <p>This way of working requires an adaptive workforce that provides services in a different way to traditional therapist or support work roles. Staff have been passionate and invested in this way of working.</p> |

16.3 Is anyone better off?

The evaluation provides evidence for the benefits of the enhanced integrated practice teams for people accessing services and supports, for those providing services and supports, and for the wider system. At this stage of implementation, we did not anticipate that we would be able to see changes in referrals to psychological support services or prescribing. While there are areas to improve and build on, the achievements to date have exceeded expectations.

16.3.1 A summary of key outcomes and benefits

This aspect of the overview draws on a data integration framework for mixed methods data integration. This approach to analysis reviews the levels of evidence for the key findings of an evaluation to support decision makers in understanding the level of evidence that exists for the key findings. The level of evidence ranges from low to high, with consideration also given to emergent evidence. A high level of evidence requires support from multiple data sources gathered through an evaluation and triangulation of this evidence, such as consistencies in outcome measurement and consistent findings in interview data. Moderate evidence is likely to reflect evidence from one key data source and low levels of evidence reflects little evidence for the phenomenon of interest across any of the data sources. Emergent is a category that is important for recognising the development of an evidence base and the limitations of an evaluation to make a judgement about the level of evidence in an evaluation. The table below summarises the level of evidence for the key findings for the implementation of the Awhi Ora Support expansion, HIP and Health Coach roles in the ADHB and WDHB regions.

Table 7: Levels of evidence for the key benefits of the enhanced integrated practice teams (Awhi Ora Supporting Wellbeing, HIPs and Health Coaches)

| | LEVEL OF EVIDENCE | QUANTITATIVE EVIDENCE | QUALITATIVE EVIDENCE |
|---|-------------------|--|--|
| Outcomes for people accessing services and supports | | | |
| Improvements in mental health and wellbeing | High | Baseline and follow-up measurement (validated tools) Client feedback survey results | Consistent theme in client feedback and client and practice staff interviews |
| Access to services and supports to address broader determinants of wellbeing, such as housing, money matters and employment | High | Service data on options required and accessed | Consistent theme in client feedback and client and practice staff interviews |

| | LEVEL OF EVIDENCE | QUANTITATIVE EVIDENCE | QUALITATIVE EVIDENCE |
|---|------------------------------|---|---|
| Outcomes for people accessing services and supports | | | |
| Immediate or fast access to services and supports | High | Service data 55% HIP clients and 69% Health coach clients seen same day. 85% HIP and 92% of Health coach clients were seen within five days. Eight in ten people introduced to Awhi Ora were seen within five days Better access and engagement compared to psychological services | Consistent theme in client and practice staff interviews |
| Improved access for Māori, Pacifica and youth | High | Service data in comparison to enrolled or local populations. Health Coaches and Awhi Ora important here | Key theme in some client and practice staff interviews |
| Access for people whose needs would have gone unmet | High | Service data on complexity of need; availability of BAU supports | Consistent theme in client and practice staff interviews |
| Benefits for people providing services and supports | | | |
| Reducing the burden on general practice teams | Moderate | Impact on throughout cannot be easily identified in PMS systems as high needs practices are so busy – throughput remains high | Consistent theme in staff interviews |
| Giving general practice staff confidence to 'have the conversation' | High | N/A | Consistent theme in staff interviews |
| Practice and system outcomes | | | |
| Reductions in prescribing for antidepressants | Moderate and emerging | Reduction in SSRI prescribing at practice level (data for one practice). Trend was emerging prior to FfTF funding but increases for FfTF | Theme in some GP interviews (those who indicated high engagement) |
| Supporting people working at top of scope | Moderate and emerging | Hard to identify in PMS. Changes in throughput cannot be identified in PMS of busy high needs practices | Consistent theme in staff interviews |

| | LEVEL OF EVIDENCE | QUANTITATIVE EVIDENCE | QUALITATIVE EVIDENCE |
|--|-------------------|---|--|
| <i>Outcomes for people accessing services and supports</i> | | | |
| Better use of psychological support services, reduced demand overall | High | Service data from practices with HIPs and Health Coaches and some Awhi Ora practices. | Key theme in some staff interviews, particularly those in project leadership |

Based on this mixed methods integration, the evaluation provides good evidence through which to understand the contribution of the enhanced practice teams to people with mild to moderate mental health needs. More specifically, the evaluation demonstrates the positive contribution that the enhanced practice teams make and the value of continuing to support and further roll out their implementation.

17. GETTING FIT FOR THE FUTURE

17.1 Improvements and modifications in the enhanced integrated practice teams

The relatively early phase of implementation is acknowledged. This is a time of learning and rapid cycles of improvement. The sections on Awhi Ora and HIPs and Health Coaches have identified intervention specific improvements. Across the support landscape the themes for future improvements are:

- **Continue the work to develop and clarify roles**, so the scope of HIPs, Health Coaches and Awhi Ora roles are understood by not only role holders but the practice team, introduction partners and others in the support landscape.
- **Explicitly working to defined models of practice** enables fidelity to a model. This can be monitored and enables practitioners to practice in a way that is safe for them and the people they support. Leadership, shared learning and routine use of data at practitioner and practice or programme level will support this for HIP, Health Coach and Awhi Ora roles.
- **Understanding the optimal configuration of enhanced integrated practice team roles** through ongoing implementation and testing considerations relating to role and practice contexts, such as level of need, population size, existing workforce skill sets and practice structures.
- **Continuing to strengthen, understand and support the contribution of different roles to respond to the cultural needs of people accessing supports.** Ensuring that the cultural knowledge and expertise available (most commonly provided by Health Coaches and Support Workers) is considered in the configuration of roles, functions and pathways across the support landscape.
- **Consider other potential within the practice landscape** as there are FfF funded initiatives that were out of scope for the evaluation and may be future contributors to the capacity and capability within integrated practice teams.
 - o The role of credentialed nurses warrants exploration as newly trained nurses become available to practice teams. Initial implementation has highlighted the value of these roles, when given the time, supervision and support to use their expertise.
 - o Telehealth support (based on HIP function) could be an effective way to provide support for smaller or rural practices, or to cover extended practice hours.
- **Enhancing pathways to support integration with secondary services.** This pathway is a significant weakness with most Framework practices identifying a gap between primary and secondary services. The Direct Telephone Access provided in WDHB offers some opportunities to address this.
- **Development of a common measurement model** that includes accessibility, equality of access, client experience and outcomes in terms of improvements to

wellbeing is advised. Collecting information beyond a single presenting need will further support the increasing evidence base in relation to the mental health support needs of people in primary care.

17.2 Future sustainability and expansion

FtF has achieved great things in what has been, operationally, a very short time frame. The learning can therefore contribute to the discussion about sustainability and expansion, rather than identify next steps in terms of the financial, organisational and delivery aspects of enhanced practice teams in detail.

Funding is the most pressing and fundamental risk to sustainability. The needs and volume of demand cannot be met within the existing business as usual resources of NGOs and primary care, and for the most part FtF funding ends in September 2018. These roles are much needed and already well established – any change will present significant challenges for the practices involved and the people who are being supported. Such is the success of this work that none of the organisations have developed a transition back to business as usual – this has to be business usual for them.

The **collaboration of DHB, primary care and NGO partners** has been supported by guidance from the DHB to unify the multiple organisational and local agendas under the FtF umbrella. Sustainably and/or expansion will require ongoing collaboration and leadership. Should the initiative reach beyond ADHB and WDHB boundaries, it makes sense for this to be PHO led, though DHB will be key contributors and need to play an active part in strengthening links with secondary services and enabling NGO community support.

Economies of scale are always a consideration of sustainability. The half-time HIP supported in the only practice belonging to Auckland PHO has required a disproportionate amount of investment to operationalise (e.g. IT platform amendments, project management). The success of the FtF initiative should give PHOs the confidence to embrace this approach, not try it out with a HIP or HC for a few hours a week. The collaboration of PHOs has enabled economies of scale related to training and supervision to be realised for FtF – fundamentals that are beyond the reach of individual practices and small PHOs.

The enhanced practice teams involved in FtF have been urban, mostly large in terms of practice populations and identified with high needs. The transfer of these roles to **other types of practices may require adaptations** that have as much to do with feasibility as population need. It is unfortunate that the Telehealth HIP role has not had the opportunity to be tried out in the same timeframe, as this could be a solution to some of those pragmatic issues.

HIPs are a **new workforce and the budding support structures**, such as training, trainer development, learning groups and supervision will need continued investment as they are potentially vulnerable given their scale and newness. This emergent workforce can be bolstered by credentialed nurses, or people in other roles (such as GPs and nurses) training in the model or upskilling in behavioural health techniques.

18. CONCLUSIONS AND RECOMMENDATIONS

The evaluation evidence demonstrates the importance of providing services and supports for people with mild to moderate mental health need in primary care. The evaluation also highlights the value that can be provided for people needing services and supports when DHBs including support from PHOs and NGOs partners to strengthen the capability and capacity of primary mental health.

The enhanced integrated practice teams have demonstrated the value of:

- providing immediate access to services and supports for people in primary care
- providing services and supports that respond to the psychological, social and economic determinants of ill health and wellbeing without barriers to entry.

The evaluation also indicates that people with complex mental health needs can be managed within primary care, if it is equipped with the capacity and capability to do so.

The findings also suggest that without providing support for people with mental health need in primary care, there is a risk that these people's needs will continue to go unmet, and that they will continue to experience poorer health and wellbeing outcomes that impact on their ability to go about their daily lives and contribute to the wellbeing of others. Existing evidence also suggests that without appropriate support, a high proportion of these people will go on to require supports from secondary services and/or continue to require other supports from government agencies and organisations.

Based on the evidence presented in this evaluation and considerations of existing evidence relating to services and supports for people with mental health needs in primary care, we would recommend:

- extending the current enhanced integrated practice teams and provide additional funding to support the expansion of the HIP, Health Coach and Awhi Ora Support Workers to other high needs practices.
 - o Consideration should also be given to supporting reach for Māori, Pacifica, Asian and youth when selecting future practices (as it was for the FfF funding).
 - o Emphasis should be placed on whole-of-practice education to promote speedy and effective implementation.

In terms of the enhanced practice team themselves, we would recommend:

- ensuring that practices with HIP and Health Coach roles have an Awhi Ora support worker connected to them
- expanding the provision of Awhi Ora support workers across a broader range of practices but have the HIP or Health Coach as they key point contact, reducing the burden and ongoing challenge of support workers trying to negotiate access to practices. This will maximize the value of the support worker expertise
- ensuring that practices understand that Awhi Ora is much more than housing and social support. Awhi Ora provides an important opportunity to meet the

needs of people with a wide range of support needs, including emotional support.

In terms of meeting the needs of Māori, Pacifica and young people:

- Awhi Ora and the Health Coach roles are also important for supporting a culturally responsive approach for Māori and Pacifica, and it is important that this is considered in any future roll out. Any integration or overlap of roles in specific practice contexts that might not be able to sustain or require all three roles must ensure that these skills are not lost.
- Considerations for youth highlight the potential value of connecting NGOs with expertise in engaging young people with youth specific organisations, such as *HealthWEST* in WDHB. This would support the sector in providing a broader range of options for young people, in addition to the current packages of care and be an efficient way for NGOs to reach youth.

There is a need to enhance the interface between primary and secondary care to further strengthen the enhanced integrated practice teams. This should be supported by some of the interventions being implemented in WDHB, and direct telephone access to specialist support in particular. This provides an immediate link to a community psychiatrist who can provide support that enables GPs to better manage the needs of people in primary care. The psychiatrist provides support through being able to share secondary service information not visible to GPs, providing advice in relation to prescribing and the navigation of other services and supports.

APPENDIX ONE: AWHI ORA SUPPORTING WELLBEING

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|--------------------------------|--|
| Name | Awahi Ora-Supporting Wellbeing |
| History | <ul style="list-style-type: none"> - The Tamaki Wellbeing project began in 2013 taking a community development approach to developing and delivering health and wellbeing services that meet the needs of local communities. From one of five workstreams, an initial Mental Health pilot began in April 2015 with three NGOs and two primary care practices. This 'walk alongside community support service' was expanded to the seven NGO providers and thirteen practices from October 2016. FfF funding enabled further expansion – to include 23 practices and some non-health sector partners. - https://www.tamakiwellbeing.org.nz/awhi-ora-supporting-wellbeing |
| Theory formal-implicit | <ul style="list-style-type: none"> - Awahi Ora provides community-based support to help people manage challenges that impact their wellbeing. - People can access support easily when they need it and can access that support through trusted people and organisations (predominantly their GP). Navigation, practical and emotional support. |
| Principles | <ul style="list-style-type: none"> - 12 principles for practice developed by the Tamaki project. |
| Who is the target group | <ul style="list-style-type: none"> - Awahi Ora is described as 'walk alongside' support for people experiencing life challenges to their wellbeing or experiencing stress in their lives. In keeping with its principles, there is deliberately no definition of stress or criteria for accessing support. Awahi Ora is not a clinical service. |
| Practitioners | <ul style="list-style-type: none"> - Community support workers. NGOs have used senior and experienced staff to deliver Awahi Ora. These may be qualified social workers and/or people in practice leader positions. Some NGOs have a dedicated Awahi Ora worker, others use staff from their large community teams as required or practice a combination of these two approaches. - NGOs have noted that the knowledge and skills from mental health community support are transferrable to this wider population group, but staff also need to be able to work more responsively and flexibly with people. Some staff have not adapted to this way of working. |

| | |
|------------------------------------|--|
| <p>Who provides it</p> | <ul style="list-style-type: none"> - NGOs contracted to provide mental health community support have been given variations to their contracts to deliver Awhi Ora. - In ADHB there are seven NGOs, two of which were involved in the original pilot, the rest joined the initial roll out in 2016. There has been a staged roll out across the district. These NGOs are able to redirect 5.66% of their community support hours contract and have FfF funding to provide additional hours of support. - In WDHB there are ten NGOs that are contracted to deliver Awhi Ora. Six have been able to redirect 5.76% of their contract funding to Awhi Ora, two have received additional funded hours only and two have additional funded hours and can use redirected funding. - Flexi funding. |
| <p>Delivery description</p> | <ul style="list-style-type: none"> - Awhi Ora Supporting Wellbeing is designed to enable primary care practices and other sector agencies to have a lead NGO they can introduce people to who would benefit from wellbeing or social support. - Some NGOs are on site at primary care practices, usually for a few hours at the same time each week. This enables them to see any people the practice has booked in for them, be available for warm handovers or collect introductions to follow up. - There is a one-page Awhi Ora introduction form that can accompany introductions. - The Awhi Ora network of providers is intended to work collaboratively. People may be introduced on to other providers in the network who may better meet their needs or preferences. - Following an introduction, people are seen by a support worker. This may be in the GP clinic, their home or in the community. A plan to address the person's presenting need is developed with the support worker. Support is usually brief – typically weekly for up to three months – but varies according to need. Sometimes one-off support is all that is required (for example providing navigation support to connect people to resources). Other people with multiple or more complex issues may require support for a longer period. - NGO provides face-to-face support in the community. This includes phone and text communication. People are seen individually or with whānau. Support includes practical and emotional support, navigation and connection to services and community resources, or providing information. |



| | |
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| Key tools and approaches | <ul style="list-style-type: none"> - Person-led goal planning is the key mechanism of service delivery. There is no prescribed planning process, and plans can be formal (written process) or simply an agreement about who is going to do what. - For evaluation purposes, NGO providers used the Kessler 10 on entry and exit from services. The tool's presentation was reformatted and presented as a survey about 'how I have been feeling'. |
| Success | <ul style="list-style-type: none"> - Success is described as people having greater control over their lives and maximising their health and wellbeing. |



APPENDIX TWO: HEALTH IMPROVEMENT PRACTITIONER

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|-------------------------------|--|
| Role name | Health Improvement Practitioner ProCare and Auckland PHO use the name Health Improvement Practitioners (HIPs) and ETHC is now calling them Wellness Advisors. |
| History | The role is based on the behavioural consultant model (BHC) developed in the United States in response to the very high prevalence of psychosocial health issues, low rates of detection in general practice, demand exceeding primary care capacity to respond, low uptake of referrals to talking therapies and other mental health services and limited access to these services. Training for Framework practice HIPS has been provided by Mountainview Consulting Group, a US consultancy headed by Patricia Robinson (PhD). Mountainview Consulting Group provides training and ongoing support for the integration of behavioural health services into primary care. https://www.mtnviewconsulting.com/ |
| NZ context/connection | ProCare has introduced the BHC model to New Zealand and facilitated the training provided by Mountainview. The first training was conducted in November 2017 with a second tranche delivered in March 2018. BHCs are working to Mountainview's BHC model and this initial implementation is an opportunity to explore how well the model transfers to the New Zealand context. |
| Theory formal-implicit | Mental health practitioners can deliver effective interventions in shorter duration consultations and for fewer sessions than is the case in conventional referral-based talking therapy approaches. Integrating mental health practitioners into the primary care team can greatly increase access and enable enhanced responses to psychosocial issues by all team members, thereby reaching far more of the population need. The BHC model has three aspects to their role. Firstly, they provide support directly to people (individuals, couples or families) in short, structured consultations. Secondly, they build capacity within the general practice team through education, and thirdly, they identify and develop responses to the health needs of the practice population. |
| Principles /practice | The components of the role are described by Mountainview Consulting as: <ul style="list-style-type: none"> - generalist – sees all ages and all behavioural issues - accessible – sees most people the same day - team based – is a member of the general practice team - high productivity – sees 8+ people daily |

| | |
|--------------------------|---|
| | <ul style="list-style-type: none"> - Educator – builds practice knowledge re behavioural interventions - routine pathways –develops pathways and protocols to support high impact patient groups. <p>The role is integrated into the practice team and the HIP is a present and easily accessible member of the team providing feedback and advice about anyone seen to the general practitioner, who remains the person's care manager.</p> |
| Target population | <p>People of all ages in primary care with psychosocial issues impacting on their wellbeing. People do not have to have a mental health or addiction diagnosis or meet a severity threshold to access a HIP. For FttF this role is intended to reach people with moderate mental health needs. The role aligns with the mental health practitioner included in the practice landscape.</p> |
| Practitioners | <p>Registered mental health professionals who have proficiency in brief psychological therapies. Within the Framework practices there is a mix of health psychologists, clinical psychologists, nurses and psychotherapists. Most HIPs have previously worked in primary and/or secondary mental health services. One general practitioner has also been trained as a BHC.</p> |
| Where provided | <p>BHCs are based in general practice teams and are expected to work as an integrated member of the team. When not consulting with patients they spend their time in shared work areas where they are easily accessible for advice and can actively support practice staff to identify patients who may benefit from their services. They are flexible regarding rooms in which they deliver interventions which tend to be close to the central hub of the practice.</p> |
| Delivery mode | <p>HIPs work with individuals and families/whānau across the age span and can provide services face to face or over the phone. They can also run groups for common issues such as anxiety and depression. HIPs work with other members of the general practice team to identify who would benefit from their services. People access HIPs in several ways including:</p> <ul style="list-style-type: none"> - warm handover referrals from other members of the team and where practicable immediate consultations - morning 'huddles' each day to review bookings for the day and who of those people may benefit from contact with a BHC - agreed pathways within each practice for common issues; e.g. depression or anxiety. <p>Consultations focus on what is happening now for the person, focus on one issue only, and draw on a range of tools to assess</p> |

| | |
|----------------------------|--|
| | <p>the person's life context then a functional analysis to identify the issue, understand what's happening and develop a behaviourally based plan that the person can use to self-manage.</p> <p>BHCs are expected to schedule alternate half hour consultations, leaving at least every other 30-minute consultation free for warm handovers and same day bookings. First consultations are expected to be completed within 30 minutes. Should subsequent sessions be required, these may require less than 30 minutes.</p> <p>People can be booked in for follow up sessions (there is no defined limit) but are also encouraged to return when, and only if, required.</p> |
| Key tools/approach | <p>BHCs draw from a range of evidence-based models and approaches which include Focused Acceptance and Commitment Therapy (FACT). This is a condensed version of acceptance and commitment therapy that uses mindfulness techniques. It is a transdiagnostic approach that helps people who are 'stuck' (rather than diagnosed) to develop psychological flexibility through becoming open, aware and engaged. A range of scripts and tools that can be used to support contextual and functional analyses are provided in the training to support this process that results in a behaviour change plan.</p> <p>HIPS receive coaching that includes building the following skills that they are unlikely to have received in previous training or experience:</p> <ul style="list-style-type: none"> - working as a general practice team member - undertaking 30-minute consultations - delivering Focused Acceptance and Commitment Therapy (FACT). <p>A key aspect to the approach is providing training within each general practice to enable both HIPs and other general practice team members to utilise the role appropriately.</p> |
| Outcome measurement | <p>The Duke Health Profile (Duke) is a 17-item health profile measure, used for adults to identify a range of function and dysfunction across three wellbeing domains – physical, mental and social. The BHC model advocates for using Duke at every consult.</p> <p>Additionally, the HIP at ETHC has also used PHQ9 (used as screening tool in the practice).</p> <p>ProCare uses the Strengths and Difficulties Questionnaire for those aged 3–17.</p> |

| | |
|----------------|--|
| | The HIP at Orakei practice has been using Kessler 10 as an outcome measure. This was a pragmatic decision based on the existing capability of the PHO's practice management system. |
| Success | <ul style="list-style-type: none">- Improve access to psychological interventions.- Improve health outcomes.- Small changes in wellbeing for many people.- Support efficiency of GPs.- Support capability of general practice teams.- Prevent morbidity for those at high risk.- Cost effective. |



APPENDIX THREE: HEALTH COACH

| | |
|-------------------------------|--|
| Role name | Health Coach |
| History | <p>Health coaching is the use of evidence-based skilful conversation, interventions and strategies to actively and safely engage client/patients in health behaviour change</p> <p>ETHC Health Coaches work to a model developed by the University of California Centre for Excellence in Primary Care (https://cepc.ucsf.edu/health-coaching). This model has an evidence base with use within primary care clinics by the addition of non-clinical health coaches. This model is used in various settings for training of behavioural health assistants who work alongside behavioural health consultants in some clinics in the US.</p> <p>Health coaching skills are useful for all persons working in a clinical setting, but this model includes evidence and practical guidance for a dedicated health coaching role within a primary care clinic.</p> |
| NZ context/connection | <p>ETHC invested in sending a health psychologist to train in the CEPC Health Coaching Curriculum at San Francisco General Hospital, San Francisco. ETHC have adapted content of the curriculum for the New Zealand context, with permission from CEPC. ETHC has set up guidelines and supervision within the New Zealand setting in order to make it a safe model for testing.</p> <p>Multiple trainings have been offered by ETHC with approximately 150 trainees from various health settings trained. ProCare and ETHC self-management course trainers/leaders have all trained in the model. ETHC has been testing the use of a dedicated health coach in several clinics for people with diabetes with promising results.</p> <p>Counties Manukau DHB have developed their own Health Coaching training incorporating key components of overseas models adapted for the NZ context.</p> <p>ProCare Health Coaches have completed a mix of the ETHC run programme and the Counties Manukau DHB programme.</p> |
| Theory formal-implicit | <p>Health coaching is a patient-centred practice that empowers people to be more actively involved in their health care and enables general practice teams to better support patients whose needs cannot always be met in the standard 15-minute GP consultation.</p> |

| | |
|-------------------------------|---|
| | <p>Health coaching acknowledges that it is the patient who is the most important person in the clinic with a continual patient-centred approach.</p> <p>Health coaching is not a standalone intervention but is effective when a 'teamlet' or small team is created where the health coach works directly with the clinical staff and patient.</p> |
| Principles of practice | <p>Core functions of this role are to</p> <ul style="list-style-type: none"> - provide support for their client to manage their condition themselves - bridge the gap between their client and their doctor - help their client find their way around the healthcare system - offer their client emotional support - be their client's ongoing first person to contact if they have a question. |
| Target population | <p>Anybody that GPs feel need extra support beyond the standard 15-minute consultation. As an example, people with multiple comorbidities (physical and/or mental health conditions)</p> |
| Practitioners | <p>Health coaching can be performed by anybody in a general practice team, such as medical assistants, health care assistants, or nurses.</p> <p>Health Coaches are people who are health literate and have held social/health-related roles such as a community support worker, navigator or kaiawhina. Health Coaches need to be reflective of and responsive to the local population. Overall, this is a non-regulated workforce. One of the ProCare Framework practice teams has a practices nurse who has completed the Counties Manukau DHB Health Coach training and incorporates health coaching into her work. Health Coaches can also be people with lived experience of long term conditions – an approach taken at ETHC.</p> <p>Health Coaches may be selected also for their cultural expertise and/or language skills that enable them to engage effectively with the practice community.</p> |
| Where provided | <p>Health Coaches are based in the general practice and are expected to work as an integrated member of the practice team.</p> |
| Delivery mode | <p>Health coaches work with individuals and families/whānau across the age span. They also run groups such as the Triple P parenting programme, self-management groups such as the Stanford Programme along with other group programmes to enhance self-management of health and wellbeing.</p> |

| | |
|-----------------------------|---|
| | <p>Health Coaches work with other members of the general practice team to identify who would benefit from health coaching. People access Health Coaches in several ways including:</p> <ul style="list-style-type: none"> - warm handover referrals from other members of the team - morning 'huddles' each day to review GP appointment bookings - agreed pathways within each practice where all people who meet a certain criterion (e.g. a certain HbA1c level) are routinely introduced to a Health Coach - Health Coaches contacting an agreed list of people e.g. those classified as 'high needs'. |
| Key tools/approaches | <p>Health Coaches draw from a range of evidence-based models and approaches including</p> <ul style="list-style-type: none"> - motivational interviewing - goal setting and active listening - Stanford Self-Management Resource Center tools, such as problem solving, brainstorming, decision making - Flinders University Chronic Condition Management Program (The Flinders Program) - brief intervention training - FACT (Focussed Acceptance and Commitment Therapy) - nutrition training - smoking cessation. <p>Health coaches at ETHC use the Wellness Wheel where this is needed to help clients identify issues and their own priorities across numerous life domains, to refer or connect them to the appropriate support or service. Health Coaches also assess mental health need through the PHQ9 and have confidence to hand over to a clinician if need is medium to high.</p> |
| Outcome measures | <p>ProCare Health Coaches have used Partners in Health (PIH). This tool measures patient activation and is designed for people with long term conditions. Health Coaches are now also able to use the Duke Health Profile where this is a more appropriate fit.</p> <p>Health Coaches at ETHC have been using PHQ9 (used as screening tool in the practice).</p> |
| Success | <p>Improved self-management and improved biological markers (e.g. HbA1c). Activated patients and activated clinic staff.</p> |

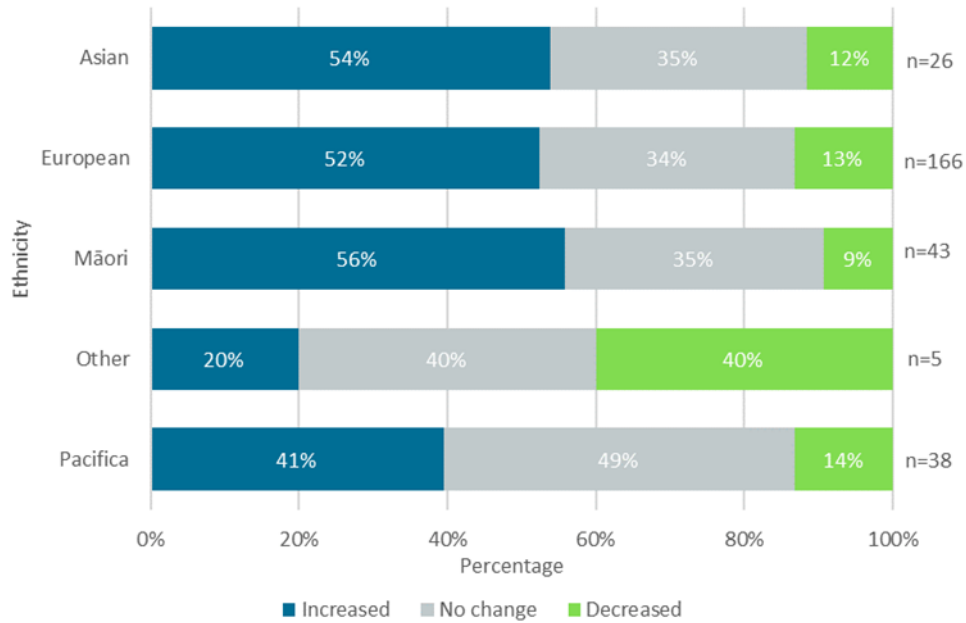


APPENDIX FOUR: DUKE ANALYSIS

Category changes

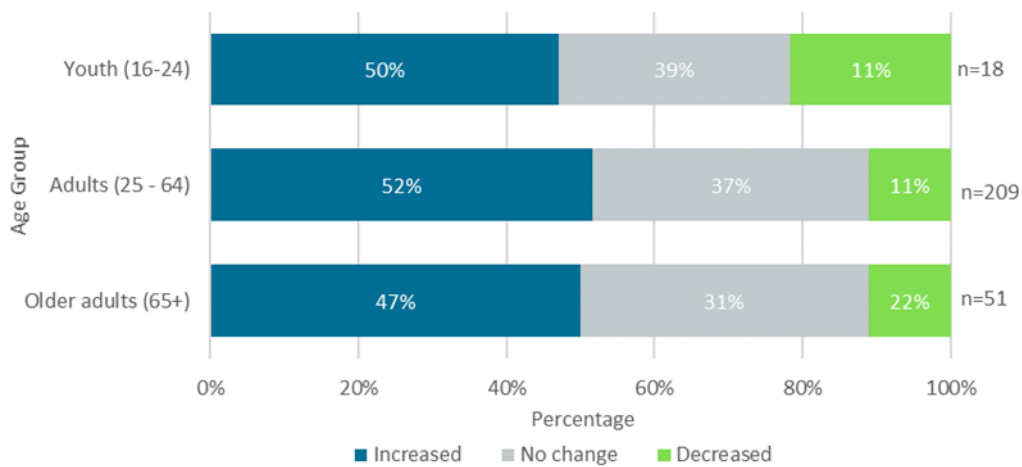
This section identifies the changes in Duke category scores by ethnicity and age group.

Figure 41 Category change in Duke total score by ethnicity (n=278)



There is less improvement in the wellbeing of 'other' ethnicities. As this is based on ratings from only five people it is not conclusive but will be something to monitor for those practices with high refugee and migrant populations.

Figure 42 Category change in Duke total score by age group (n=278)



When considering category change, those whose score increased (wellbeing improved) is similar across all age groups. While youth were twice as likely to rate a decrease in wellbeing (22% compared to 11% for adults and older people) this needs to be interpreted cautiously as youth is a small group (n=18).

Raw score changes

The following tables identify the raw score changes by ethnicity, age group and Framework practice.

Table 8: Raw score changes in Duke total score by ethnicity (n=287)

| | People with improved wellbeing | | | Stayed the same | | | People with decreased wellbeing | | | Everyone | |
|----------------|--------------------------------|------------|------------|-----------------|-----------|-----------|---------------------------------|-----------|------------|-------------|------------|
| | Mean change | n | % | Mean change | n | % | Mean change | n | % | Mean change | n |
| Asian | 20 | 23 | 74% | 0 | 1 | 3% | -10 | 7 | 23% | 13 | 31 |
| European | 18 | 123 | 72% | 0 | 13 | 8% | -11 | 34 | 20% | 11 | 170 |
| Māori | 18 | 32 | 74% | 0 | 3 | 7% | -12 | 8 | 19% | 11 | 43 |
| Other | 53 | 1 | 20% | 0 | 1 | 20% | -28 | 3 | 60% | -6 | 5 |
| Pacifica | 19 | 25 | 66% | 0 | 2 | 5% | -10 | 11 | 29% | 9 | 38 |
| Overall | 19 | 204 | 71% | 0 | 20 | 7% | -12 | 63 | 22% | 11 | 287 |

A larger proportion of people aged 25–64 (74%) and people aged 65+ (72%) had their raw score increase than youth aged 16–24 (59%) (Table 9). However, the change for those who did get better is the same for all three age groups. The average change for people who got worse was the same across all three age groups, and a higher proportion of youth got worse than those aged over 25, a finding to be interpreted with care given the small sample size.

Table 9: Raw score changes in Duke total score by age group (n=287)

| | People with improved wellbeing | | | Stayed the same | | | People with decreased wellbeing | | | Everyone | |
|--------------------|--------------------------------|------------|------------|-----------------|-----------|-----------|---------------------------------|-----------|------------|-------------|------------|
| | Mean change | n | % | Mean change | n | % | Mean change | n | % | Mean change | n |
| Youth (16–24) | 20 | 32 | 59% | 0.0 | 6 | 11% | -11 | 16 | 30% | 8.7 | 54 |
| Adults (25–64) | 18 | 159 | 74% | 0.0 | 13 | 6% | -12 | 43 | 20% | 11.2 | 215 |
| Older adults (65+) | 17 | 13 | 72% | 0.0 | 1 | 6% | -8 | 4 | 22% | 10.4 | 18 |
| Overall | 19 | 204 | 71% | 0.0 | 20 | 7% | -12 | 63 | 22% | 10.7 | 287 |

The mean change in raw score, both increase and decrease, is similar for Health New Lynn, Mangere, Peninsula and University (Table 10). Glen Innes had larger mean changes for both those who got better, and those who got worse. The university had the smallest proportion of people who increased, at 59%, which accounts for the difference for youth. Glen Innes, Health New Lynn, and Mangere had similar proportions for those who increased, stayed the same and better, with 67–71% of their patients improving. Peninsula saw a greater number of their patients increase, with 80% of their patients having an increase in raw score.

Table 10 Raw score changes in Duke total score by Framework practice (n=287)

| | People with improved wellbeing | | | Stayed the same | | | People with decreased wellbeing | | | Everyone | |
|-----------------|--------------------------------|------------|------------|-----------------|-----------|-----------|---------------------------------|-----------|------------|-------------|------------|
| | Mean change | n | % | Mean change | n | % | Mean change | n | % | Mean change | n |
| Glen Innes | 23 | 18 | 67% | 0 | 3 | 11% | -16 | 6 | 22% | 12 | 27 |
| Health New Lynn | 18 | 83 | 71% | 0 | 7 | 6% | -11 | 27 | 23% | 10 | 117 |
| Mangere | 19 | 31 | 69% | 0 | 4 | 9% | -12 | 10 | 22% | 10 | 45 |
| Peninsula | 18 | 53 | 80% | 0 | 2 | 3% | -10 | 11 | 17% | 13 | 66 |
| University | 17 | 19 | 59% | 0 | 4 | 13% | -11 | 9 | 28% | 7 | 32 |
| | 19 | 204 | 71% | 0 | 20 | 7% | -12 | 63 | 22% | 11 | 287 |

APPENDIX FIVE: FRAMEWORK PRACTICE PROFILES

The next pages present a profile of each of the Framework practice sites and key metrics.



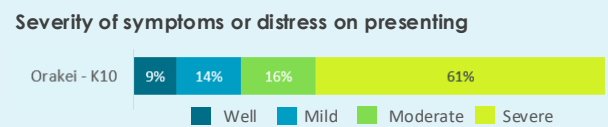
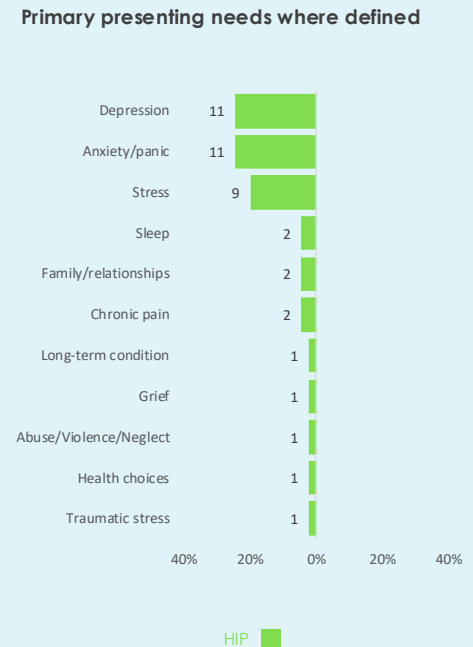
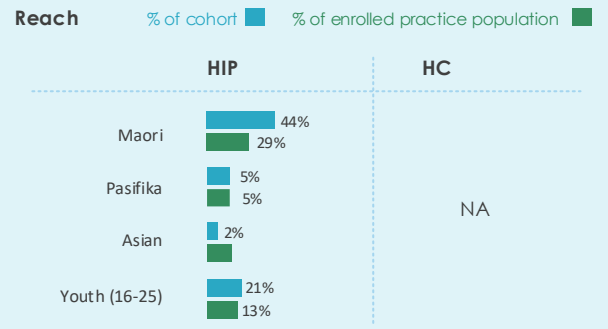
| How much | | |
|---------------------------|-----|----|
| 1 April-13 July 2018 | HIP | HC |
| Total referred | 45 | NA |
| Conversion | 96% | NA |
| Delivered consults | 62 | NA |

| How well | | |
|-------------------------|-----|----|
| 1 April-13 July 2018 | HIP | HC |
| % Seen same day | 49% | NA |
| % Seen same week | 96% | NA |

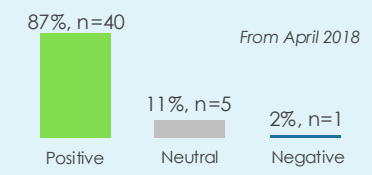
"The HIP is explained as 'people who are able to help manage their problems'. Someone who has the skills necessary to give you practical advice now."

| Better off | |
|---------------------------------------|----------|
| Kessler 10 entry and follow up change | |
| Improved | 3 people |
| Stayed the Same | 4 people |
| Decreased | |

Practice population



Client feedback



Practice information

| | |
|-------------------------------|---------------|
| Practice population | 4500 |
| Number of GPs | 2.5 |
| Number of Nurses | 3 |
| Number of HIP | 1 |
| Number of Health Coach | 0 |
| Awhi Ora provider | Kāhui tū Kaha |

"Financially its more beneficial for nurses – their time is not caught up so much so can see more fee paying patients."



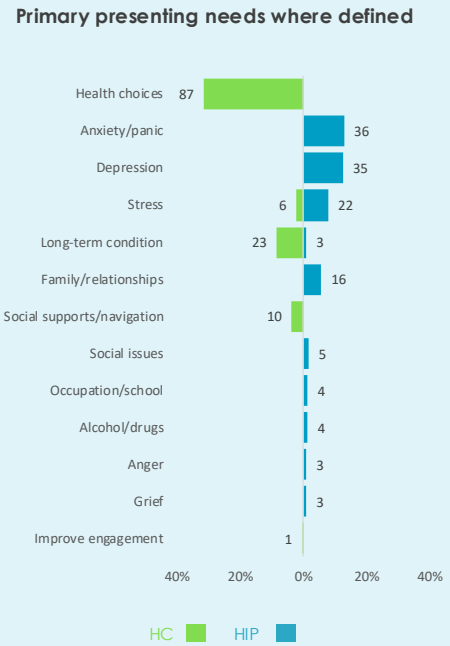
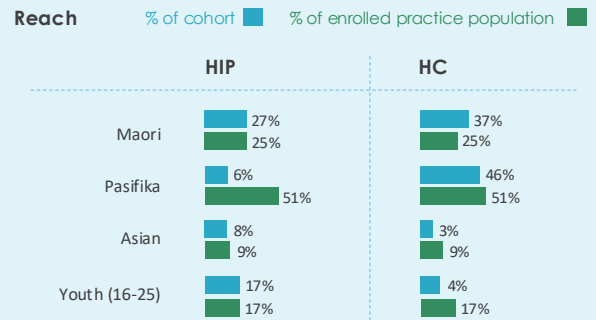
| How much | | |
|----------------------|-----|-----|
| 1 April-13 July 2018 | HIP | HC |
| Total referred | 145 | 132 |
| Conversion | 93% | 77% |
| Delivered consults | 168 | 128 |

| How well | | |
|----------------------|-----|-----|
| 1 April-13 July 2018 | HIP | HC |
| % Seen same day | 71% | 83% |
| % Seen same week | 90% | 91% |

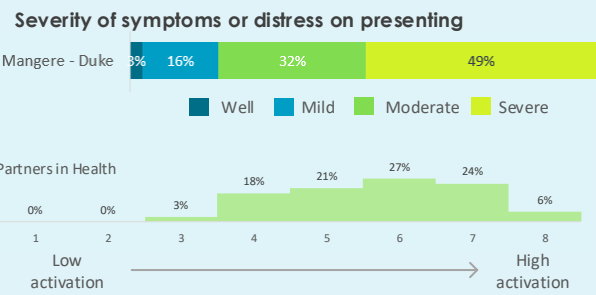
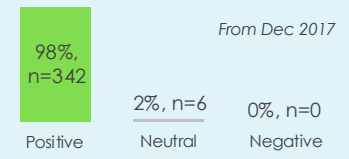
"That water cooler type connection is more valuable than a written referral...when we have down time we use the opportunity to catch up and discuss cases, just as you would with GP and nursing colleagues. It's more of an expanded practice team rather than someone here for four hours a week and you never get to get those connections with them."

| Better off | |
|-------------------------------|--------------|
| HIP Duke, entry and follow up | |
| Improved | 69% (n = 31) |
| Stayed the Same | 9% (n = 4) |
| Decreased | 22% (n = 10) |

Practice population



Helpfulness



Practice information

| | |
|---------------------|--------|
| Practice population | 11 985 |
| GP FTE | 6.8 |
| Nurse FTE | 7.4 |
| HIP FTE | 1 |
| Health Coach FTE | 0.8 |
| Awhi Ora provider | 1LoC |

"We are convinced the warm handovers and HIP Health Coach constant presence here is the key."

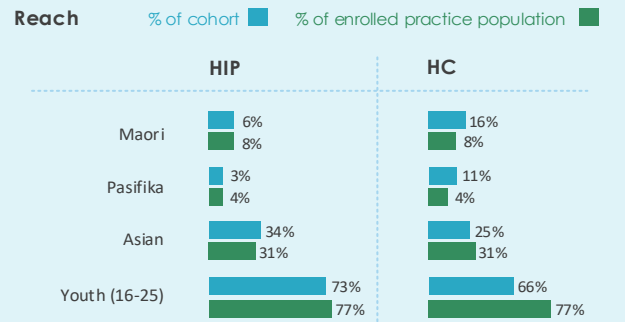
| How much | | |
|---------------------------|-----|-----|
| 1 April-13 July 2018 | HIP | HC |
| Total referred | 197 | 46 |
| Conversion | 81% | 95% |
| Delivered consults | 248 | 62 |

| How well | | |
|-------------------------|-----|-----|
| 1 April-13 July 2018 | HIP | HC |
| % Seen same day | 49% | 76% |
| % Seen same week | 78% | 93% |

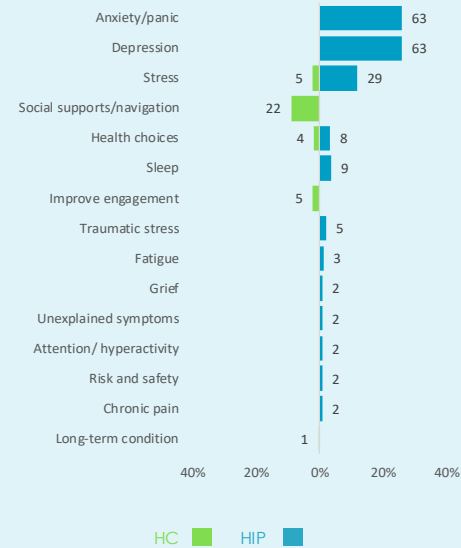
"The are the warm handovers, but often instead of a warm handover it'll be, oh, we'll book you in for the next day, we'll book you in for tomorrow morning...so it's still kind of a warm handover, and I think it's warmer than any other handover we do in other services anyway."

| Better off | |
|-------------------------------|--------------|
| HIP Duke, entry and follow up | |
| Improved | 59% (n = 19) |
| Stayed the Same | 13% (n = 4) |
| Decreased | 28% (n = 9) |

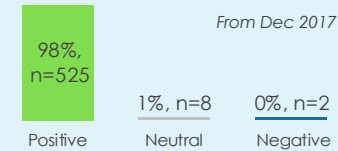
Practice population



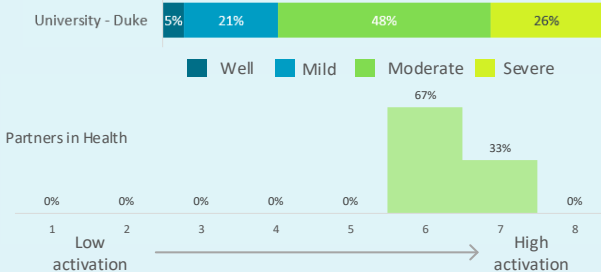
Primary presenting needs where defined



Helpfulness



Severity of symptoms or distress on presenting



Practice information

| | |
|----------------------------|--|
| Practice population | 9590 (including 3000 international students) |
| GP FTE | 7.2 |
| Nurse FTE | 0.8 |
| HIP FTE | 0.8 |
| Health Coach FTE | 0.5 |
| Awhi Ora provider | Pathways |

"When we first heard about HIP we were desperate for it to happen - most people coming through door have some mental health presentation. We hadn't anticipated so many."

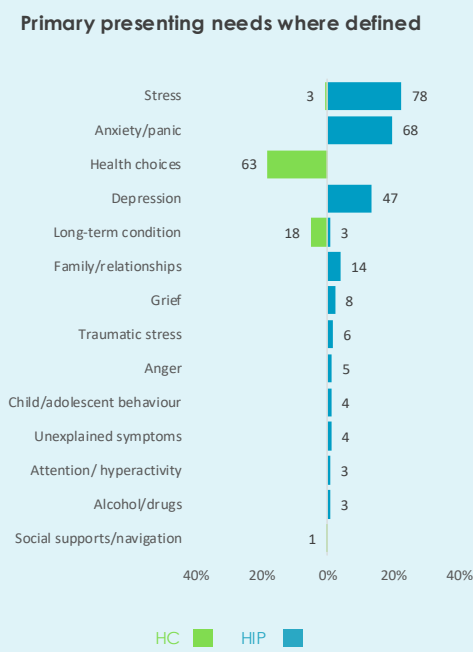
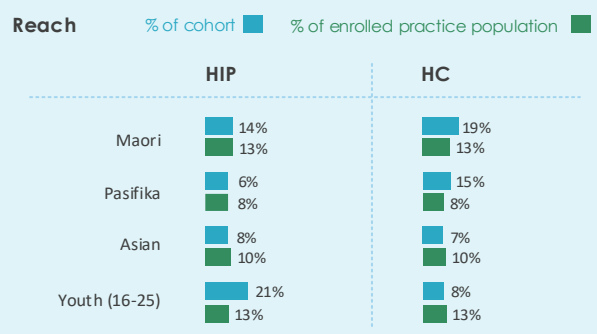
| How much | | |
|----------------------|-----|-----|
| 1 April-13 July 2018 | HIP | HC |
| Total referred | 258 | 88 |
| Conversion | 98% | 91% |
| Delivered consults | 306 | 75 |

| How well | | |
|----------------------|-----|-----|
| 1 April-13 July 2018 | HIP | HC |
| % Seen same day | 51% | 46% |
| % Seen same week | 89% | 93% |

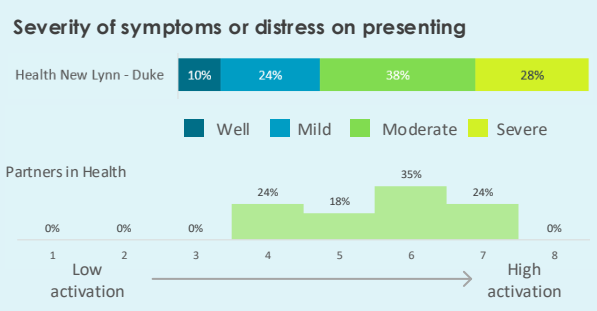
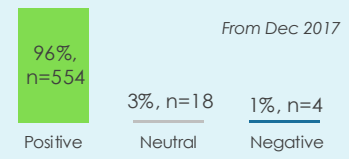
"The immediacy of the HIP and Health coach is a huge benefit – having them on site and available to see a patient then and there is great. The practicality of the care and advice they give is superb – they can help the patient now and don't need to spend months getting to the root of the problem - they focus on providing coping mechanisms that will help in real time."

| Better off | |
|-------------------------------|--------------|
| HIP Duke, entry and follow up | |
| Improved | 71% (n = 83) |
| Stayed the Same | 6% (n = 7) |
| Decreased | 23% (n = 27) |

Practice population



Helpfulness



Practice information

| | |
|---------------------|----------|
| Practice population | 17895 |
| GP FTE | 10 |
| Nurse FTE | 15.1 |
| HIP FTE | 1.3 |
| Health Coach FTE | 0.5 |
| Awhi Ora provider | Pathways |

"Feedback has been very good from patients – they are accessible specialists who are able to provide immediate help. Being able to get an appointment on the same day or at the latest within the next week is extremely beneficial. People have gone out of their way to express their happiness with the HIP and Health Coach."



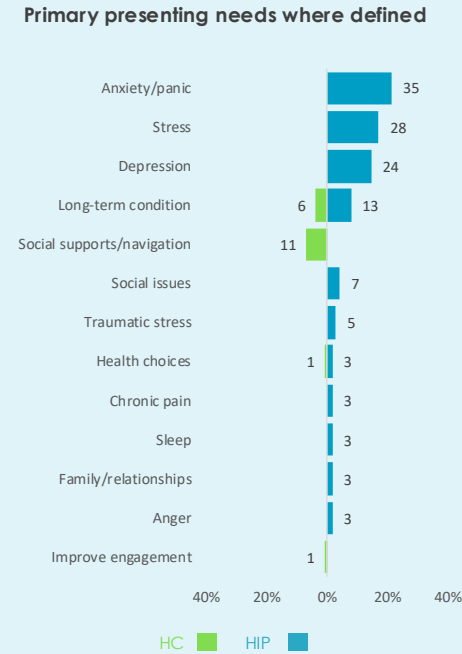
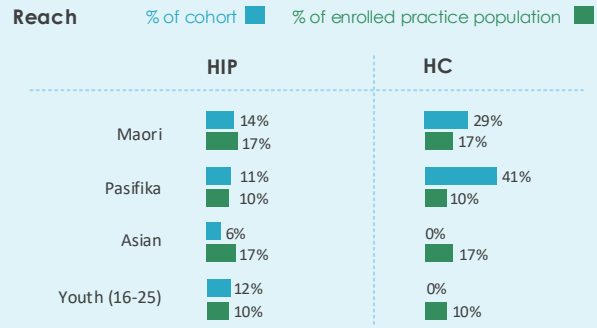
| How much | | |
|---------------------------|-----|-----|
| 1 April-13 July 2018 | HIP | HC |
| Total referred | 144 | 19 |
| Conversion | 94% | 88% |
| Delivered consults | 161 | 18 |

| How well | | |
|-------------------------|-----|-----|
| 1 April-13 July 2018 | HIP | HC |
| % Seen same day | 59% | 80% |
| % Seen same week | 94% | 93% |

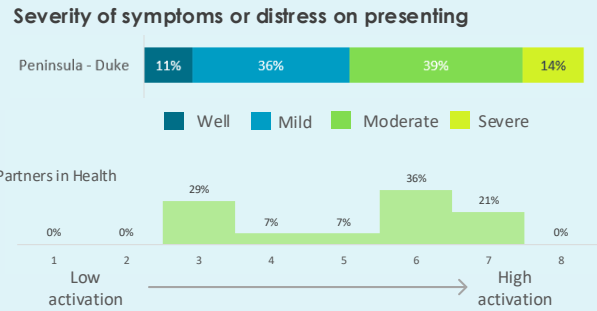
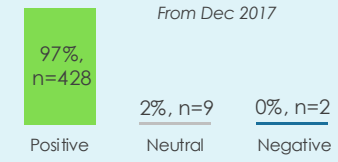
"Having them here means that if the patient has other problems and [the GP] can't address them, there is a different approach."

| Better off | |
|-------------------------------|--------------|
| HIP Duke, entry and follow up | |
| Improved | 80% (n = 53) |
| Stayed the Same | 3% (n = 2) |
| Decreased | 17% (n = 11) |

Practice population



Helpfulness



Practice information

| | |
|----------------------------|-------------|
| Practice population | 8700 |
| GP FTE | 6 |
| Nurse FTE | 4 |
| HIP FTE | 0.7 |
| Health Coach FTE | 0.3 |
| Awhi Ora provider | Walsh Trust |

"HIP's mental health nursing background is very helpful for taking pressure off doctors in acute situations and having that immediate support."



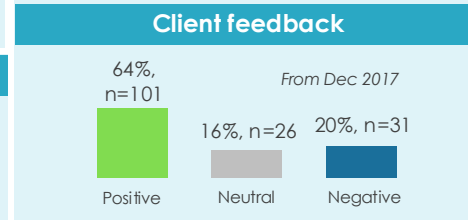
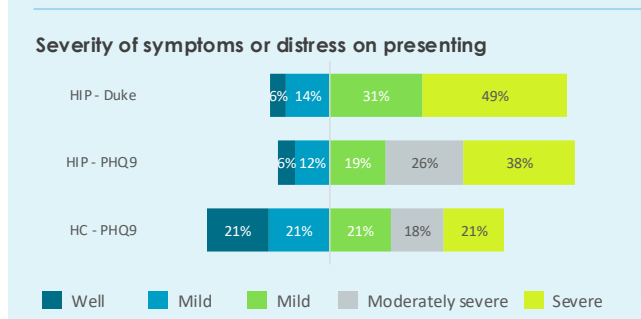
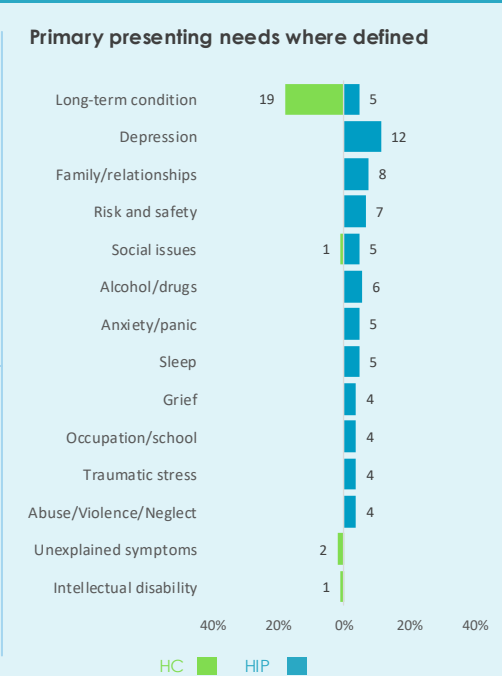
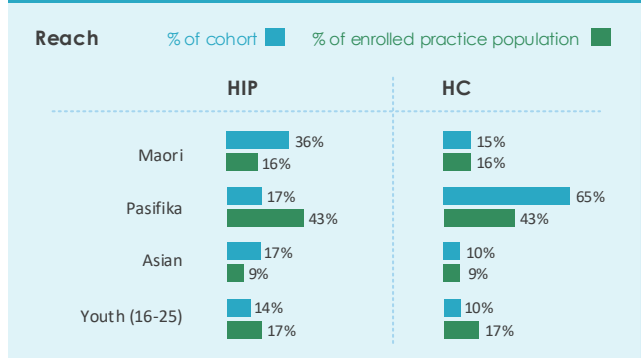
| How much | | |
|---------------------------|-----|-----|
| 1 April-13 July 2018 | HIP | HC |
| Total referred | 83 | 23 |
| Conversion | 94% | 85% |
| Delivered consults | 143 | 30 |

| How well | | |
|-------------------------|-----|-----|
| 1 April-13 July 2018 | HIP | HC |
| % Seen same day | 59% | 59% |
| % Seen same week | 86% | 95% |

"The best thing about the training was permission to have a short session and continuously reinforcing it – avoiding the therapy bait – and focus on what happening for person right now. Keeping the boundaries good."

| Better off | |
|-------------------------------|--------------|
| HIP Duke, entry and follow up | |
| Improved | 67% (n = 18) |
| Stayed the Same | 11% (n = 3) |
| Decreased | 22% (n = 6) |

Practice population



Practice information

| | |
|----------------------------|------------------------|
| Practice population | 14522 |
| GP FTE | 8 |
| Nurse FTE | 6 |
| HIP FTE | 1 |
| Health Coach FTE | 1 |
| Awahi Ora provider | Pathways and Mind&Body |

"It's a consult relationship with the rest of the practice team – a most important dynamic as the patient sees them as a team and feels more at home at clinic."

