DESCRIPTION OF THE DAY: RAISE HOPE STEPPED CARE RAPID IMPROVEMENT EVENT 28 APRIL

Opening Addresses

The day commenced with a beautiful Mihi Whakatau from Maori Health Directorate Mental Health team setting the kaupapa for a successful day of work, followed by a Waiata, Karakia and refreshments.

This was followed by a welcome from John MacDonald, Independent Chair - Raise HOPE who affirmed the common motivations of the participants and encouraged the assembled group to be bold and courageous in thinking about how they could improve the experience of vulnerable people experiencing the services in the sector. Our current system was not designed it evolved, but can we do it better, more effectively, more inclusively, can they have a better experience and can we prevent many of them from becoming so unwell? We have a new Health Strategy which aligns well with Raise HOPE. There are 5 key themes to this new strategy and they include; People Power, In Raise HOPE we want our people and their Families and whanau to be at the centre of all we do. We want services 'Closer to Home' and in the communities in which our people live. We want 'Value and High Performance' - Outcomes focused, valuing the peoples experience and making better use of funding. And we want 'One Team' - Striving to become one integrated whole system and sector Smart System. Please be bold and creative, we are going to ask you to imagine what the user experience would be like for our people, families and whanau, imagine a model and system that would work together to support and empower our people on their wellness journey. What would a person focused stepped care experience look like?

The Chief Medical Officer Nigel Millar then gave a powerful keynote address in which he characterised the challenges ahead for the programme and some perspectives and considerations that could assist in achieving a successful outcome. The following summary is made with apologies to Nigel for any inaccuracies and omissions. Nigel pointed out that, in common with bees and ants, human achievement was a result of cooperation; not just individual effort. That it is in the nature of humanity that cooperation will wax and wane so encouraged perseverance reminding the group that people (including doctors) do not readily change their minds in a meeting but can do so later if relationships are preserved. Consensus doesn't require all to agree but that all have the chance to be heard. Nigel pointed out that the health system had not resulted from perfect design but rather it had evolved. It could be thought of as a series of islands, on some of which excellent services were being delivered. Some of those islands too, were well joined up, but there were many islands with less-excellent standards and large areas of (shark infested) water between islands. He urged the group to think in terms of a System which he described as a set of common objectives, delivered via a set of activities and unified by a set of standards (summarised). He challenged the group to be optimistic that they could contribute to changing our imperfect system but they would need to be persistent and think in terms of a system that could deliver a designed-standard of service joining up all the islands and closing the gaps between.

The work of the participants then commenced for the day. They were shown a snapshot of a moment in time during a health care interaction and asked to describe what they noticed. They were then asked to hold that thinking during the following exercises and describe the nature and quality of the interactions rather than job titles and structures.

WORKSHOP ACTIVITIES

The day was made up of three exercises.

Exercise 1 Posed the question: What is most important in our lives and for today? And was designed to have the participants think about things that are fundamentally important in life; linking that spirit to achieving outcomes for the day; focus on people, set the tone and objectives for working together and capture the themes further creating the Kaupapa for the day. The participants focussed specifically on:

- what things do you most value about the way you live?
- who are the people most important to you every day?
- what would most make this day enjoyable and satisfying?
- The group responses are shown under workshop outputs below.

Exercise 2 Challenged the participants to create a people, family and whanau centred experience, using a stepped care approach. The participants were split into four groups each of which was given a different presenting profile of a person needing help that will involve some level of engagement, screening and/or assessment, support, or ongoing care and to create an experience, that with the least steps ensures the person gets the help they need. The experience was to focus on wellness and include consideration of self help, early intervention and use in-common screening and/or assessment protocols. A 'one team' approach would ensure that the least intervention for the circumstances can occur, with active client family/whanau involvement in planning and in-common health records (that the client develops with you and consents to sharing).

They were challenged not to be constrained in their thinking by 'what is', but rather to set those current service and practice arrangements aside, along with structural constraints and imagine an experience tailored, with the least steps possible, to be a seamless experience of healthcare for the person, for family/whanau and for practitioners.
They were also asked to assume that: Accessible, in-common record-systems exist; Shared screening or assessment protocols can be used; Referrals are accepted, capacity exists; Joined-up teams actual or virtual across health and social services; Funding follows the client.

The group responses are shown under workshop outputs below.

After a short lunch the participants were back to work.

Exercise 3 Challenged the Groups to capture what would need to happen for the experience that they created (that morning during exercise 2) to be possible?
They were tasked to detail the capability and capacity necessary to support delivery of the people, family and whanau centered experience, that they had created so that the person needing help got the help they needed in a manner consistent with stepped care.

RIE Workshop Outputs

Group responses to each exercise (taken from the flipcharts compiled by the groups)

A quote from the day: "At the end of the day it is about the whanau receiving a quality service and feeling and believing that they have received a quality service".

Exercise 1: All attendees responses/contributions in summary.

1. What things do you value most about your life?:

- Freedom
- Choice
- People around
- Stability
- Environment I live in
- Food in my belly and a roof over my head
- Family and resource
- Connection with others

2. People most important to you every day?:

- Family
- Whanau
- Friends
- Whanui
- Barista
- Workmates
- Clients
- People around you and community connections

3. What would make today enjoyable and satisfying?:

- Tangible outcomes
- Evidence that our contribution is used we can see
- Transparency about what is used and what is not and why, feedback on today
- Discussion and debate
- Progress happens - paralysis stops and we move forward
- Keep out focus on communities and the people we work with
- Completely open minds
- A shared joined up way of moving forward that results in action
- From 'Hui to doey'
- A movement toward true integration
- A rural model considered and included - urban model of delivery won't work everywhere
- Family and whanau involvement
- A sense of hope for a better future with access to services

- Culturally connected services - a knowledge of cultural need
- Remember consent - for every 100 people who want whanau involved there is a person who doesn’t
- Making new friends and connections
- Stick to time!

EXERCISE 2: WORKSHOP OUTPUTS BY THE 4 GROUPS

Group Blue: Facilitator Sarah
Scenario: Pauline - 66 years old

Profile

Pauline is a 66 year old woman
Suffering from incontinence which is embarrassing getting her down
Diabetes for years
Very independent managing herself well
Usually cheerful and pleasant
Works part time in a GP surgery
Recently getting up at night being noisy
Neighbours in the next flat complaining
Becoming irritable and rude to family and friends

Life Event - Stroke

Snapshot One: The development of a wellness plan happens with Pauline at her home. Present are a health-care worker, a support person, and a network support person/guide. Pauline has had the choice of where this conversation happens and who is present, and has chosen her home as this is where she feels most comfortable. She has also chosen to have her friend Mary with her rather than family. The conversation focuses on what Pauline wants the next few weeks and months to be like. This includes a broad conversation encompassing elements to support achieving wellness, not limited to specific physical or, mental health services. For example housing or nutrition may be included in the wellness action plan. The focus is on the near to mid term rather than service specific planning. It becomes Pauline's plan rather than a service plan for Pauline. She is able to access and amend the plan as time goes by.

Noticing: Pauline feels safe, given choice of where and who is involved. Pauline is able to actively participate, she has access to information and access to her plan. Decision shared - Pauline feels more in control. Trust and confidence have been built by the process of having choice and having her wishes respected. Roles are clear and status is based on mutual respect for roles in Pauline's care not hierarchy. Education and information.
Feeling: Trust and confidence and respect between parties. Pauline feels listened to and understood. Connected with support. Life changing nature is acknowledged.
Thinking: Focus of support is on Pauline's wellness. Level of service is consistent. Trial and error can be okay - Pauline needs to explore new world of what is possible. Different support options offered. There is a shared language so Pauline and all present can contribute and understand. Connected with the supports wanted and needed - support is linked up and broad. While Pauline choose not to have her family present, discussion has included consideration of family and whanau support and need.

Improvement ideas:
Regular updating of Pauline's plan - not set in stone
Regular follow-up
Primary care contact established

Snapshot Two: Pauline attends a regular check up appointment in relation to her diabetes. The health professional is aware that Pauline has a wellness plan. Pauline is able to bring/show her plan, discuss and update elements of it through the conversation with the practice nurse.

Noticing: Pauline has access to her information and is able to modify her wellness plan. The health professional has awareness that Pauline has a wellness plan in place.

Improvement ideas:
Clarity about 'lead organisation'

Group Red: Facilitator James
Scenario: Marama 17 years old

Profile
Marama is a 17 year old maori woman
Has been becoming increasingly unhappy since starting her new job
Recently moved to town for the job and into a flat with her friends
Friends are in the main not employed
Late nights early mornings
Alcohol and drugs are regularly used socially
She has attracted some unwanted attention from a male flatmate
She is feeling worthless, trapped and doesn't know what to do or where to go

Life Event - Some money is missing at work and she has been told that she will be interviewed in a disciplinary hearing and job loss could result

Snapshot One: Marama is concerned about how she is feeling in her life and she is surfing through google looking for help. She is able to easily find a directory of services and advice. The search comes up easily and the access to support seems connected - it hadn't mattered the terms that she has used to search - she is quickly able to see who she can talk to locally and quickly. There is information including videos and self help questions that help Marama feel that she is not the only one who has experienced this sort of circumstance. The video give her some hope that what is happening can be resolved and she can see a different future. There is some immediately useful advice plus a number to call to speak to someone, choices about video link and also chat options, so she can use what she is most familiar with. It also means at this low threshold she doesn't have to be recognised. There is an inviting place to go that seems doable; a 'Wellness Centre'.

Noticing: Marama is gaining a sense of control - a way to get help and advice and the idea that she may be able to navigate through her current circumstances. There is no stigma attached to accessing the web information.
Feeling: Marama is feeling calmer and more in control.
Thinking: There is positive action/ steps that Marama can take to get advice and support and control over her life.

Improvement Ideas:
Health promotions have made it more likely that Marama is aware that service and support is accessible to her.

Snapshot Two: Marama visits the 'stigma free' Wellness Centre. This is easy to find and recognisable and branded. This is a 'wizzbang' one stop shop where Marama is able to get help for the most immediate of her needs. This is calming and empowering and helps clarify her thinking about what next steps she wants to take in her life. One guide/navigator/support is able to walk with Marama through this.

Noticing: Marama is welcomed and guided. Her most immediate needs are addressed and a plan/steps identified to support other aspects. The welcome Marama receives includes culturally responsive aspects affirming her as a person.
Feeling: Affirmed, comfortable, safe, calmer, empowered
Thinking: Marama thinks it's okay to talk about aspects of her life. There is a 'naturalised' response to the problems Marama is having i.e it is normal to go through patches in your life that aren't smooth sailing. Non judgemental.

Improvement Ideas:
Findable - the web info and wellness centre are conspicuous, branded and easy to find.
This service has the ability to refer to more acute services (different levels or other services outside mental health, including marae based interventions)
This needs to work in rural centres - so not restricted to a bricks and mortar main centre sort of configuration. Could be mobile or combined with health/social or community services.

Group Green: Facilitator Ruth
Scenario: Tony
Tony is a 40 year old man
Holds a responsible well paid job
Well educated and well dressed
Married with 3 kids
Thinks that people at work are talking about him
Thinks his work colleagues are going in and changing his work
Thinks his work colleagues are moving things in his office and on his desk
He is asking his wife where she is going to and checking her phone
Believes he can tell what other people are thinking
He is wakeful

No other relationships known with the wife
Spending long periods of time in the garage on his own

Life Event - Disciplined and loses job

Snapshot One: First contact.
Tony is in a space where he feels comfortable (choice?). There is continuity of relationship with service individuals so he does not need to repeat his story. This exchange has come about quickly - there has been very little waiting and no build up of trepidation for Tony.

Noticing: His feelings and nervousness are acknowledged. His mana is acknowledged - his culture and beliefs respected. Communication is good because plain language is used, and Tony is an active participant.
Feeling: Initially Tony arrives feeling unsafe, paranoid and untrusting. During the exchange Tony is able to shift to feeling safe. He is feeling recognised. He is not rushed and the sense that time is available adds to his sense of being respected.
Thinking: Health care professionals considering whole person and their whole story. They begin to talk about planning with Tony - that this is the start of a process together. Respectful inclusion. Understanding of Tony's values and preferences and consider options which will match.

Improvement Ideas:
At this first point of contact the person talking with Tony needs to:
Know where to go next given Tony's level of risk.
Ensure quality of Interaction, and
Work on the connection to next step.

Snapshot Two: Next step
Noticing: Skilled people are brought in as needed. Continued inclusion of Tony and others so that Tony does not have to repeat the story. Informed consent. Planning together. Questions are welcome from Tony and whanau using language that can be understood by all.
Feeling: Tony feels safe and so do his family, whanau and supporters (if any). Safe - informed - connected. Environment and people lead to continuity of feelings.

Improvement ideas:
Ongoing risk assessment.

Snapshot Three: Care planning
Noticing: Continue to acknowledge Tony's thoughts and distress experience. Acknowledging the family's experience.
Thinking: How do we meet the needs of the family, consider vulnerable children? Continue to check in with family and whanau.

Improvement ideas:
Open access to own care-plan for Tony
Discussion with family regarding the care-plan to
Early warning of risks
How will his family and Tony access information/education on an on-going basis?

Snapshot Three: Experience of (Tony's) Family
Thinking:
We don't understand what is happening
We are the only ones
We don't have skills to cope
We blame ourselves
Feeling:
Confused
Anxious, Terrified, Scared, Fear of the unknown
Stressed
Judged

Preferred Experience
Feel welcome at the first moment, treated together as a family unit inclusive of children, have empathy, feel included, give hope.
Screening to be longer than ten minutes.
Family are experts and the biggest resource to support wellness. Use of common understandable language. Responses respectful, culturally appropriate and not dismissive.
Any door the right door, early intervention including family member raising concern.
There is a navigator/advocate for family and patient.
Actions
Better resources, Families need education and support.
Staff need education.
Family need advocacy and need to be included in care plan/ EWS risk sheet. Identify risk from family perspective.
Children need support/ education aimed specifically at children.
Be family inclusive/ whole whanau with ongoing support for family. Inform families of risk, especially suicide risk.
Patient needs to know that they are not alone
Families have to have services offered - if families are equipped with tools and information they can better support their loved ones.

Group Black: Facilitator Jacqui
Scenario
Shane is a 26 year old male
Stable employment
Close knit family
Has a girlfriend that stays with him on a regular basis in his flat and is very close to his family

Has recently started to be picked up for erratic driving and has now had 2 DIC charges
His girlfriend and family are concerned about his drinking and driving
This is causing them to argue because they want him to get help
An argument becomes physical
Parents call the Police and he is arrested for assault

Life Event - Girlfriend killed by drunk driver

Snapshot One: First point of contact came through family who noticed what was happening initially. Alcohol and violence initiated first intervention via Police. However early screening meant that it was possible to plan support for Tony. There is access to help and advice with family and whanau involvement - able to intervene early. Health profession able to facilitate access to other intervention and self help.

Noticing: Responsive to both individual and family and whanau - including education and online resources.
Feeling: Supported, acknowledged. Getting useful information and advice and support.
Thinking: Intervention could have occurred at any time in this scenario.
Improvements:
Options to all meet together or separately.
Holistic approach i.e care for girlfriend - someone holds the holistic view.

Snapshot Two: Desirable experience: access to services, acknowledgment that there are options at any time in the scenario. Caring and coordination provided. Direction. Tony as a sense of the options. Rights of the individual are attended to and listened to. Any time Tony comes into contact with services information is available. Integrated records available.

Noticing: Tony is listened to.
Feeling: Tony feels approached and 'met' and supported and cared for.

Improvement Ideas
Could have immediate contact with someone with skills and experience.

<u>Carpark Items Noted - for follow up</u>
Communicating what is known about the implementation of stepped care elsewhere
Research that supports the premise that Mandatory A&D Vs Voluntary has better outcome

EXERCISE 3: WHAT WOULD BE NEEDED TO ACHIEVE THE EXPERIENCE YOU CREATED?

In the afternoon, all groups were asked to review the experience they had created for their scenarios and to identify the capability and capacity that would be needed to deliver the experience they had created. Across each scenario the groups identified many key in common areas for capability and capacity development. These have been captured and combined in the table below.

Cultural considerations (ensuring culturally appropriate experiences)	Quality training to ensure culturally responsive service
	Maori providers available
	Language support, translation etc
People Considerations	Listening/Good Communication skills
	Working in Partnership, With Respect
	Good system knowledge
	Practitioners are open minded
	Broad range of generalist skills
	Technology savvy
	Cultural diversity or skills approach
	Local community knowledge
	Aroha for ourselves as well as for our Mahi
	Practice culture is family inclusive
	Behaviours are open-minded are caring, curious, interested, respectful, honest
	Plain language
	Quality supervision
	Shared values
	Self awareness
	Code of ethics owned across sector
	Recruitment processes across services and agencies

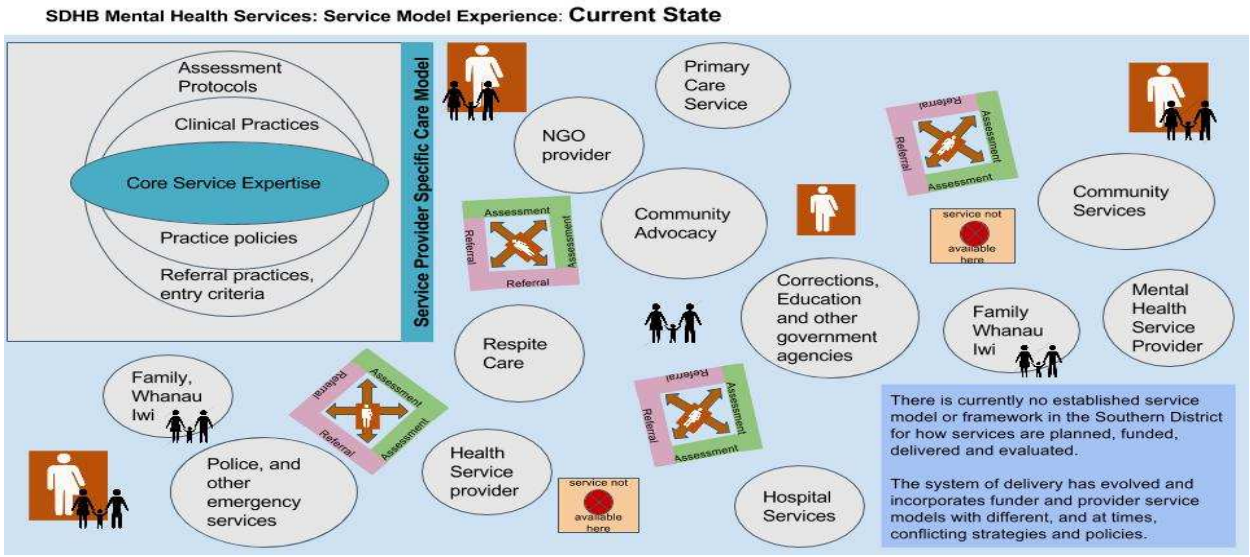
	Ongoing education - keeping current
	Making psychological 1st Aid common
	Welcoming
	Easy to understand
	Responsibility to follow the person in their journey
	Mobile and virtual/multiple team configurations
	Intentional Peer Support
	Resilience - Managing / increasing personal capacity
	Some understanding of family systems
	Basic training in family wellbeing
	Knowledge and understanding of alcohol use and misuse
	System-wide rollout of tools and training
	Community liaison roll
Tools and Processes (including technology)	One record/One source of truth
	Appropriate access including consumer
	Processes enable conversations across network
	Tailored pathways
	Process across both mental and physical health and other
	Universal access
	Flexibility and eligibility criteria and use of funding
	Simple transparent funding model follows the person and incentivised wellness
	Consistent message and approach
	Peer Support networks
	Continuity and transition processes for clients

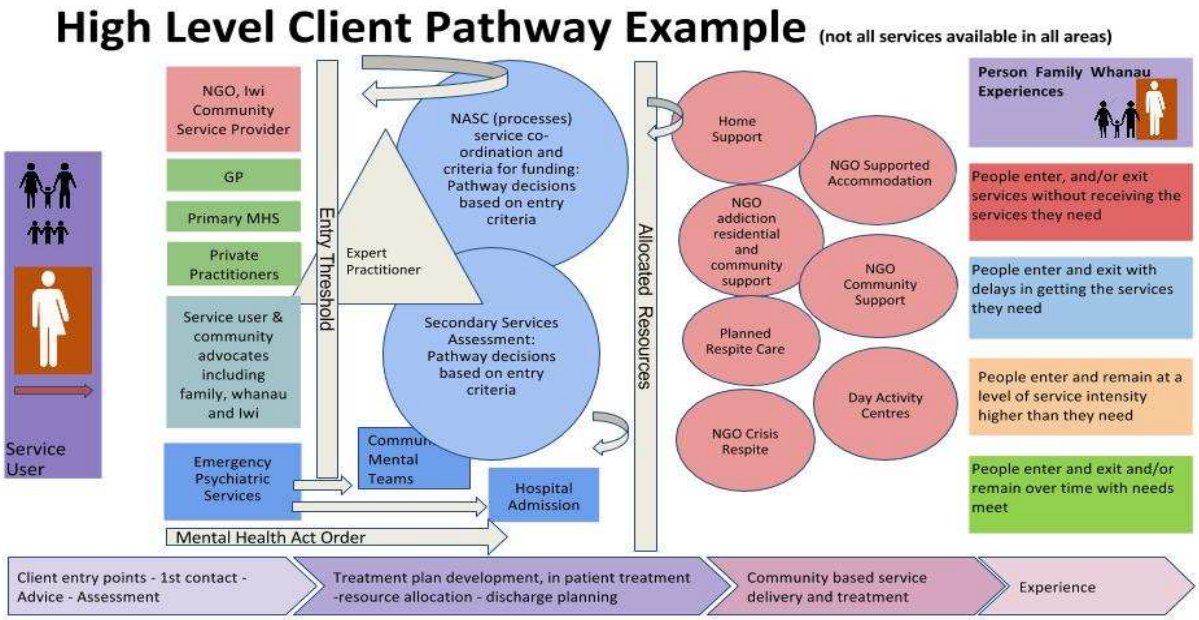
	High quality and moderated support-information, orientated to the individual e.g. youth, culture, person specific
	Marketing of services and promotion of information
	Branding for acceptability
	No stigma attached to health
	Database and directory of skills and services
	Consistent use of agreed screening tools across sector
	Agreed patient outcomes-recording
	Shared patient story document
	Online processes tools and screening
	Global community much more aware
	Strengthening support ties
	Dial 222 for information on mental health
	Information and technical access maintained and funded
	One assessment - not multiple - including self administered
	Feedback process uses tools real-time
	A warm hand-off
Policies and Legislation	Common agreements between services and across systems
	Privacy governed by the person
	Measuring for outcomes
	Evidence-based tools and education and standards
	Health pathways plus access to information including workplace wellbeing

Poroporoaki concluded the day, complete with a Waiata.

APPENDIX 2: CURRENT AND FUTURE STATE DESCRIPTION

The high level conceptual service model descriptors below have been developed following the review of available documentation, survey responses, and further refined through focus group feedback. The purpose of these descriptors is to focus attention on the the client's experience of the current state of services, and the preferred experiences. A facilitated discussion of these and the specific functional changes needed to enable development of an DIAP will occur through the Rapid Improvement Event process. These diagrams have been consulted on and confirmed with the focus groups and changed according to their feedback.

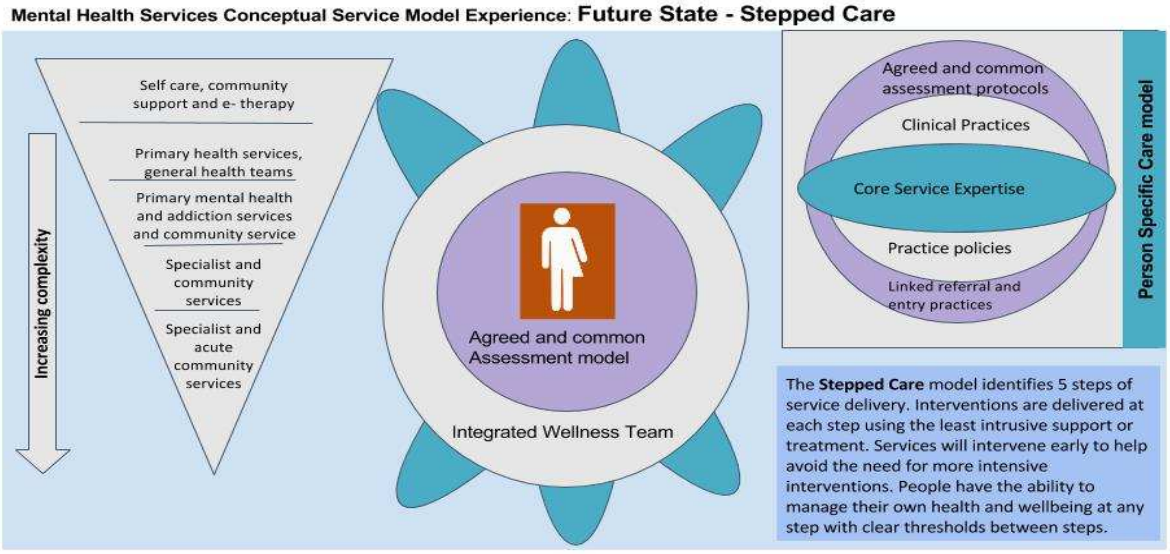


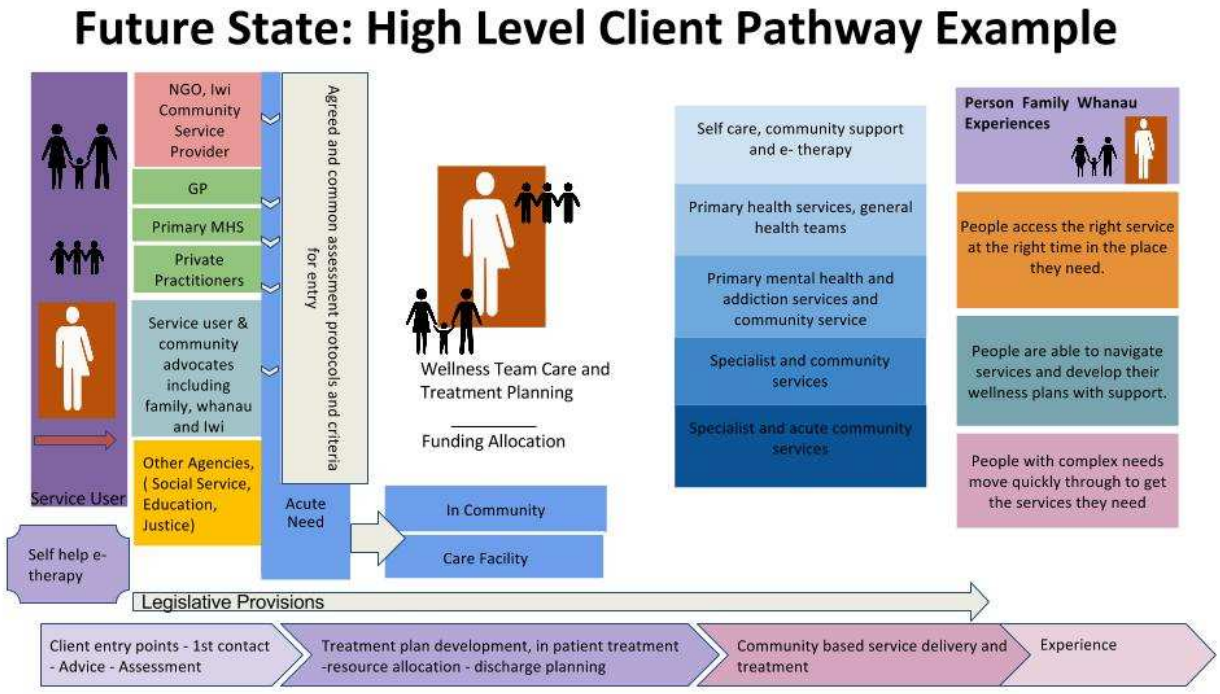


The current state is characterised by:

A health service and practitioner rather than client/whanau/Family led wellness focused perspective of care and treatment in a wider social context

Disjointed service delivery for clients, Whanau and practitioners, where silos operate and collaboration and coordination are limited.
Delays and/or barriers to accessing care or treatment exist as a result of the existing cultures, structures, practices and funding relative to growing demands





The future state is characterised by:
A client/whanau/Family led wellness focused perspective of care and treatment in a wider social context.
Joined up highly coordinated service delivery with clients, Whanau and practitioners, collaborating as one team wherever they are operating from, whatever their discipline.

Cultures, structures, practices and funding that is responsive growing demands and takes out barriers - by focusing on the right level of engagement, at the right time and place including;
In common screening and assessment
Inclusion of family, and whanau in developing a wellness plan
Early intervention at an appropriate level
Increased access to self help and greater client led activity
Client information portal, sharing of one record

-END-