Frontline Services

THE CARDIAC REHABILITATION PILOT
A CASE STUDY OF KOTAHITANGA

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Salome has worked at Te Whānau o Waipareira for the past seven years, starting out as a senior nurse and progressing to team leader for the Pakeke Ora Specialists Rōpū, where she now oversees the Community Cancer Navigation Team, Whānau Ora Mobile Nurses and delivers the Cardiac Rehabilitation Programme. Salome, in her 25 years' nursing experience, strongly believes upholding and incorporating Te Kauhau Ora (code of conduct) into her daily practice is a fundamental guiding principle for working with Māori whānau and making a positive impact on the lives of those in the community. She believes understanding whānau needs, giving respect and building a strong and trusting relationship will contribute to achieving positive health outcomes. Her approach epitomises the Whānau Ora health care model.

Abstract

The Cardiac Rehabilitation Programme prototype (2018) was developed with the initiative of the Māori Health Gains team, supported by Waitematā District Health Board Cardiology Department and Te Whānau o Waipareira (TWOW); specifically for Māori, Pacific and Quintile 5[1] patients within the TWOW catchment area in West Auckland. The programme aims to support whānau following acute coronary syndrome event (heart attack/unstable angina) with the emphasis of incorporating kaupapa and tikanga Māori frameworks and Whānau Ora best practice within a 12-week programme to promote better whānau health outcomes. This case study depicts kotahitanga due to the combined effort of the wrap-around services that have contributed to the patient 'hitting the road' to recovery with short-term goals achieved and working progressively towards long-term goals.

Key words: cardiovascular disease (CVD), coronary, rehabilitation, whānau, Whānau Ora

[1] Deprivation is reported in 'quintiles'. Quintile 1 represents the least deprived section of the population while quintile 5 represents the most deprived section. https://www.health.govt.nz/new-zealand-health-system/my-dhb/auckland-dhb/population-auckland-dhb

Introduction

Kotahitanga is one of ten of the fundamental guiding principles for kaimahi to follow as reflected in the Te Whānau o Waipareira (TWOW) Te Kauhau Ora (code of conduct). Working together in unity or with the Whānau Ora approach enables healthy lifestyles to be improved for so many in our community. For instance, in the Cardiac Rehabilitation Programme prototype, in order to achieve better health outcomes for our Māori patients, a combined effort of secondary and primary health care is encouraged. Therefore, it is of great importance that we work collectively with secondary care providers, without prejudice, to provide the best care possible for our Māori whānau.

Phase 2 Cardiac Rehabilitation Programme Prototype

Goble & Worcester (1999), defines cardiac rehabilitation as:

> *The coordinated sum of interventions required to ensure the best physical, psychological and social conditions so that the patient with chronic post-acute CVD may, by their own efforts, preserve or resume optimal functioning in society and through improved health behaviours, slower reverse progression disease.*

For Māori and Pacific populations, the current status in terms of cardiovascular disease (CVD) shows a clear indication of inefficacy in the health system. In 2010-2012, the total CVD mortality rate amongst Māori was more than double the rate of non-Māori, and the hospitalisation rate for CVD was 1.5 times more for Māori than non-Māori in 2012-14 (Ministry of Health, 2018). In 2016/17, statistics show Māori were also 1.37 times more likely to be diagnosed ischaemic heart disease (IHD) compared to non-Māori and the mortality rate for IHD was almost twice in Māori as non-Māori in 2015 (Ministry of Health, 2016).

Through Māori Health gains funding, the Cardiac Rehabilitation pilot programme was instigated, to be delivered at Waipareira using a collaborative nursing model of care. This involved working collaboratively with the Waitematā District Health Board (WDHB) cardiac team and the TWOW community nurse. The focus was on clients within the West Auckland WDHB catchment area. The socioeconomic status of those living in Waitematā (West Auckland) varies depending on the specific suburb one lives in, but pilot inclusion criteria was for Māori, Pacific and Quintile 5 whānau.

This programme was aimed at predominantly Māori and Pacific whānau following an acute coronary syndrome event, being either a heart attack and/or unstable angina. It was a complex and intense 12 week intervention programme, which included health education on the following:

- cardiovascular risk reduction
- heathy food choices
- medications
- physical exercise
- stress management

The programme encompassed:

- community home visits
- WDHB cardiac rehabilitation classes (two hours morning or evening sessions weekly)
- AUT Millennium exercise programme
- cardiac resource pack – reading material
- lifestyle management programmes information
- outreach visit pack
- Smile Dental referral – provided they meet criteria
- referral to appropriate wrap-around services
- nurse practitioner - able to give script refills for current medications
- smoking cessation support and nicotine replacement therapy (NRT) script if required

The team was comprised of:

- WDHB cardiac rehabilitation nurse specialist (CNS) to lead clinics
- TWOW community nurse – to lead community outreach and navigation of care to wraparound services
- WDHB nurse practitioner – to manage patient scripts and clinical advice
- cardiologist support as required – to support the community based CNS clinics led at Whānau House
- clinical exercise physiologists from AUT Millennium to deliver the 12-week exercise programme at West Wave Pool and Leisure Centre

The pilot programme commenced in June 2018 with the target of 20 clients, with access to patient's health information via Shared Care Connect.

All eligible patients who had experienced an acute coronary syndrome event within WDHB were advised by the cardiac rehabilitation nurse specialist (CNS) of the programme and invited to participate. Verbal consent was obtained and a referral was sent to the TWOW cardiac rehabilitation nurse via the Wai-referral system. Two weeks following discharge from hospital, the patient would have their first clinic appointment at Whānau House. All patients were seen by either the WDHB nurse practitioner (NP) or CNS, alongside the TWOW community nurse.

During the initial clinic appointment, the team discussed the following with the client:

- individualised care planning
- Depression, Anxiety, Stress Scale (DASS1) tool assessment – a quantitative measure of distress along the three axes of: depression, anxiety, and stress
- risk assessment
- client triage
- referral to appropriate wrap-around community services

Following completion of the initial clinic appointment, the team then gave the green light for the patient to undertake the CEP assessment at their preferred location, being either Whānau House in Henderson or AUT Millennium in Albany.

Although there were predefined topics for this programme, as mentioned above, each care plan was individualised and focused on the areas seen as a priority first, with the overall emphasis being improving health literacy. Community outreach care was also offered to all patients, however, engagement was at their discretion.

Throughout the 12 weeks, contact was made through a number of avenues, including weekly home visits, phone calls and email. All patients were to complete the community exercise physiologist programme prior to the final clinic visit. What this meant was that a CEP from AUT Millennium worked alongside each patient to help build individualised exercise programmes according to assessment which ran alongside the cardiac rehabilitation programme. This programme was free of charge to pilot clients and was based at West Wave Pool and Leisure Centre in Henderson, or AUT Millennium, Albany (initial assessment). Upon completion of the exercise programme, the patient was referred to a final clinic appointment at Whānau House prior to discharge from the programme.

Final visit patients were then discharged to a GP for continuity of care and also advised around accessing the Whānau Ora Mobile Service for a 12-month period.

MR SB: A CASE STUDY

Mr SB is a 60-year-old Māori male who was the first candidate into our cardiac rehabilitation pilot programme. This was following an acute admission and discharge from hospital with a primary diagnosis of NSTEMI (Non-Segment Elevation Myocardial Infarction) an acute type of heart attack, which requires a stent to clear heart blockage associated with mild diaphoresis, and a secondary diagnoses of hypertension, pre-diabetes.

Following discharge from the hospital Mr SB was advised of the programme, which he was reluctant to join at first. In his mind, all he was thinking of was: “Am I going to be able to go back to work? What is my chance of survival? What do I need to do? I want to spend more time with my moko.”

The initial phone communication to remind Mr SBs of his two weeks post discharge clinic appointment cleared part of his gloomy thoughts after a brief kōrero over the phone. I introduced myself and my role in the cardiac rehab programme. He said he looked forward to attending an initial clinic visit.

On the initial specialist appointment, Mr SB presented with sleep deprivation, anxiety, stress and loss of appetite. The full team was there to support him through his journey. The team consisted of: a cardiac nurse specialist, a cardiac nurse practitioner, a clinical exercise physiologist, a CNS specialising in cardiac failure and a Waipareira community cardiac nurse.

Mr SB’s current medical history:

- heavy smoker
- hypertension
- pre diabetes
- high waist circumference
- coronary artery disease

Working in collaboration with the WDHB CNS, we were able to create a plan to support him to quit smoking, reduce his stress level, anxiety, and address his poor appetite and other social issues.

During engagement with Mr SB, we spoke a lot about healthy eating, medication compliance, completing the exercise programme, quitting smoking and its benefits. We discussed in-depth healthy food choices and options, how medication works, the effects of stress, and the quit smoking programme (although Mr SB was already on quit smoking, prior to my engagement). We also discussed reducing working hours to accommodate more rest and referred him to a social worker and wraparound services to deal with anxiety and other pending issues.

After the 12 weeks with Mr SB, he appeared to benefit immensely from the programme.

During this time, I felt I built a positive relationship with Mr SB, in that he felt comfortable coming to me with his concerns, was able to be open and honest about his health concerns and reached out frequently.

Outcomes:

- Mr SB has now completed the 12-week cardiac rehab programme
- Mr SB completed his 12-week exercise programme with good results
- Mr SB said he feels he has more knowledge around his disease and how to manage it appropriately
- Mr SB was successful with the quit smoking programme and is now saving $800 per month
- wraparound services were effective in dealing with social issues
- stress and anxiety levels have been managed well
- Mr SB signed up with a gym after the programme for continuity of physical exercise – changed previous views on the gym only being for youth
- improved quality of life
- an advocate at his workplace for quitting smoking
- making healthier food choices
- good experience of prototype
- behaviour and knowledge changes accomplished

The Cardiac Rehabilitation Programme and Whānau Ora Outcomes

Morbidity and mortality from cardiovascular disease continues to be one of the largest burdens of disease for New Zealanders. By working collectively with patients using the Whānau Ora model, good management of risk factors, and prevention of further acute coronary syndrome events or complication, morbidity and mortality from cardiovascular disease could be reduced.

Whānau Ora is about working alongside patients and their whānau to create care plans that not only address the physical needs of the whānau, but their spiritual, social and mental needs also. It is a whānau-centric model which can help to significantly improve health outcomes for the patients.

There is evidence that cardiac rehabilitation reduces:

- mortality rate
- morbidity rate
- rate of hospital re-admissions

And improves:

- quality of life, psychological well-being and exercise capacity.

There is evidence of behavioural and habitual changes by patients and their whānau, due to having a better understanding of their disease and the knowledge and drive to want to make better decisions, ultimately resulting in a healthier lifestyle. This is evidenced by continued engagement and completion of the Cardiac Rehabilitation Prototype Programme and whānau involvement.

The pilot can also be seen as a stepping-stone for more collaborations of contracts with WDHB, and other like-minded organisations who share our common goal of wanting the best outcomes for whānau. It is hoped that the pilot will progress into a funded, co-delivered programme that can be rolled out to offer a more cohesive pathway for whānau from hospital to home, providing the tools for which whānau can become more self-sufficient under the model of Whānau Ora. Under this model, whānau are at the centre and treated with cultural understanding in order to achieve the best outcomes.

It's all about whānau.

Cardiac Rehabilitation nursing team

Cardiac Rehabilitation Pilot team at the whakatau to launch the programme

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