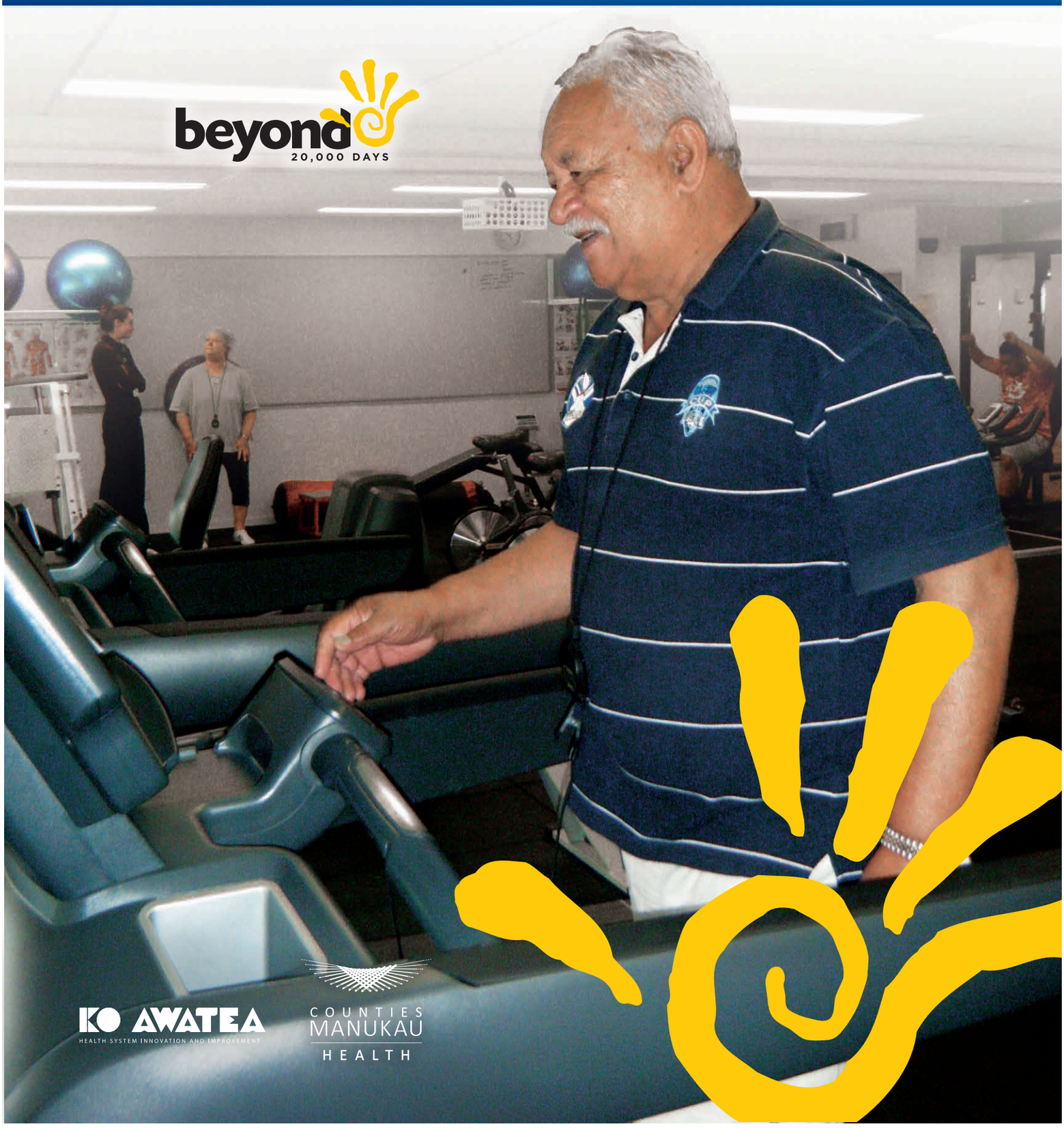
Beyond 20,000 Days

CAMPAIGN




beyond
20,000 DAYS
"We all have a part to play in
improving the health of
our community"
SMART – Safer Medical Admission Review Team
Well Managed Pain
Supporting Life after Stroke
Kia Kaha, Manage Better, Feel Strong
Inpatient care for people with Diabetes
Gout Busters
ACE Acute Care for the Elderly
Medical Assessment
Franklin Health Coordination Service
Mental Health Short Stay
Memory Team
Environmental Cleaning
Feet for Life
Healthy Hearts Fit to Exercise
Healthy Skin
Helping at Risk People
TOWARDS SUSTAINABLE HEALTHCARE
KO AWATEA
HEALTH SYSTEM INNOVATION AND IMPROVEMENT
COUNTIES MANUKAU HEALTH

Superheroes of Improvement

On 1st July 2014 teams, patients and families gathered to celebrate the amazing achievements from the 20,000 Days and Beyond 20,000 Days campaigns.

Geraint Martin, CEO

It's been over two years since the first campaign (20,000 Days) began, initiated in response to increasing demands on resources across the healthcare system. It's been a remarkable journey. The 20,000 Days campaign was successful in giving back 23,060 healthy and well days to our community. Beyond 20,000 Days has continued to build on this success, with 16 collaborative teams working across the system to anticipate and prevent acute health problems, respond quickly and effectively in the community and provide timely and safe care to people admitted to hospital.

As you will read, the Beyond 20,000 Days campaign has enabled us to better manage the demands on our hospital and had a profound effect on the patients and families involved.

Patients like Mike, who joined the Healthy Hearts: Fit to Exercise programme, following a heart attack. Mike has now turned his life around. He is fitter, healthier and more confident. Earlier this year Mike completed Round the Bays with other Fit to Exercise participants – what an amazing achievement!

Then there is Elizabeth, who following a stroke is now doing her rehabilitation at home, thanks to the Supporting Life After Stroke: Early Supported Discharge programme. "I like doing my rehabilitation at home - I can walk around, help my sister in the garden and do the cooking," says Elizabeth. "Home is where I want to be." And who can forget George from the first 20,000 Days campaign, who with the help of the Very High Intensity User team went from 28 admissions in one year down to three admissions the following year. The importance of these health and lifestyle gains for patients and their family/whaanau cannot be overstated.

Over the next few months we will be supporting 10 Beyond 20,000 Days collaborative teams to implement, embed and spread the changes permanently into practice.

These 'superheroes' of improvement now have the skills, knowledge, confidence and a proven methodology to enable them to spread their work further and help transform our health system ... one step at a time.

Congratulations to everyone involved. You should all be proud of what you have achieved.

Geraint Martin, CEO, Counties Manukau Health

Our team

Back row (left to right): *Delwyn Turcich (Personal Assistant), Janet Haley (Senior Communications Advisor - Internal), Jacqueline Schmidt-Busby (Collaborative Project Manager), Ian Hutchby (Improvement Advisor), Matt Cope (Improvement Advisor), Danielle Farrell (Collaborative Project Manager), Stephanie Easthope (Internal Faculty Manager), Stephen Ayliffe (Collaborative Project Manager), Prem Kumar (Improvement Advisor), Monique Davies (Collaborative Project Manager).*

Front row (left to right): *Diana Dowdle (Delivery Manager), Trish Hayward (Writer), Alison Howitt (Collaborative Project Manager), Suzanne Proudfoot (Projects & Campaign Manager), Brandon Bennett (Senior Improvement Advisor), Dr David Grayson (Campaign Clinical Lead).*

beyond 20,000 DAYS

A Collaborative Project Manager's perspective

Achieving exceptional results is possible when working with high performing teams using the Model for Improvement as a tool for testing and embedding change within the project's timeline.

The project manager's role working with this improvement model is one of working alongside the team, translating improvement work into business as usual and supporting the group in achieving their pre-agreed project deliverables.

We also create a culture within the team to embrace change in their improvement work and motivate people through the inevitable ups and downs of the project.

Project managers act as a lynchpin for stakeholder engagement, communication and building on relationships, which are key to overall success.

Removing barriers and enabling change requires initiative, creativity, enthusiasm and an innovative mind set! Our reward is the satisfaction we get from working with teams who are passionate about improving quality for their patients.

An Improvement Advisor's perspective

It is rewarding working as an improvement advisor, helping to nurture teams as they go through their improvement journey. Working so closely with the teams while they improve the processes for their patients, it is invigorating to stop and reflect.

It is amazing to think how far the teams have come since they had to stand in front of the dragons' den to pitch their ideas. At this time some teams had experience of using the Model for Improvement, while for many others it was a new concept. At the learning sessions all the teams were exposed to the methodology, including Plan Do Study Act (PDSA) cycles and measurement for improvement. As improvement advisors we helped the teams take this knowledge and apply it to their projects. By building the team's confidence in using the tools we were able to build improvement capability within the organisation – the stories in this booklet are a testament to this.

Although we have focused on the project teams, pausing also allows us to self-reflect and think about the journey we have gone through as improvement advisors. By working with the project teams we gain a greater insight into the system we work within, and we have also performed our own PDSAs to improve the way we work.

We feel very privileged to have been invited into these teams and to share the improvement journey, which makes a difference to the lives of so many patients.

Building on success

Mr Potato Head 'Oscars' presented at the Beyond 20,000 Days celebration in July 2014

In July 2013, we celebrated the success of the 20,000 Days campaign in giving 23,060 days of enjoying health and wellness out of hospital and at home in the community to the people of Counties Manukau. Through the campaign, we have improved care for our patients, reduced demand on our hospital, and created a network of healthcare professionals with the skills and commitment to achieve sustainable change. We have produced health system improvement guides to spread the successes we've achieved throughout the healthcare sector.

But we knew we could do even more.

The Beyond 20,000 Days campaign was launched with the aim of continuing to give back healthy and well days to our Counties Manukau community by 1 July 2014. Sixteen new collaborative teams were established from across the health sector. These teams have implemented a range of interventions that put improved individual and family/whaanau care at the heart of everything they do. Beyond 20,000 Days is about delivering care in a different way, so that people can stay well: at home, out of hospital, making healthy lifestyle choices.

The campaign has achieved its aim. We have saved more hospital bed days, increased access to community based support, improved efficiency, reduced costs and continued to build on the improvement methodology expertise established by 20,000 Days. Ten of our collaborative teams are implementing new services or making permanent changes to sustain the progress made.

"It is energising to be part of a revolution for improvement across Counties Manukau. We have consolidated the progress from our first campaign and made an even greater impact on our system," says Dr David Grayson, Clinical Lead for the Beyond 20,000 Days campaign.

But it's the difference the campaign has made in the lives of the patients and families it has touched that truly shows the value of what the Beyond 20,000 Days campaign has achieved. Patients with heart failure in the Healthy Hearts: Fit to Exercise programme successfully completed the 8.4km Round the Bays fun run; Feet for Life patient Shannon walked for the first time in two years; and Merle Mapuna Samuels, a patient suffering from arthritis, asthma and chronic pain, trained as a chronic disease self-management programme leader through Kia Kaha: Manage Better, Feel Stronger. The programme has given her, not only the power to improve her own health, but also the confidence to help others. She now supports people in her community who suffer from chronic disease to manage their health.

None of this would have been possible without the dedication of the clinicians, managers, patients and families involved in the campaign.

Thank you and congratulations to everyone involved.

Our Journey

Through our journey we have achieved many key successes and continued to learn a lot about essential collaborative components required to contribute to successful outcomes.

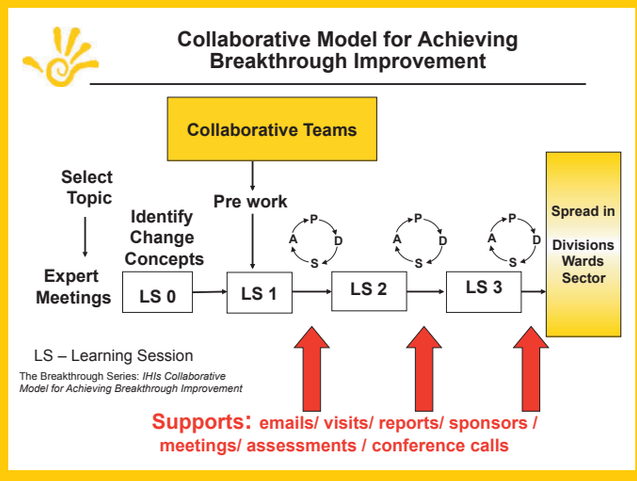
What **worked well** for our campaign?

1. Alignment around a common goal

The campaign had a unifying goal to reduce demand on the hospital, which all of the collaborative teams shared. In addition, each collaborative had specific aims and change ideas. These ultimately contributed to the overall campaign goal.

2. Leadership and expert support for the teams

- CEO Geraint Martin (Campaign Sponsor) and Professor Jonathon Gray, Director Ko Awatea, were actively involved throughout the campaign, meeting regularly to ensure the vision and milestones were met.
- Each collaborative had regular Expert Group meetings for the teams to gain valuable support, insight and direction from both clinical leads and operational managers.
- The campaign team provided continuous support via the campaign manager, campaign clinical lead, collaborative project managers, improvement advisors and the communications coordinator.
- Supporting the campaign team were also data analysts, and Operational and Leadership Groups from Counties Manukau Health.



3. Multi-professional teams working across the health sector

- Collaborative teams included health professionals, managers, clinical leaders, project managers, improvement advisors, data analysts and community members.
- Collaborative teams had subject matter knowledge and expertise in the topic areas.
- Teams were working on projects across the sector in many sites including primary care, secondary care and in the community.
- Because the project ideas came from within the teams and not 'top down', there was engagement, will and accountability for achieving the results from within the teams.

What is a collaborative?

A collaborative brings together groups of practitioners to work in a structured way to improve aspects of the quality of their service. It involves meetings to learn about:

- **best practice in the area chosen**
- **quality improvement methods**
- **change ideas**

It's also an opportunity to share their experiences of making changes in local settings.

Ovretreit et al. (2002)

"Counties staff are delivering results that compare with the very best in the world, using a proven framework for effective change."

Professor Jonathon Gray, Director, Ko Awatea

4. The Model for Improvement

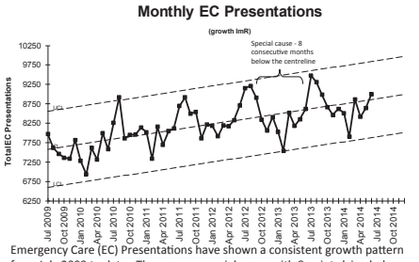
- Each collaborative team applied the Model for Improvement, which asks:
  - What are we trying to accomplish?
  - How will we know that a change is an improvement?
  - What change can we make that will result in improvement?

  Teams then tested their theory of change through Plan Do Study Act (PDSA) learning cycles.
- Teams tested many ideas, initially through small tests to gain confidence in their change ideas, then to larger scale tests before moving to implement them across the organisation or area of work.
- The campaign team developed 'PDSA trees' to track and capture each of the learning cycles, with the final set of implemented change ideas formulated into a 'change package'.
- 'Change packages' have been captured in booklets called "how to guides" to be shared with other health service providers to support improvement initiatives beyond Counties Manukau Health. These guides show what the teams did, as well as the results they achieved.
- Measures have been defined at the Beyond 20,000 Days campaign level, as well as for each of the collaboratives. The measures were analysed and displayed monthly on dashboards.

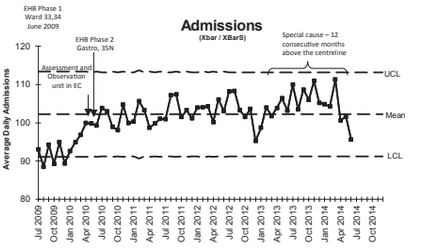
5. A structured series of milestones and activities

- The campaign had a clear set of milestones for the collaborative teams to meet, which provided focus and direction. All of the campaign milestones were achieved.
- The Breakthrough Series approach provided an ongoing series of structured activities to support the teams in their use of the methodology and promote collaboration between teams.
- During the campaign there were a total of five days of learning sessions attended by 100-120 people! Significant expertise has been built up across the organisation in the improvement methodology.
- The times between learning sessions were periods of action, where support and coaching continued to be provided to the teams while they undertook their tests of change.
- The collaborative methodology has proven to work extremely well as a structured way to implement evidence based practice that has been enhanced by using local knowledge and skills within the Counties Manukau context.

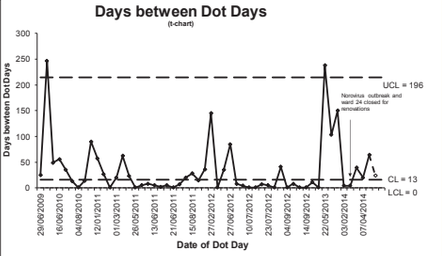
Teams continue to be supported to implement and spread their improvement initiatives. Six collaborative teams are returning to business as usual with the improvements and ten are implementing changes permanently.



Emergency Care (EC) Presentations have shown a consistent growth pattern from July 2009 to date. There was a special cause with 8 points lying below the expected centreline, analysis indicates that this special cause is the result of seasonality.



A special cause with 12 points above the centreline (April 2013– March 2014) has been noted on the graph



There was 1 Dot day in June (10th June) - the total so far for 2014 is 6

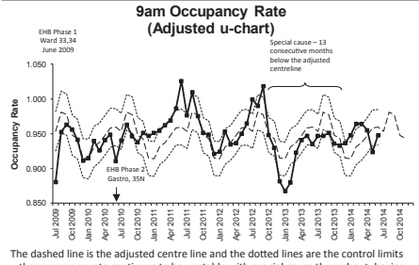
Notes

As the scope of the Beyond 20,000 Days Campaign has expanded, the data for the admissions, length of stay and readmissions now includes ARHOP and Mental Health in addition to the Surgical and Medicine divisions – it specifically excludes Women's Health, Paediatrics and those discharged directly from EC/Short Stay Units
The occupancy graph is now displayed as a rate to reflect the data shown in the Daily Dose e-newsletter.

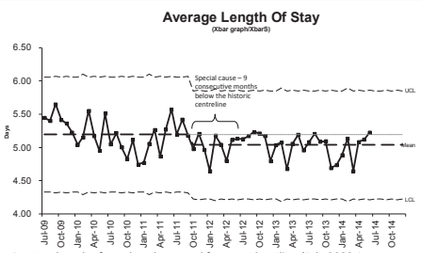
Beyond 20,000 Days
Campaign Dashboard
June 2014

Analysis

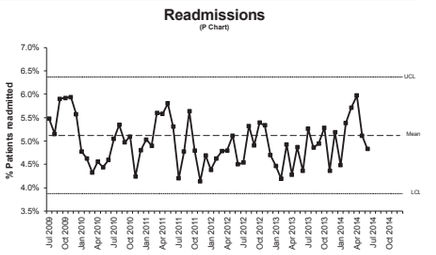
All graphs continue to demonstrate predominantly normal variation only.
Admissions showed a sustained period above the entreline (12 months) but this has not sustained with the last 3 months being below.



The dashed line is the adjusted centre line and the dotted lines are the control limits – the occupancy rate continues to be unstable with special cause throughout, having noted the 12 months below predicted centre line the last 3 months have been outside the upper control limt (ie greater than would have been predicted)



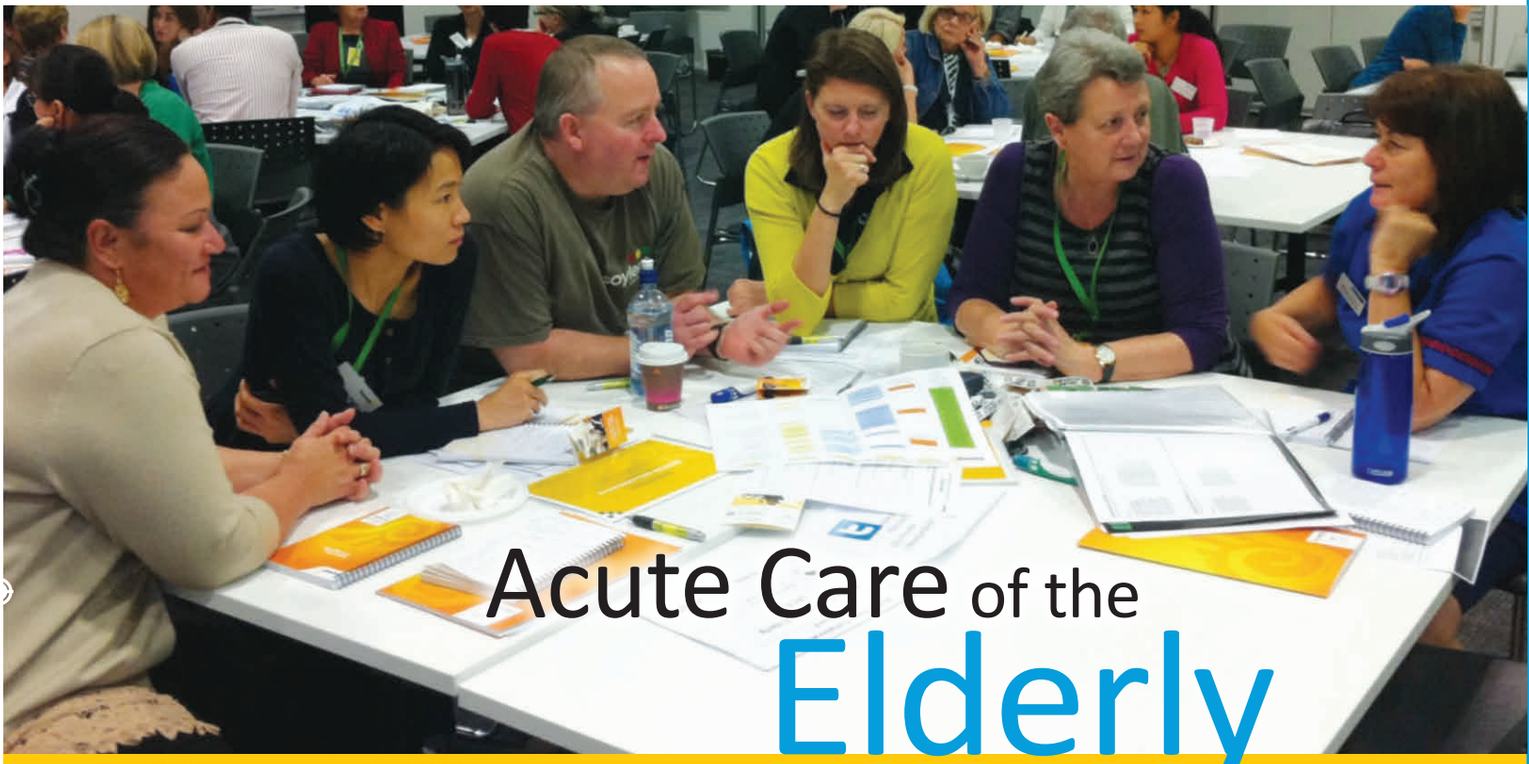
Average length of stay has decreased from our baseline (July 2009-June 2011) and shown common cause variation at a reduced level since November 2011.



Readmissions have shown common cause variation only

Campaign Manager : Diana Dowdle
Clinical Leader: David Grayson
Improvement Advisor: Ian Hutchby, Prem Kumar & Matt Cope

The Collaboratives



Acute Care of the Elderly (ACE)

ACE collaborative members at a Beyond 20,000 Days campaign learning session

Our aim

ACE aimed to improve the care of acute medical patients aged over 85 years by developing and implementing a model of acute care for the elderly.

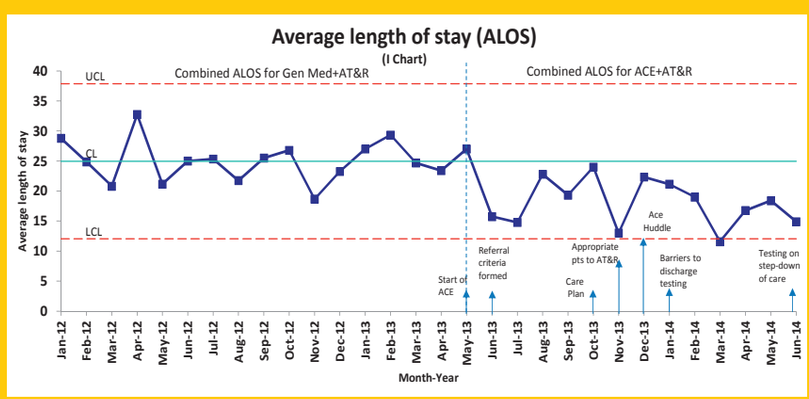
Key achievements

- The ACE Model, which includes an improved comprehensive multidisciplinary assessment plan, has been operationally introduced.
- We developed a screening tool that has proven to be predictive of patients at risk of step down of care (i.e. not returning to their previous level of care after hospitalisation).
- The ACE Huddle is showing promise in reducing length of stay.

Since the ACE Model was introduced:

- the re-admittance rate has come down from 6% to 4%
- the step down of care rate has decreased from 14% to 8%
- Acute to Assessment, Treatment & Rehabilitation average length of stay (ALOS) has dropped from 25 to 18 days
- Acute ALOS has reduced from 8.5 to 8 days.

This collaborative is now in the implementation phase.



Healthy Hearts

Fit to Exercise participants in the women-only class

Our aim

The Healthy Hearts: Fit to Exercise programme aims to improve the cardiovascular health of people with heart failure (HF) living in South Auckland whose health and fitness needs are not currently met through existing programmes. We aim for a mean improvement of 20% in the exercise tolerance test and health index questionnaires.

Supporting participants to set and achieve their own goals is also an important aim, as is achieving a positive consumer satisfaction response from at least 75% of participants completing the programme.

Key achievements

- Seventy-five people with heart failure have attended comprehensive assessments. Of these, 77 have enrolled in Fit to Exercise programmes including 'early bird' and 'women only' classes, 13 opted for home/walk or community programmes and five people declined input.
- The did not attend (DNA) rate is 8%. This is well below normal DNA rates for outpatient services.
- Initial results indicate improvements in clinical outcome measures, achievement of participant goals, a high level of consumer satisfaction with the programmes and successful participant transition to independent exercise.

Next steps

Data evaluation is on-going and will be used to inform change and future developments.

Further testing is planned to grow capacity, expand into different locations and design programmes to fit the needs of this unique population of people with heart failure.

> ***"I want to...***
> ***...be able to walk my grandchild to school...***
> ***...drop a dress size...***
> ***...feel lighter and fitter...***
> ***...be able to walk up stairs without stopping"***

Participants

Feet *for* Life

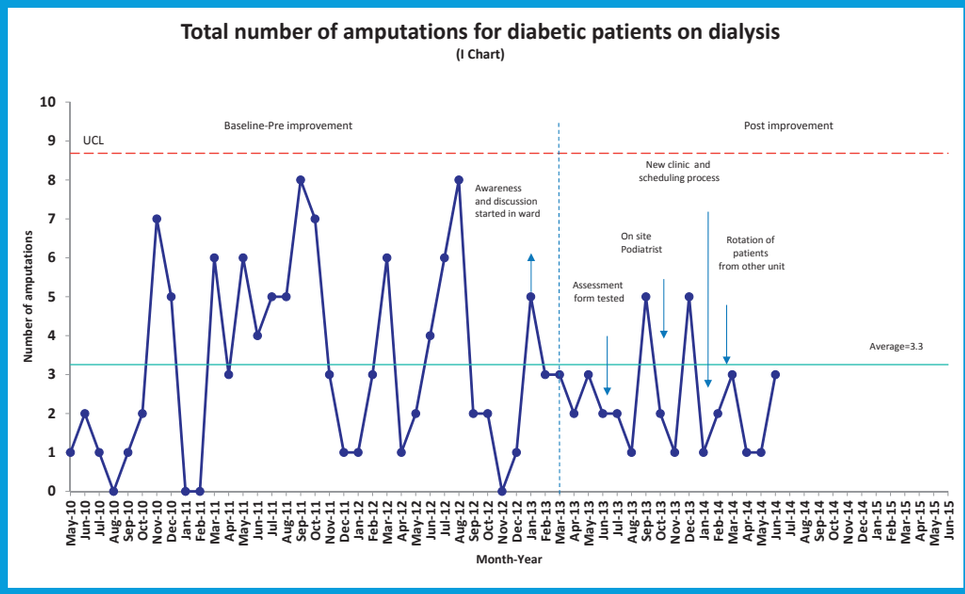
A consultation with a Feet for Life patient

Our aim

The focus of the Feet for Life collaborative project is to improve access to podiatry services for renal patients with diabetes in Counties Manukau by incorporating palliative podiatry care into the dialysis units. Our aim was to reduce the number of lower limb amputations by at least 10% (from 42 per year to 37 per year) by 1 July 2014.

Key achievements

- Reductions in amputations, hospitalisations (presentation, admission, ALOS, re-admissions), mortality, waiting time, did not attend rates, and costs.
- Increases in patient quality of life, patient/whaanau satisfaction, staff skills and knowledge, and self-management skills (and support).



"Feet for Life is not only reducing amputations and the impact on patients and their families… Feet for Life is saving lives!"

Staff member

FHRR Collaborative members at a Beyond 20,000 Days campaign learning session

Franklin Health Rapid Response (FHRR)

Our aim

The aim of FHRR was to develop a service that would respond rapidly to residents* within the Franklin locality to reduce avoidable presentations to Emergency Care (EC) by 4% and to support a smooth transition back into their community.

* For residents aged 16+, excluding maternity and mental health patients

Key achievements

- FHRR has developed a coordinator role to rapidly respond to referrals within 24 hours, to hand over the rapid response episode of care to the relevant health professionals within the patient's medical home and to support discharge from hospital in a timely manner.
- By the 10th of May 2014, 85 patients had been through the service. The average time from receipt of referral to the first contact with the patient was 1.35 hours and the average time to complete an intervention from referral to discharge/handover was 2.22 hours, which indicates a high level of responsiveness.

> ***"It is a great option for our staff to have in their toolbox. It has given the crews on the road another alternative to consider when assisting a low acuity patient who doesn't need urgent care."***

Glen Metcalfe, Franklin Territory Manager,
St John Northern Region

healthy Skin

Dr Jennifer Njenga showing Healthy Skin patient Melody how to apply cream correctly to her skin problem

Our aim

The aim of the Healthy Skin collaborative is to support families to prevent and manage skin infections by providing high quality and well integrated health services in the community. Specifically, we aimed to achieve a 20% reduction in recurrent presentations for skin infections among patients 18 years of age or under enrolled at the Otara Family and Christian Health Centre by 1 July 2014.

Change concepts

- Improve health literacy by fostering better patient understanding of skin conditions and treatment, providing testing aids to help with demonstrations and encouraging clinicians to spend time talking through information sheets with patients.
- Promote best clinical practice by using nurse training, mentoring and education to improve competency.
- Make better use of consultation time by utilising phone triage and phone call consultations with patients.

Key achievements

- Increased number of patients attending each skin clinic.
- GPs have more confidence in skin clinic nurses to support and resolve skin problems.
- Patients coming to the practice and requesting to be seen by the skin clinicians.
- Reducing actual appointments and freeing time for clinicians and patients by using telephone consultations for some skin follow-ups.

> *"After five weeks, Melody was perfect and 100%. All the eczema on her skin was gone. It's gone! Gone!"*
>
> Patient's father

Kia Kaha

Manage **Better,** feel **Stronger**

Our aim

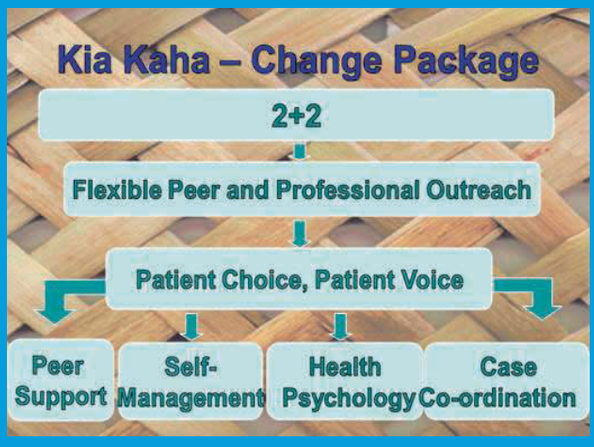
The aim of Kia Kaha was to achieve a 25% reduction in overall hospital and GP utilisation for 125-150 individuals with medical and mental co-morbidities engaged in the programme by 1 July 2014.

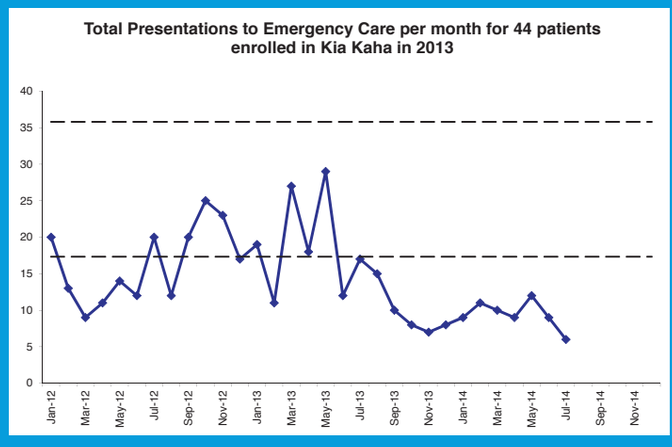
The programme targets high users enrolled in primary care in Otara, and facilitates the activation and engagement of patients, whaanau and services.

High users are defined as patients with more than two medical conditions (including mental health) who have been admitted to hospital or presented to Emergency Care more than twice in 12 months.

Key achievements

- Development and addition of a primary care peer support specialist role to our team to successfully engage hard-to-reach patients.
- Creation of a health psychology and self-management education focused intervention bridging secondary and primary care.
- A 40 - 45% reduction in EC presentations maintained over the last 6-12 months for participants enrolled in 2013.
- Caregivers and whaanau, as well as patients, have been able to benefit from our change package.





Next steps

We are working on streamlining our processes and change package to the core elements, so that the programme can be implemented on a wider level and become available to more patients and whaanau.

> ***"I'm much happier, much healthier, and not only that, I'm much freer - and that's what Kia Kaha is all about – better yourself and feel stronger."***
>
> Participant

"I felt like that there were other people who could help…things like how you feel, ways to get through things…by the time I had finished the programme, my stress level was down from 100 to 10 per cent." Whaanau member of participant

Supporting Life *after* Stroke

"Home is best." – Mrs Elizabeth Tua

Our aim

Our aim was to develop and implement a model of care to support early discharge for patients with mild to moderate stroke, by providing specialist rehabilitation services in the patient's own home rather than in hospital.

By July 2014, we aimed to achieve:

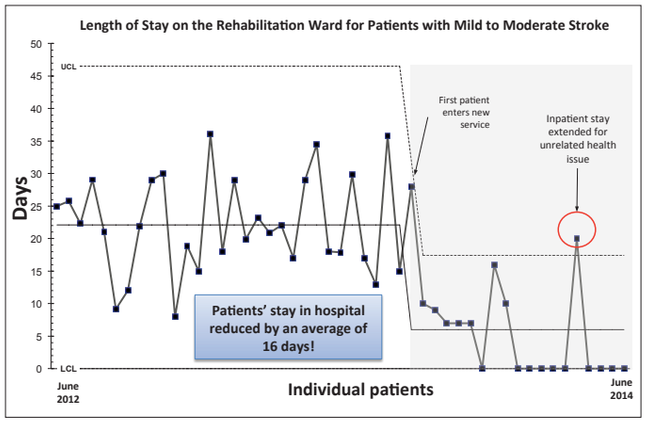
- a reduction of four days in the average length of stay
- functional improvements comparable to inpatients
- a patient satisfaction score of 95% or greater.

Key achievements

The expertise of the Supporting Life after Stroke team in providing stroke care and their experience in community work were key factors contributing to the success of the programme. Enthusiasm and support of change from all levels were also important. Key achievements include:

- designing the Early Supported Discharge (ESD) programme and initially testing it with 32 patients from the rehabilitation ward, later adding patients from the acute stroke unit and general medical wards
- FIM (Functional Independence Measure) and NEADL (Nottingham Extended Activities of Daily Living) scores that demonstrate clinically significant outcomes comparable with inpatients
- exceeding our target for patient and carer feedback by achieving a 99.5% positive response.

"Look at me now - I'm my own man, my own self and I enjoy being home with my wife and son." Mr Williams, ESD patient



Next steps

- Expand ESD into other areas.
- Investigate factors that could predict outcomes and help prioritisation.
- Undertake a cost comparison with inpatient rehabilitation.

"Patients get the same intensity of therapy that they would as an inpatient, but in the home setting."

Dr S. Adiga, Consultant, Adult Rehabilitation & Health of Older People

Well Managed Pain patient Friday Tomai

"I felt there was a solution…a way to help me."

Our aim

The aim of Well Managed Pain (WMP) is to complete a multidisciplinary assessment for 100% of patients referred to the WMP team within four days from referral, if the individual is still inpatient and in conjunction with the patient and primary care, to develop and document a multidisciplinary pain care plan.

Change concepts

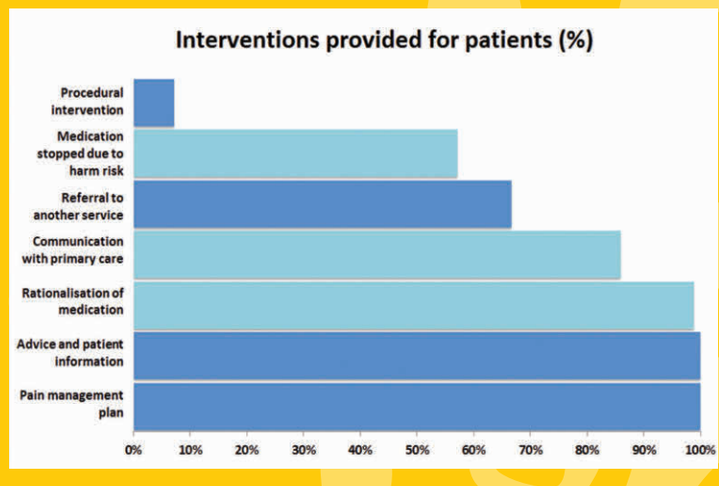
- Development of an algorithm utilising hospital data that could identify patients who are at high risk for having severe pain while in hospital.
- Standardisation of a multidisciplinary assessment, intervention and discharge form.
- Refinement of the criteria and process for primary care consultations for patients who are being reviewed by the WMP team.
- Development of a more patient/whaanau-influenced service using patient satisfaction questionnaires.
- Development of a pain management plan for every patient seen by the WMP team.

Key achievements

- Medication changes included starting and stopping medications to reduce risk to patients.
- The team has developed a multidisciplinary care plan.
- Gaps have been identified in psychological care for the patients referred to the service. These are being addressed.
- Questionnaires completed by post-intervention patients have shown overall positive responses.
- 100% of patients are now receiving a multidisciplinary assessment within four days.

Next steps

The longer term goals of the project are to consolidate processes, develop guidelines, demonstrate robust clinical care and be able to see positive financial outcomes.



The SMART pharmacists

(Safer Medical Admission Review Team)

Our aim

SMART was developed to address increasing waiting times for patients in Emergency Care and an unacceptably high rate of medication-related harm at Counties Manukau Health.

Our aim was to have the SMART model applied to 90% of triage category 2-5 patients presenting to Emergency Care (EC) who are referred to General Medicine between the hours of 8am and 10pm, Monday to Friday, by 1 July 2014.

Change concepts

We developed the SMART model to provide a safer, more efficient model for admitting patients to General Medicine. The model uses admitting pharmacists to conduct patient reviews in collaboration with the admitting doctor, providing medication history and reconciliation in EC. Prospective rather than retrospective care allows pharmacists to prevent errors arising, rather than intervening after they occur.

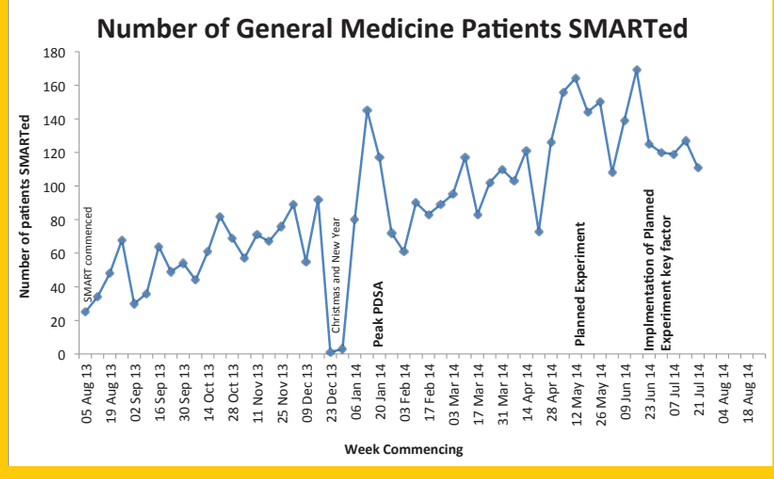
Key achievements

- 298 interventions recorded where pharmacists prevented medication-related harm.
- Projected cost avoidance per annum due to prevention of medication errors through the SMART model of $256,955.[1] This is likely to increase as SMART sees a greater proportion of patients.
- 1083 contributions recorded by pharmacists for SMART patients. The number of patients seen by SMART is increasing steadily.
- Opportunity for further expansion of the pharmacist role in the team environment with a highly engaged workforce.
- Support and teaching between doctors and pharmacists.
- Identification of ACC claims for medicine-related admissions.
- Since implementation in December 2013, SMART has been embedded in daily operation throughout General Medicine.

1. Shneider PJ, Gift MG, Lee Y, et al. Cost of medication-related problems at a university hospital. American Journal of Health-System Pharmacy. 1995; 52:2415-8.

"Working together as a team to benefit the patient"

SMART pharmacist



Inpatient care *for people with* Diabetes


The Diabetes Team

Our aim

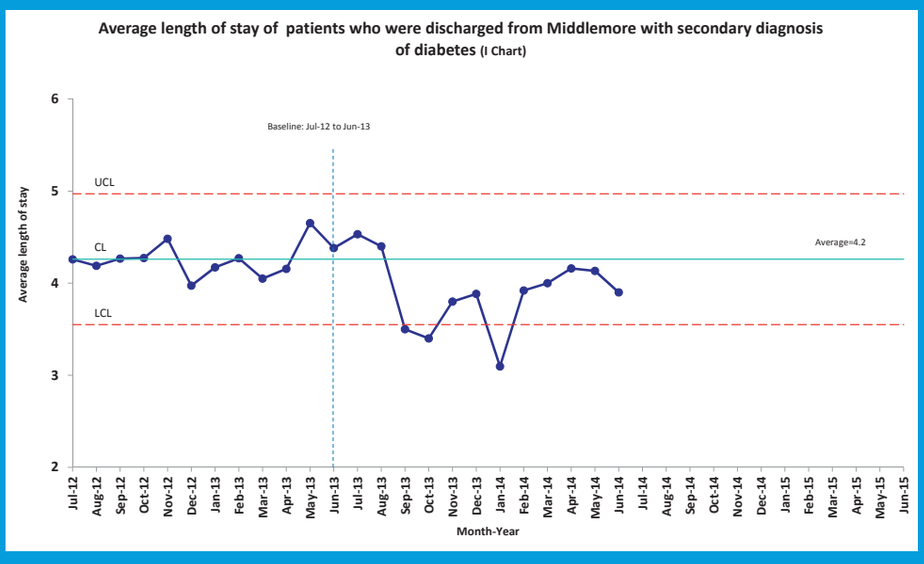
Our aim was to reduce length of stay and readmissions for people with diabetes by changing the model of inpatient diabetes care from reactive review to virtual review. We aimed to implement virtual review for all diabetes inpatients, and provide clinical input in accordance with the triage tool, by 1 July 2014.

Key achievements

- Improved process for identification of inpatients requiring diabetes review to enable the team to see patients sooner.
- Reduction in average length of stay in people admitted with a secondary diagnosis of diabetes.
- Introduction of an inpatient podiatrist to review high risk foot patients with active foot problems.
- Improved referral to the diabetes podiatry ulcer clinic.
- Development of a process for all people newly diagnosed with type 1 diabetes to be reviewed by a specialist dietitian.
- Increased diabetes nursing resources in the inpatient team.

Next steps

Increasing the visibility of diabetes inpatient care plans and advice is the next area of focus for this collaborative.



> ***"This project has highlighted how we can do things better, faster and smarter!"***
>
> Diabetes clinical speciality nurse

Gout Busters

Our aim

We aimed to have screened 200 patients with a history of gout using the Gout Trigger Tool by 1 July 2014.

Identified at-risk individuals benefit from a specialist gout clinic, with the goal of improving their health status within six months.

Change concepts

- A focus on testing and developing a model for risk assessing patients with gout, or with a history of gout, and providing appropriate treatment and support in the community.
- Receptionists identify target patients and nurses screen and question them. A virtual review is carried out, and finally patients attend a clinic run by a GP with a special interest and a senior medical officer.
- Follow up with a nurse after 1 week and again in a long term condition clinic after 4 weeks.
- Increasing consultation times and using a health literacy approach to support treatment and care.

Key achievements

- Gout Trigger Tool identifies at risk individuals.
- Triple booking of clinic appointments provides an appropriate attendance.
- Fixed booking of clinicians for clinics into diaries allows better planning.
- Gout Trigger Tool identified and screened over 450 patients with gout.

Helping *At Risk* Individuals

Our aim

The aim of Helping At Risk Individuals was to reduce unplanned hospital admissions for our identified at risk population by providing co-ordinated planned management in the community.

Key achievements

- The Helping At Risk Individuals collaborative has contributed to developing tools, guidelines, resources and planning on how best to manage high risk people in primary care in two initial pilot practices (Otara and Mangere).
- The collaborative contributed to developing a core guidelines package to introduce practice management styles to newly-recruited GP practices.

Next steps

The collaborative's learning will merge into the new At Risk Individuals programme.

Environmental Cleaning

Our aim

This project aimed to reduce the incidence of multi-resistant organisms by 10% across Middlemore Hospital by 1 July 2014. We planned to achieve this by using three additional Bioquell cleaning machines for a proportion of our isolation cleans.

Key achievements

- The Environmental Cleaning collaborative has helped with the standardisation of processes.
- There has been a reported significant downwards trend in hospital-acquired cross-transmissions despite elevated community incidents of the target organisms.
- The collaborative's work has enabled the development of a business case in support of the acquisition of Bioquell cleaning machines.
- Approval was not given to purchase the Bioquell machines in 2013/14 due to financial constraints.

Testing a new cleaning technique for an isolation clean in a double room at Middlemore Hospital

beyond 20,000 DAYS

"Health is not just the absence of a disease. It's also having a warm and dry house, a safe environment and families who understand the importance of keeping well."

Dr Jennifer Njenga
General Practitioner

Inspiring Stories

Elizabeth Tua – Supporting Life After Stroke: Early Supported Discharge

The Early Supported Discharge (ESD) programme is doing wonders for patients like Elizabeth, who was admitted to Middlemore Hospital in November 2013 with a stroke. After spending two weeks in acute care and one week in rehabilitation, Elizabeth was keen to return to her own home, which she shared with her sister. Her sister, with whom she has a very close relationship, was making the journey into the hospital every day to assist Elizabeth with her care.

"I couldn't wait to go home. I felt happy and excited about having the rehab at home – it made me really push myself," says Elizabeth. "I like the rehab at home. I can do most things now."

Elizabeth is seen every day by a team of specialist clinicians which include a physiotherapist, occupational therapist, speech language therapist, nurse, social worker and rehab assistant; all in the comfort of her own home – even on Saturdays. Although it has taken a lot of determination and hard work, Elizabeth is seeing great results. On discharge from hospital, she required assistance with all daily tasks and a wheelchair to mobilise, but she is now independent with her mobility, transfers and personal care. Elizabeth feels she is able to help her sister again and has taken control of her diabetes as well as made positive lifestyle changes to reduce her stroke risk.

"Patients like Elizabeth are the reason we established the ESD programme, and we are delighted at the progress she and others are making," says Katrina Moles, Section Head of the Community Based Rehabilitation Team.

Mrs Anderson - Acute Care of the Elderly

Mrs Anderson is 101 years old. She was admitted to ACE with a urinary tract infection (UTI) after suffering a fall.

Mrs Anderson stayed in hospital for 12 days, where she received antibiotic treatment for her UTI, nursing care and input from a multidisciplinary team including an occupational therapist, physiotherapist, dietitian, social worker and a needs assessor. On discharge, she was assessed as needing private hospital-level care, but her daughter wanted to care for her at home.

ACE put supports in place to help Mrs Anderson's daughter care for her mother effectively at home. Mrs Anderson's personal care was increased to seven days a week, and carer support and respite were allocated. Her intake of Fortisip nutritional supplement was charted, and she was referred to a community dietitian for follow-up. She was also referred to St. John for an alarm to reduce the risk of further falls.

Since her involvement in the ACE programme, Mrs Anderson has been cared for at home and has not been readmitted to hospital.

*Patient's name has been changed.

Shannon Wetere – Feet for Life

Shannon Wetere is a renal patient who has undergone multiple surgical debridements to his right heel for chronic osteomyelitis over the past two years. He has spent a total of 133 days in hospital.

In August 2013, Shannon and his wife Gina were both invited to become patient and whaanau advocates for the Feet for Life team. In October of the same year, an onsite podiatrist began at the haemodialysis unit in Ward 1 at Middlemore Hospital with the aim of incorporating palliative podiatry care within the dialysis unit and therefore improving overall quality of life.

Shannon attends haemodialysis three days a week, with regular bedside wound debridement and specialist podiatric treatment. Seeing a podiatrist at the same time as receiving dialysis treatment has effectively reduced the number of outpatient clinics Shannon needs to attend. It has also significantly improved his access to the treatment required to manage a complex disease.

Despite being advised by his vascular surgeon in December 2013 that he would need to undergo a below-knee amputation, Shannon has not been admitted to hospital since the Feet For Life project commenced. Additionally, Shannon has been ulcer free for four months and is currently training to walk again, so that he can stand and korero on the marae.

Friday Tomai – Well Managed Pain

Friday was admitted to Middlemore Hospital with severe weakness and almost complete loss of use in his arm. He was given a working diagnosis of regional pain syndrome, but scans failed to reveal exactly what was wrong.

"When I came into Middlemore I was very concerned and scared. Feeling the pain was really scary. I was worried I would have to lose my

arm and wondering if it would get better. Even the specialists didn't know what was happening," he says.

Friday was seen by the Well Managed Pain (WMP) team, who created a pain management plan for him by adjusting his medications and arranging for physiotherapy and input from a neurologist. "I felt there was a solution…a way to help me. I had hope that I would get better. [The team] answered my prayers."

Physiotherapy has made a huge difference to restoring movement in Friday's arm, and the new medications have helped him to manage his pain.

"I still have some pins and needles, but I'm really happy that I can move my arm. I would say to someone else in my situation, 'I used to have what you have and there is help there so don't give up. The pain team were like angels.'"

Healthy Hearts: Fit to Exercise Reaching patient goals

"WE DID IT!"

These were the words uttered by seven participants in the Healthy Hearts: Fit to Exercise programme, their family/whaanau and CM Health staff as they crossed the 2014 Round the Bays finish line! Completing the 8.4km walk represented a significant achievement for everyone who took part, especially the participants, who had never dreamt of attaining such a level of fitness following their diagnosis of heart failure.

Healthy Hearts: Fit to Exercise is a twice-weekly programme running over eight weeks for people with heart failure, sponsored by the Beyond 20,000 Days campaign and the Department of Cardiology. This pilot programme aims to assess people with heart failure and improve their fitness by providing specialist advice and support and opportunities such as home/walk/community programmes or CM Health-supervised exercise classes.

Prior to joining the Healthy Hearts: Fit to Exercise programme, many participants had never attended a gym and had been unwell. Concerns about lack of fitness, fear or anxiety about exercise and not knowing where to start were common reasons to enter the programme. Individualised goals such as 'being able to walk my grandchildren to school', 'losing weight', 'wanting to feel lighter and be able to do more' were all achieved on re-assessment immediately after the programme.

Round the Bays was set as a challenge to sustain the gains achieved at the programme and help participants realise their exercise potential. One participant has already enrolled in the Ironmaaori half marathon.

"We did it!"

"Kei waenganui I toku mahi hei takotoranga teTikanga me Kawa Maori I roto I te wahi Hauora"

Merle Mapuna Samuels – Kia Kaha: Manage Better, Feel Stronger

In early 2013, Merle sought help from her primary care team for arthritis, asthma and chronic pain issues. She felt isolated from her family and community. Through her GP, she was referred for health psychology input and was invited to train as a Stanford Chronic Disease Self-Management Programme leader for Kia Kaha.

She began to lead self-management programmes in the community and through this work found the power to improve her own health and the confidence to help others. Kia Kaha supported Merle to become a master trainer of the Stanford programme. She is now employed as a peer support specialist in the peer/professional team as part of the Kia Kaha: Manage Better, Feel Stronger programme, engaging with hard-to-reach patients and their whaanau.

Merle believes that the process of empowerment through self-management education and training has allowed her to become a vital part of her medical team. She believes that if what she has experienced as a Maaori woman was multiplied within primary healthcare, it could change the accessibility of medical care to Maaori throughout New Zealand.

"Naku te rourou
Nau te rourou
Ka ora ai nga tangata katoa
With your food basket and mine, the people are nourished
Arohanui."

Mrs Roberts - Franklin Health Rapid Response (FHRR)

Mrs Roberts is 72 years old and lives alone. She is wheelchair-bound due to an above-the-knee amputation, and suffers from multiple conditions including ischemic heart disease, chronic obstructive pulmonary disease, peripheral vasular disease, hypertension and a chronic wound resulting from complications from a hernia mesh repair. She receives home help three times a week for personal care.

Mrs Roberts presented to Emergency Care following a fall. The FHRR coordinator identified that she was in hospital and asked the liaison nurse to assess her situation, but Mrs Roberts was discharged before this assessment could take place. The discharge summary stated that she was managing well at home.

However, when the coordinator telephoned Mrs Roberts the next morning, she reported that she was not managing well. Her confidence had been shaken by her fall. The coordinator immediately arranged a home visit. Mrs Roberts was pale and emaciated, too afraid of falling to get out of bed, and had not had anything to eat or drink.

Mrs Roberts agreed to receive support from the Assessment, Treatment & Rehabilitation (AT&R) Ward at Pukekohe Hospital. The coordinator liaised with the AT&R charge nurse and Mrs Roberts' GP to arrange the admission. As a result, Mrs Roberts was able to receive care in her local community and avoid further admissions to Emergency Care at Middlemore Hospital.

*Patient's name has been changed.

What they say:

"The Beyond 20,000 Days campaign is without doubt the most powerful example I have experienced of building will, generating and harvesting ideas, and crucially, of executing successful change."

Professor Jonathon Gray, Director, Ko Awatea

"CM Health has moved away from having a fractured approach to improving care to a co-ordinated effort, which is achieving positive results for patients and their families."

Brandon Bennett, Senior Improvement Advisor

"The stories, learning and the richness we have got from Beyond 20,000 Days are absolutely stunning."

Dr Lee Mathias, Chair, Counties Manukau Health

"I have learned to self-manage better. It has given me the know-how."

Patient

"By having a better understanding about my condition and the support I need to stay well, I can take charge of my own health."

Patient

"This project has been a great quality improvement lesson, learning how to correctly apply the quality improvement methodology and seeing test results which inform our decision making."

Diabetes Clinical Speciality Nurse

"One of the greatest benefits of the campaign has been to improve the understanding of and capacity to be engaged in multidisciplinary collaboratives. The multiple points of view, brought to a clinical situation, have broadened my perspective and ultimately made it easier to approach patients with openness to their perspective. I have also been inspired by the energy and enthusiasm of the collaborative members."

Beven Telfer, GP Liaison, Counties Manukau Health

"The Feet for Life project and onsite podiatrist in dialysis unit means I can have confidence that my concerned patients will be seen and treated appropriately and in a timely manner by podiatry. Monitoring patient progress in collaboration with an onsite podiatrist gives me a sense of job satisfaction by fulfilling the responsibility to provide good nursing care."

Babu Ramalingham, Dialysis Technician

"For me this project has been a fascinating learning curve – what we thought we were going to be doing, and the change package as it stands now, are very different. The best 'evidence-based practice' is useless if the people who we think need it do not see it as relevant to them. Our experience illustrates on the one hand that implementing evidence into 'real life' practice is challenging; BUT on the other hand the critical importance of using improvement science to manage any change process so as to be sure the change we are implementing is actually making the difference we were striving to make."

Dr David Codyre, Consultant Psychiatrist, Kia Kaha Programme/East Tamaki Healthcare

The Next Steps

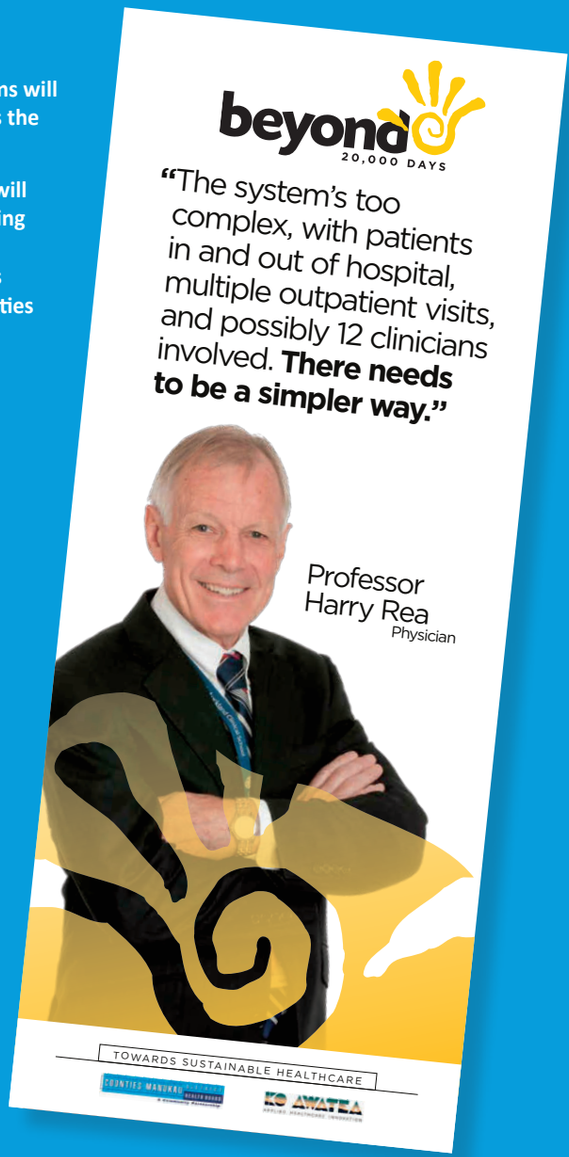
Auckland Blues mental skills coach Isa Nacewa presents Healthy Hearts patient Sid with a certificate of achievement

Over the next year 2014-2015, ten Beyond 20,000 Days collaborative teams will be supported to implement their changes permanently and spread across the health sector.

To build on the improvement work already achieved, the next campaign will be established to provide self-management support for 50,000 people living with long term conditions in Counties Manukau. The campaign is aligned and builds on the Very High Intensity Users (VHIU) and At Risk Individuals (ARI) programmes within the localities and priority programmes for Counties Manukau Health.

> ***"Our community deserves access to proven self-management support. The next campaign is about learning from and with our communities to develop innovative approaches that ensure that no one is left behind and patients are actively engaged in managing their own care."***

Professor Jonathon Gray,
Director, Ko Awatea



For further information about the
Beyond 20,000 Days campaign,
go to
www.koawatea.co.nz

KO AWATEA
HEALTH SYSTEM INNOVATION AND IMPROVEMENT

COUNTIES MANUKAU HEALTH