20,000 Days Campaign
From small revolutions to Big Change
“Last year I went to hospital 28 times!

By looking after myself and having a better understanding of my condition I’ve only been twice so far this year.”

George
Patient
From the CEO

Health systems worldwide are struggling with rising patient demand and Middlemore Hospital, which services a growing and ageing population, is no exception.

Counties Manukau Health’s solution is 20,000 Days – a campaign to reduce hospital demand by returning 20,000 well and healthy days to our community.

This whole of system approach has brought together 13 collaborative teams to build on existing improvement work and deliver care in a different way. Some patients are better treated at home or in the community and, by providing care in the most appropriate place, this has enabled Counties Manukau Health to continue delivering excellent specialist care to those who really need to be in hospital.

As you will read, the 20,000 Days Campaign has helped manage hospital demand and had a profound effect on the patients involved. By delivering care in a different way, patients are staying well - out of hospital, making healthy lifestyle choices and returning to work. The importance of these health and lifestyle gains for patients and their family/whaanau cannot be overstated. While our key indicators (such as length of stay and admissions) are coming down, it’s these results that really convey just how successful this campaign has been.

I’m extremely proud of everyone involved for all they have achieved over the past two years. Change in health seems to happen incredibly slowly but thanks to their passion and commitment, we are beginning to turn in a new and very promising direction.

This bodes well for the next phase of this campaign, Beyond 20,000 Days, which will further increase the quality of care we deliver, and continue to support our community so that they enjoy good health and wellbeing.

Geraint Martin, CEO, CM Health
“It’s important to support Programmes that encourage healthy lifestyles”

Brad Mika, Auckland Blues
On 2 July 2013 health professionals from across the sector, along with patients and family gathered to celebrate the success of the 20,000 Days Campaign.

And what a success it’s been with 23,060 bed days being given back to the people of Counties Manukau... days that would have otherwise be spent in Hospital.

It’s been an amazing journey, starting 2 years ago when health professionals from across the health sector gathered to seek solutions to the growing demands on our health system.

Fast forward to today and we have a collective team of clinicians, project managers, patients and their families, mobilised towards a common aim of keeping people well in the community and reducing the demands on our Hospital. It just shows you that with the right kind of skills, commitment and improvement science, small revolutions can result in big change.

While it was inspiring to hear the success stories from the collaborative teams it was humbling to hear how the campaign has made a difference to the lives of patients and their families.

Patients like Keni, who through the Better Breathing Programme can now mow his lawn without being out of breath and Alan who now looks forward to getting up in the morning and facing each day with renewed energy.

Paul, a participant on the Healthy Hearts programme is now enjoying a new lease of life and is motivated to do the things he couldn’t in the past, and Barbara said her mother wouldn’t have been able to spend quality time at home with her family if it wasn’t for the help of the VHIU (Very High Intensity User) programme.

It’s stories like these that really convey the enormous value in what we are doing.

Health professionals across the sector are also noticing a positive change with reduced demands on the hospital, fewer Dot Days (when the hospital is full) and improved partnerships between secondary, primary and community care.

“We seem to be moving away from a siloed way of working to a multi-disciplinary approach where health professionals, from different disciplines and specialties work together to improve patient care,” says Professor Harry Rea, Physician. “This active engagement is making a real difference.”

“It’s not over yet and, while we celebrate your success, we keep moving forward,” says Jonathon Gray, Director Ko Awatea. “What 20,000 Days has built is a reusable network of skilled, passionate and committed health professionals who have the knowledge, skills and methodology to bring about sustainable change across the health sector.”

Well done to everyone involved.
The 20,000 Days Campaign began with a launch in October 2011 and in May 2012, 13 Collaborative teams came together to test a range of interventions that would contribute to the Campaign’s aim of returning 20,000 well and healthy days to our community - so reducing hospital bed days by 20,000.

Through our journey we have achieved many key successes and learnt 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. This goal recognised that we needed to do things differently and all of the Collaborative Teams shared in this goal. In addition, each Collaborative had specific aims and change ideas that would all ultimately contribute 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 weekly 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.
   - The Campaign partnered with the Institute for Healthcare Improvement (IHI) to provide continuous learning opportunities and guidance for the Collaborative Teams.

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.

“The great thing we are starting to see is true collaboration across the entire health sector.”  
David Grayson, Clinical Lead, 20,000 Days Campaign
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 both the 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 the use of the methodology and promote collaboration between teams

- During the campaign there were a total of 6 days of Learning Sessions attended by 100-120 people! Significant expertise has been built up across the organisation in the improvement methodology

- The time 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 Counties Manukau context.

Teams are continuing to be supported to implement and spread their improvement initiatives. Four teams are returning to business as usual with the improvements and 8 teams are implementing changes permanently.

“It was useful to get together, share ideas and learn from the other Collaboratives. To have all that knowledge and skill in one room was invaluable.” Martin Chadwick, Director Allied Health
Sarah Candy, Pulmonary Rehabilitation Co-ordinator

The Better Breathing Collaborative is a comprehensive intervention for people with chronic respiratory conditions, located in the community and provided by an interdisciplinary team.

Our Aim
To keep people well in the community by increasing the number of places available in pulmonary rehabilitation programmes from 220 to 470 per year.

Key achievements
Accessible
- Community venue
- Assistance with transport
- Programme options

Responsive
- Cultural mindfulness
- Tailoring information to learning requests
- Exercise - taking good habits home

Sustainable
- Integrating with Primary Care
- Self management support
- Transition to community led groups

Since June 2012 the Better Breathing Collaborative has been able to offer 244 places, in Community Pulmonary Rehabilitation Programmes in Otara and Pukekohe.

“We have seen improvements in our patients exercise tolerance and health related quality of life measures,” says Sarah Candy, Pulmonary Rehabilitation Coordinator. “Patients have achieved their goals for the programme, reported being able to cope better at home and being motivated to continue to exercise.”

“We had an opportunity to develop a programme that was a little bit different.”

Sarah Candy, Pulmonary Rehabilitation Co-ordinator
Our Aim

Primary focus: heart failure diagnosis and management
To establish a detailed patient flow process for patients admitted with new/acute or established heart failure under the care of cardiology teams.

Key achievements
- Early identification and diagnosis of patients with heart failure through MDT (multi-disciplinary) ward rounds and hand held echos
- Implementation of an inpatient care bundle which includes patient education, advice, and an action plan
- A discharge telephone call regime was established
- A Medication Titration Clinic was established and an associated nurse credentialing document
- Trial of exercise/education programme for patients with heart failure shared with patients with lung problems (Better Breathing Collaborative)
- The Healthy Hearts collaborative has been extended to Phase 2 of the 20,000 Days Campaign, to establish and evaluate ‘fit for exercise’ clinics and Healthy Hearts community based programmes

What we are most proud of
Establishment of a multi-disciplinary pathway for patients with heart failure, across the continuum of admission, discharge, out-patient services and community.

"The Healthy Hearts programme has given me the confidence to start an exercise programme. Before I was too worried about my heart."
Participant

"Community based – it's where we need to go."
Kylie Beehre, Cardiology Specialty Nurse
Our Aim
To provide a Goal Discharge Date (GDD) for patients in surgical and medical wards in Middlemore Hospital.

Why?
Better planning and teamwork in working toward a Goal Discharge Date can reduce unnecessary delays, shorten length of stay and improve the patient journey.

Achievement
Embedding the concept of a Goal Discharge Date in four pilot wards (three medical and one surgical ward).

Next steps?
The team will implement GDD in the remaining medical and surgical wards and will develop a process for GDD at the Hospital ‘front door,’ prior to admission to the ward.

“*It was good for my partner to know when I would be coming home. It gave her the opportunity to prepare and plan for my discharge.*”
Patient

“It’s nice to have the whole team aware of the plan.”
Staff member
Our Aim
To increase the number of patients enrolled in the Very High Intensity User programme from 120 cases to 600 cases by July 2013. This may result in a reduction in unplanned presentations and admissions to Middlemore Hospital.

Key achievements:
- 503 patients were enrolled in VHIU Link programme by June 2013
- For VHIU enrolled patients from January 2012 - October 2012:
  - Emergency Care presentations have reduced from 718 to 398
  - Acute bed days have reduced from 2110 to 1382 (728 days in hospital avoided)
- The referral time from Emergency Care to a home visit has reduced from 22 days in May 2012 to 6 days in May 2013.

What next?
Following the success of the VHIU pilot project, a new permanent service is being implemented: the "VHIU Link Team". We aim to fully implement the permanent service by June 2014.

“Now that I have a better understanding of how to manage my condition at home, I feel well again”

Tereapii – VHIU participant
**Our Aim**

To reduce medication related readmissions by providing high risk adult medical and surgical patients with a medication management service at discharge and during the immediate post discharge period (7 days).

**Key achievements**

- Successful testing and development of a change package to deliver at discharge
- Prevention of 447 medication related errors - 134 errors were graded as having the potential to result in rehospitalisation
- Estimated financial savings for Counties Manukau Health = $291,696 per annum
- Following the success of the SMOOTH changes, we aim to implement the new medication management service at the time of patient discharge throughout Middlemore hospital.

“Ideally everyone should have SMOOTH discharge planning, as the patient gets a ‘warrant of fitness’ before they leave.”

Dr Suluama Fuimaono-Sapolu (House Officer)

‘SMOOTH aims to make medication management easier at home’
St John
(Managing low acuity patients in the community)

Aim
To increase the number of low acuity patients managed in a primary care setting - rather than transported to hospital by ambulance - from 5 patients a day to 10 from 1 July 2013.

Achievements
• These patients are being cared for in a more timely way at local Accident and Medical Centres (A&Ms).
• An average of 70 low acuity patients per month are now being managed at local A&Ms which would indicate 1300 fewer Middlemore Emergency Department presentations since January 2012.

This project is utilising POAC (Primary Options for Acute Care) funding to support an alternative to being taken and treated in the Hospital Emergency Department.

An average POAC transport to an A&M for treatment costs $84, compared to the ED cost for low acuity cases managed and discharged – assessed as being greater than $150.

Next Steps
We aim to expand this service to transporting low acuity patients to general practitioners, in addition to A&Ms.
Our Aim

• To work with the Clinical Specialist Nurse (CSN) to facilitate a reduction in the number of bed days used for patients with cellulitis by 5% by 1st July 2013

• Design and implement a care pathway for patients with a simple abscess requiring surgical incision and drainage

• Increase the number of patients transferred to TADU (Theatre Admission and Discharge Unit) both pre and post operatively from less than five to greater than 25 patients per month.

Key Achievements

• Appointment of a Clinical Specialist Nurse (CSN) for cellulitis and soft tissue infections to assist in the management of inpatients with cellulitis

• Development of the Cellulitis Care Pathway across primary and secondary care for both children and adults

• A reduction in the variation of antibiotics, used to treat cellulitis in hospital was achieved

• Development of the Abscess Pathway

• Increased use of TADU for general surgical patients with simple abscesses for incision and drainage. Patients are now going to TADU direct from Emergency Care, from home and from inpatient wards.

“Readmissions to Hospital can be avoided by seeing high risk patients early.”

Dr Vanessa Thornton
Clinical Director
Emergency Care
Enhanced Recovery After Surgery  
(hips & knees)  

(ERAS)

Our Aim
To reduce the average length of stay for hip and knee patients by 1 or 2 days, by 9am on 1st July 2013, by increasing the number of hip and knee joint replacement patients going through the ERAS pathway, improving patient satisfaction and decreasing readmissions.

Key Achievements
• Establishment of a multi-disciplinary ERAS pathway for patients undergoing primary hip and knee surgery across the continuum of pre-operative, intra-operative, and post-operative care.
• A multi-disciplinary approach from pre-admit for the management of patients who undergo primary hip and knee surgery.
• Key opportunities to prepare the patient both physically and mentally for the surgery, including setting of the expectations with regard to post operative goals and length of stay.

The data for average length of stay for hips and knees patients at MSC had an original baseline value of 5.52 days and was showing normal variation. A process shift appears to have occurred in April 2012, with 12 points below the baseline value, so new limits have been calculated with a new average of 4.86 days a reduction of 2/3 days per patient.
**Our Aim**
To increase the identification of delirium by completing a CAM (Confusion Assessment Measure) score every shift (3 times daily) on the first 5 days of admission for all patients over 65 years of age. To ensure compliance with completing the CAM the team reviewed the current tool and made it more ‘user friendly.’

**Results**
- A snapshot audit conducted in CM Health revealed that out of 19 patients, four patients (21%) were identified clinically as having delirium, and all four patients had some degree of intervention as per CAM scoring.
- 75% of patients with identified delirium had the diagnosis of delirium documented in the progress notes, however only 50% of the patients had the diagnosis included in the final discharge summary.
- The most common risk factors for delirium among patient population were neck of femur fracture, multisensory impairment, and existing cardiovascular disease. Further analysis also revealed that on average patients with ‘a delirium code’ stay 1.7 days longer than without delirium.

**Achievement**
The Delirium Pathway, which includes a CAM assessment and an intervention package is working well in Ward 4 (pilot ward). It has now been successfully rolled out to Ward 5.

The aim is to roll it out to the rest of the AT&R (Assessment, Treatment and Rehabilitation) wards over the next few months, before it is introduced to the rest of the Hospital.
Helping High Risk Patients

Our Aim
To identify high risk primary care patients and provide them with coordinated planning and management. By doing this, we aim to reduce unplanned hospital admissions and bed days by 10% (1625 bed days).

Progress
Phase 1 of the 20,000 Days Campaign allowed the team to scope requirements for the provision of a coordinated planned management set of interventions for high risk patients.

The priority focus was the development of a primary /secondary physician role based in the community, who would have the role of supporting general practitioners to improve the management of high risk medical patients with long-term conditions. This aspect of the project has now been incorporated into a larger initiative called “Localities” and continues within all four localities (Franklin, Eastern, Manukau and Otara-Mangere).

The Helping High Risk Patients collaborative has now joined Phase 2 of the campaign. The Phase 2 project, supported by the 20,000 Campaign team, will apply the improvement methodology around testing of the interventions in two selected practices in each of the four localities (i.e. 8 GP practices).

Hip Fracture Care

Our Aim
To reduce the average length of stay for >64 year old (and >54 year old Maori and Pacific) hip fracture patients from 22 days to 21 days by 30 June 2013.

Key achievements
• The average length of stay for patients with a hip fracture reduced from 22 to 21 days
• A 7-Day Rehabilitation service was implemented. This provides weekend physiotherapy for patients with fractured hips to enable them to continue their rehabilitation
• A “Barriers for Discharge Checklist” was implemented to identify and resolve potential barriers to discharge in a timely manner
• Patients who are deemed ready for transfer to rehabilitation are identified and transferred as soon as possible
• Patient Information pamphlets were created about the Acute Phase and the Rehabilitation Phase of recovery to inform patients and explain what to expect.
Agnes Marshall - SMOOTH (Safer Medicines Outcomes on Transfer Home)

Agnes was admitted to Hospital with a heart attack and history of severe coronary artery disease. Her past medical history includes short term memory loss, which has significant effects on her ability to cope with taking her medications regularly. Agnes is also taking warfarin – a medication which requires close monitoring to ensure patient safety. Agnes was unfortunately caught up in the middle of a change in funding agreements for community pharmacies, which essentially meant that her previous weekly blister packs were changed to monthly packs. This created a significant amount of confusion and unnecessary stress for Agnes as she juggled between several blister packs instead of just one pack a week.

“I was doubling up on my breakfast pills, and sometimes not taking my dinner pills. I was over dosing and couldn’t remember what I had taken.” Agnes

Agnes was referred to the SMOOTH team by one of the team pharmacists, who was concerned Agnes wasn’t coping with her medications at home. After identifying what was really troubling Agnes, the team reorganised her medications into weekly blister packs and ensured she had the financial support to cover the additional costs. In addition Agnes was given a medication card and some ideas for how she could do to remember to take her medications regularly.

On the team’s last visit Agnes was looking healthy and well. She explained how much better she was feeling and the difference the SMOOTH team had made to her life, by simply communicating with her primary care providers.

George Selwyn - VHIU (Very High Intensity User) Programme

Prior to VHIU’S involvement George presented to Emergency Care more than 28 times during 2011. VHIU enrolled George in November 2011 and in 2012 his presentations reduced to 4 during the entire year. When we spoke to George in 2012, he spoke about a new outlook on life which included giving up smoking, going to the gym and regularly seeing his GP.

As part of VHIU’s ongoing monitoring the team noted that George has been in hospital 4 times between May – June 2013. On further investigation it revealed these presentations were exacerbated by his social circumstances. For example George needs his rental property insulated as it is cold, damp and mouldy and needs continuous antibiotic cover over winter. Both of these needs are being actively followed up by the team.

George is now attending respiratory clinics and is now back doing part time work. This has ‘revolutionised’ George’s outlook on life and he has been able to plan financially for some of his personal goals.

For many patients like George, wrap around care, an understanding of their personal circumstances and continuous monitoring, is an ongoing feature of their preventative care.

‘a new outlook on life’

‘making a difference to my life’

it’s their stories that inspire US
**Paul – Healthy Hearts Programme**

Paul aged 53, was referred to the Healthy Hearts Programme from the outpatient cardiology clinic. He had a history of cardiomyopathy, increased weight, smoking, low mood and a family history of cardiac problems. Although employed, his symptoms and mood greatly impacted on his lifestyle and quality of life.

Following referral, he was assessed by the Healthy Hearts team and enrolled in the Healthy Hearts programme, a pilot study where people with heart failure exercised alongside people with lung problems in the community (Better Breathing). His participation was supported by his employers and Paul attended classes for 12 weeks. Not only were the team able to encourage his fitness and confidence to exercise, but were also able to answer his questions, promote a healthy lifestyle and help Paul manage his medicines.

Since he completed the 12 week programme, Paul has managed to sustain improvements in his exercise tolerance and health (health index questionnaires) at one and three months. He has also stopped smoking, reducing his cardiovascular risk further and made other positive lifestyle choices.

“It encourages me to be more happy and cheerful and that motivates me to do things that I otherwise wouldn’t do. It helps mentally as well as physically.” Paul

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**Ina Monga – VHUI Programme**

Ina presented to Middlemore Hospital in February 2012 and was seen by the VHUI team. During this time she was assessed by the Pharmacist and Social Worker with plans to follow-up Ina at home. Unfortunately Ina’s health was rapidly deteriorating and the family were struggling to manage her at home.

Home follow up involved educating Ina and her family about medications and strategies for dealing with Ina’s deteriorating health and the need for close family support. During a family meeting with the family, GP and VHUI the need for ACP (advanced care planning) was identified and completed.

Ina sadly passed away in December 2012. On talking with her family they expressed thanks to the VHUI team for all of their support, which allowed them to spend a quality last year with their mother with no visits to hospital and a good link up and oversight of care from her GP.

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**Keniseli Felagai – Better Breathing Programme**

Keni has COPD (Chronic obstructive pulmonary disease) and was referred to the community based pulmonary rehabilitation programme in June 2012. On assessment he was able to walk 420m and his main goal was to be able to mow his lawn.

Keni attended classes at the Otara Leisure Centre, which included one hour of individually prescribed exercise and a half hour education session, focusing on self management strategies. This programme was eight weeks in duration.

On completion Keni managed to walk 430m on a 6 minute walk test, but most noticeable was his ability to mow his entire lawn in one attempt, without needing to stop to catch his breath.

On discharge from the Better Breathing Programme, Keni was referred to the ‘Getting Started Programme’ which is offered by the Otara Health Charitable trust. This allowed Keni to continue in a formal exercise/education group.

Today Keni is well and has managed to stay in control of his chronic health condition. He has been discharged from the respiratory outpatient service and has not required hospitalisation since 2011. He continues to exercise regularly and still continues to mow his lawn.
“Regular reflection on how patients’ lives can be improved makes a huge difference for whānau and prevents hospital stays!”

Dr Richard Hulme
General Practitioner
“The success of the 20,000 Days Campaign is important for the wider health sector. What it demonstrates is if you make changes within the Hospital system and Primary Care, you can make better use of your beds, admit people to Hospital who need to be there, but also shift the care from secondary to primary care and make better use of our resources.”
Professor Gregor Coster, Chairman CM Health

“It’s about sustainability for the whole health sector.”
Peter Didsbury, ProCare Chairman and GP

“If we are going to work together to improve the health of our community, then everyone has a part to play.”
Margie Apa, Director Strategic Development

“20,000 Days shows really good collaboration by working across different teams.”
Pamela Hill, Clinical Specialty Nurse and Team Co-ordinator, VHIU

“We can’t stay where we are and 20,000 Days is the vanguard for moving forward.”
Professor Jonathon Gray, Director Ko Awatea

“Being able to have useful measures and collect data against those measures is useful to see what you are achieving and where you are going.”
Sanjoy Nand, Pharmacy Service Manager

“The campaign has given us the impetus to make the changes and be supported with the 20,000 Days Learning sessions and methodology.”
Ian Dodson, Service Manager Allied Health and Geriatrics

“We need the 20,000 Days Campaign, so people stay well at home and that hospitals are a place people come to when they are seriously ill.”
Jenni Coles, Director Hospital Services

“The 20,000 Days campaign was identified at an IHI Conference in America as one of the top 10 innovative programmes in healthcare today. So we are not just breaking new ground in Counties Manukau – we are also breaking new ground in New Zealand and overseas.”
Geraint Martin, CEO

“Before I felt hopeless, now I have hope”
Patient

“The long term effects of having something in the community is going to be incredible. It just makes it a lot easier for people to participate.”
Patient

“Without everyone coming together, it wouldn’t be possible to do all the things my mother was able to enjoy.”
Barbara – Family member of a Patient who was looked after by the VHIU Link Team.

“Over the course of the campaign, people have become more confident in their ability to test ideas and discover what will work for patients and improve quality care.”
Brandon Bennett, Senior Improvement Advisor
The great work that has been achieved during Phase 1 of the 20,000 Days Campaign will continue as collaborative teams implement the improvement changes permanently, return to business as usual with their improvement work or transition to Phase 2 to continue to develop further changes for improvement.

To build on the improvement work sixteen collaborative teams have been established in the next phase known as “Beyond, 20,000 Days.” These teams will continue to contribute to the Campaign’s aim of “giving back to our community 20,000 healthy and well days by reducing acute demands on our hospital.

**Collaborative Teams:**
- ACE (Acute Care for the Elderly)
- Environmental Cleaning
- Feet for Life
- Franklin Coordination Service
- Gout Busters
- Healthy Skin
- Healthy Hearts - Fit to Exercise
- Helping at Risk People
- Inpatient Care for People with Diabetes
- Kia Kaha, Manage Better, Feel Strong
- Medical Assessment
- Memory Team
- Mental Health Short Stay
- SMART (Safer Medical Admissions Review Team)
- Supporting Life After Stroke
- Well Managed Pain

“**The system’s too complex, with patients in and out of hospital, multiple outpatient visits, and possibly 12 clinicians involved. There needs to be a simpler way.”**

Professor Harry Rea
Physician
For further information about the 20,000 Days Campaign go to www.koawatea.co.nz