Manaaki Hauora-Supporting Wellness

Learning Session 2

Wednesday 24 June 2015

Folau I Lagi-Ma

(*Journey to Wellness)*

COUNTIES MANUKAU HEALTH

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HEALTH SYSTEM INNOVATION AND IMPROVEMENT

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Organisational "Buy in"

Aim:

To support 30 clients from Mangere Health Centre by the 18 December 2015 with long term health conditions to improve their overall EUROHIS Quality of life scale score by 2 points and have achieved at least 50 percent progress towards their self-identified health goals.

Buy In:

- Our team have a common interest in wanting to establish Occupational Therapy and Peer Support roles within primary care, and subsequently submitted a project proposal to Manaaki Hauora.
- OT and PSS values align with self-management principles
- Mangere Health Centre has identified they have a group of people with long term health conditions who are difficult to engage and have agreed with our approach and vision.

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Measures Summary

- EUROHIS Quality of Life measure – aiming to improve overall score by 2 points; this will reflect on how their health condition is having less of an impact on their daily life.

- Achieving at least 50% progress towards self-identified health goals measured by using a five point goal attainment scale.

  1_____2_____3_____4_____5

  0% 25% 50% 75% 100%

- Level of interference health condition has on daily life measured by using a five point scale reduces by at least one point.

  1_____2_____3_____4_____5

  Does not Slight Often Definite Severe

- Follow-up phone calls in 3 and 9 months time to identify whether changes made are sustainable.

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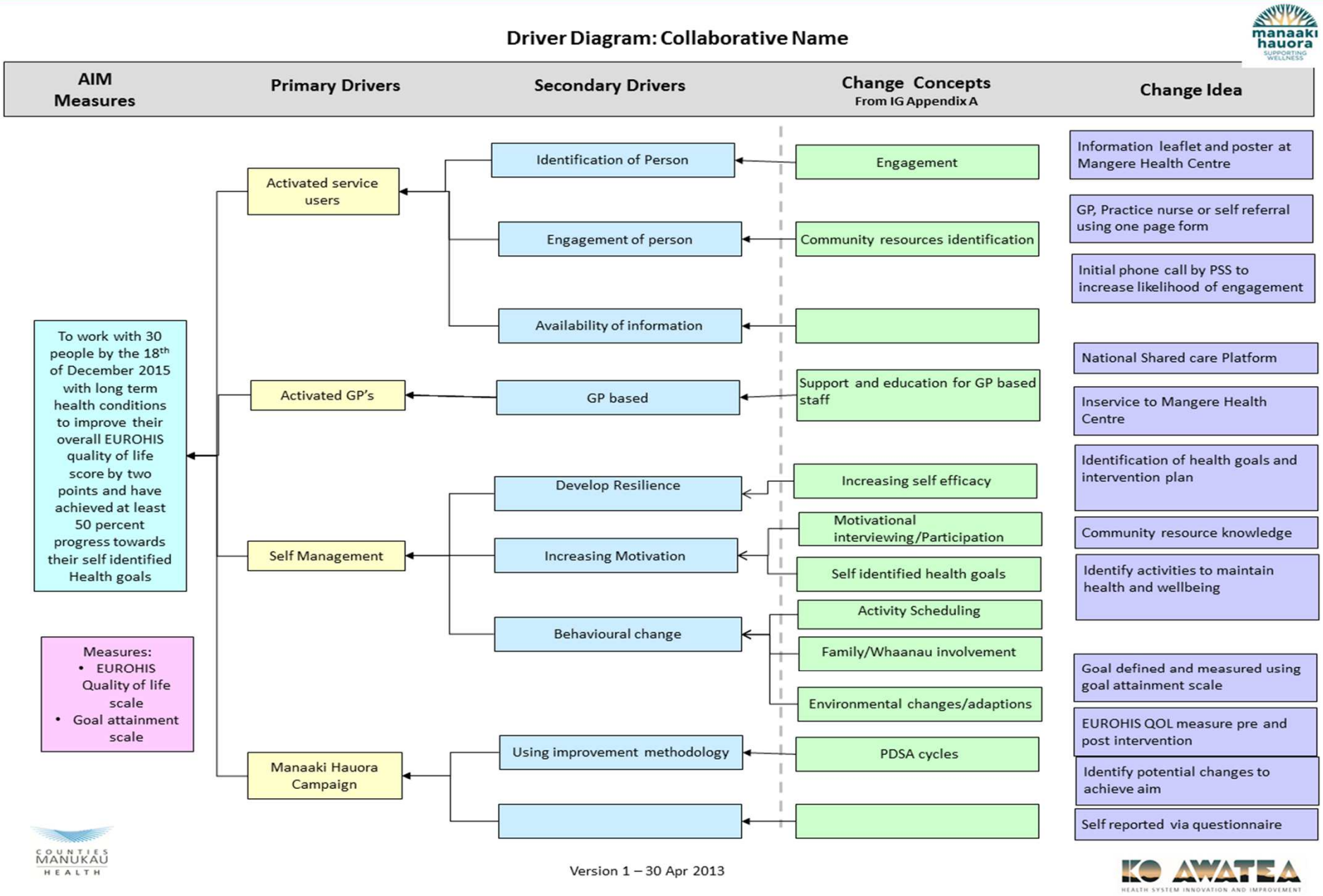
Driver Diagram



Change Ideas - Themes

- Present an in-service to Mangere Health Centre to increase understanding, buy-in and activate referrals from staff.
- Using the OT and PSS approach to increase motivation to make behavioral changes to self-manage long term health conditions.
- Referral process - self-referral or GP/Practice Nurse complete one page referral form during consult – person then books initial appointment at reception.
- Initial screening via telephone by PSS to engage, explain service and increase likelihood of attendance to appointments.
- Using the National Shared Care Platform to share goals, intervention plans and progress towards these.
- Offering 3 – 6 intervention sessions with OT and/or PSS to achieve progress towards self-identified health goals. Flexibility on location i.e. H/V or meeting in community (Education/ Health Promotion/Motivational Interviewing/Problem Solving).

Most successful PDSA cycles?

PDSA Title: Presentation about service, roles and benefits to Mangere Health Centre

- **Objective:** To activate Mangere Health Centre staff to refer to Folau I Lagi-Ma.
- **Change Idea:** Present an in-service to Mangere Health Centre about service, roles and benefits.
- **Question:** Will staff be more motivated to refer to service?
- **Prediction:** Yes, however some staff may remain reluctant and ambivalent due to caseloads and other services.
- **Measurement:** Feedback form asking whether there was an overlap with other services and whether they already had people in mind to refer to our service.
- We presented a 15 minute in-service to 10 team members (GPs and Practice Nurses) and asked them to complete a feedback form.
- 7/10 staff indicated they had people to refer to our service.
- 6/10 staff did not feel there was an overlap with other services already being offered at their practice. Two staff were unsure and one person felt there was an overlap with other services.

What Changes have you tested?

	Change Tested	Outcome
1	In-service about project, roles and benefits presented to Mangere Health Centre.	• 7/10 staff said they had people to refer to Folau I Lagi-Ma. • They requested to see the referral form and give feedback before this is finalised. • Start date for implementation of service is set for Thursday 9 July 2015. • The above suggests an overall increase in buy-in to our project.

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Highlights and Lowlights

Lowlights-

- We did not have any data prior to presenting in-service to indicate number of staff who would refer to Mangere Health Centre- However had received general feedback that suggested we were not doing different from anything they already were.
- Some delays in implementation as it has been difficult to engage with practice when they are working from a business model and generally time poor.

Highlights-

- In-service was well received and overall Mangere Health Centre seem to have a better understanding of what we were trying to achieve and our roles.
- As a result we have set a date to implement project (9th July).
- We are waiting feedback from Mangere Health Centre for our referral form to continue with the improvement process.

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Achievements to Date

- We have an agreed and clear aim for our project.
- A measurement plan has been devised for documenting and rating each person's quality of life score (pre and post intervention), progress towards attainment of self-identified health goals and the impact of each person's health conditions on their daily lives and activities.
- Each team member is aware of their role, responsibilities and expectations.

What has changed and what difference have the changes made?

- We have presented an in-service to Mangere Health Centre and have increased buy-in to our project.
- We have a start date for implementation.
- We have developed and almost finalised our resources such as the referral form and documentation templates, posters and pamphlets.

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Collaborative Team Members

Clinical Lead/s:	Shelley Kennedy
Sponsors:	Tess Ahern & Pete Watson
Project Manager:	Danni Farrell
Improvement Advisor:	Ian Hutchby
Expert Group: **Working group:**	Cassandra Laskey, Natalie Leger, Fionna Sutherland, Katrina Wahanui, Sue Cotton, Alofa Leilua, Rachel Forrest

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