Manaaki Hauora-Supporting Wellness

Project Review
Monday 7 March 2016

Folau I Lagi-Ma

(Journey to Wellness)

Collaborative Team Members

Clinical Lead: **Project Lead:**	Leigh McCabe Rachel Forrest
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, Krishna Narayan, Dr Tim Hou and Harriet Pauga

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Aim

To support 45 people from Mangere Health Centre with long term conditions to improve their overall EUROHIS Quality of Life scale score by 2 points and, have achieved at least a 2 point improvement in their occupational performance and satisfaction scores in COPM assessment by December 2016.

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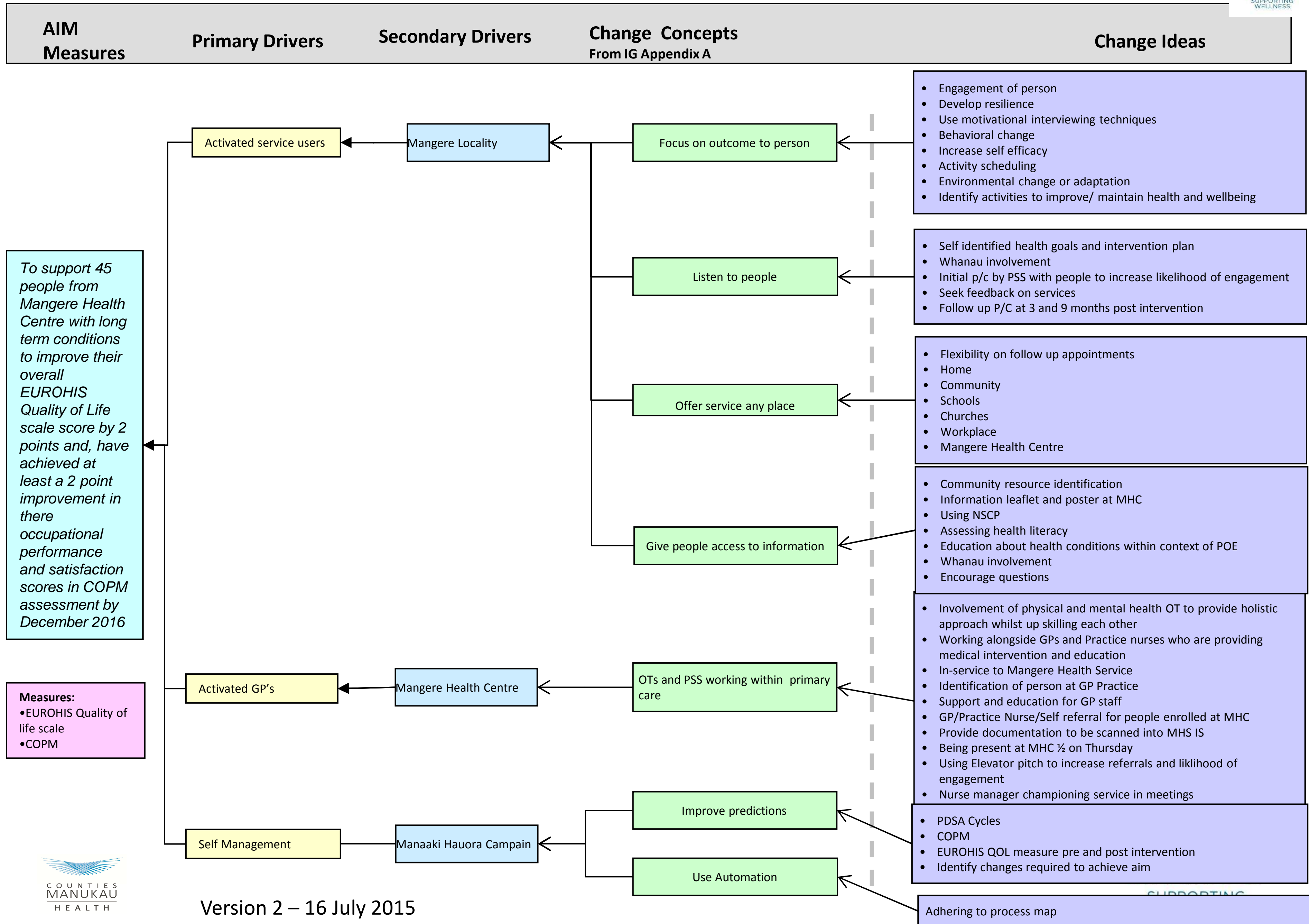
Driver Diagram: Folau I Lagi-Ma
AIM
Measures
Primary Drivers
Secondary Drivers
Change Concepts
From IG Appendix A
Change Ideas
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To support 45 people from Mangere Health Centre with long term conditions to improve their overall EUROHIS Quality of Life scale score by 2 points and, have achieved at least a 2 point improvement in there occupational performance and satisfaction scores in COPM assessment by December 2016
Measures:
•EUROHIS Quality of life scale
•COPM
Activated service users
Activated GP's
Self Management
Mangere Locality
Mangere Health Centre
Manaaki Hauora Campain
Focus on outcome to person
Listen to people
Offer service any place
Give people access to information
OTs and PSS working within primary care
Improve predictions
Use Automation
Engagement of person
Develop resilience
Use motivational interviewing techniques
Behavioral change
Increase self efficacy
Activity scheduling
Environmental change or adaptation
Identify activities to improve/ maintain health and wellbeing
Self identified health goals and intervention plan
Whanau involvement
Initial p/c by PSS with people to increase likelihood of engagement
Seek feedback on services
Follow up P/C at 3 and 9 months post intervention
Flexibility on follow up appointments
Home
Community
Schools
Churches
Workplace
Mangere Health Centre
Community resource identification
Information leaflet and poster at MHC
Using NSCP
Assessing health literacy
Education about health conditions within context of POE
Whanau involvement
Encourage questions
Involvement of physical and mental health OT to provide holistic approach whilst up skilling each other
Working alongside GPs and Practice nurses who are providing medical intervention and education
In-service to Mangere Health Service
Identification of person at GP Practice
Support and education for GP staff
GP/Practice Nurse/Self referral for people enrolled at MHC
Provide documentation to be scanned into MHS IS
Being present at MHC ½ on Thursday
Using Elevator pitch to increase referrals and liklihood of engagement
Nurse manager championing service in meetings
PDSA Cycles
COPM
EUROHIS QOL measure pre and post intervention
Identify changes required to achieve aim
Adhering to process map
COUNTIES MANUKAU HEALTH
Version 2 – 16 July 2015
HEALTH SYSTEM INNOVATION AND IMPROVEMENT

Service User Story

Seisilia* **(name changed)**

- 38 yo Samoan woman
- Lives in a HNZ home with her husband and extended family
- Multiple physical health issues
- Type II Respiratory failure
- OHS/OSA
- Morbidly obese (starting weight 240kg)
- Diabetes Type II
- COPD

Self identified health goal:

"In 6 weeks' time I would like to have reduced the barriers to weight loss and have lost a total of 8 kilograms."

Issues:

- Difficulty coping with stress and used food as coping strategy
- Experienced anxiety symptoms when leaving the house due to weight
- Experienced low mood and hopelessness at times due to current lifestyle
- Difficulty attending to ADL's - reliant on husband to assist with showering, dressing and cooking.
- Falls risk when entering/exiting the home due to 4 concrete steps with no railing
- Shower cubicle and toilet were also too small making it difficult for her to attend to her self-cares

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Interventions implemented:

- SMART goal setting and activity planning
- Using visual tools to increase motivation
- Teaching alternative coping strategies to eating when stressed
- Recommendation around housing modifications (ramp access, wet area shower, larger toilet space) and liaison with Housing NZ who approved alterations
- Education around nutrition to family
- Wellness planning
- Increasing engagement in meaningful activity
- Close liaison with GP and practice nurse who were providing education and follow up around diabetes management

Outcomes:

- Current weight 204kg
- Reports improved mood and self efficacy
- Sleeping well
- HBA1C has gone from 84 at start of intervention, now 53
- She has an improved ability to engage in meaningful occupation-

✓ attending to ADLS independently

✓ walking

✓ dancing at home

✓ aqua jogging for physical activity

(Evidence is that she has recently presented with Achilles tendonitis!)

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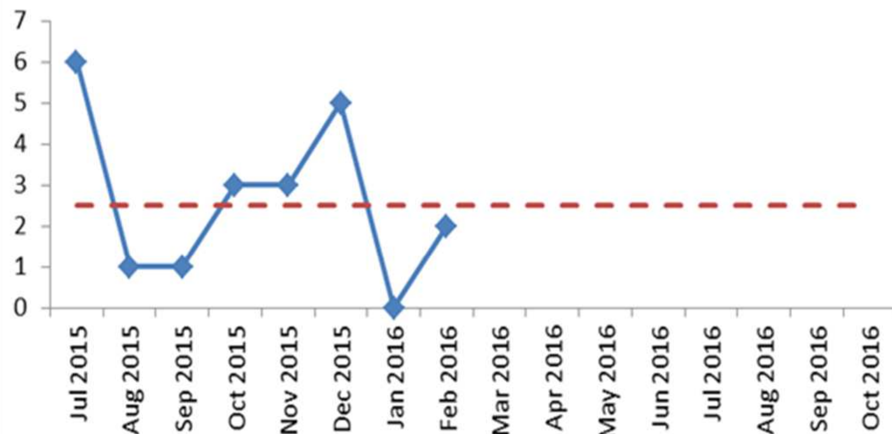
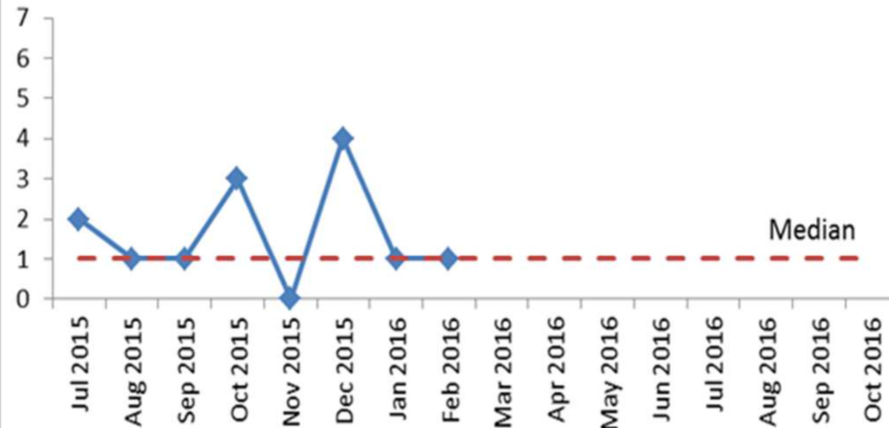
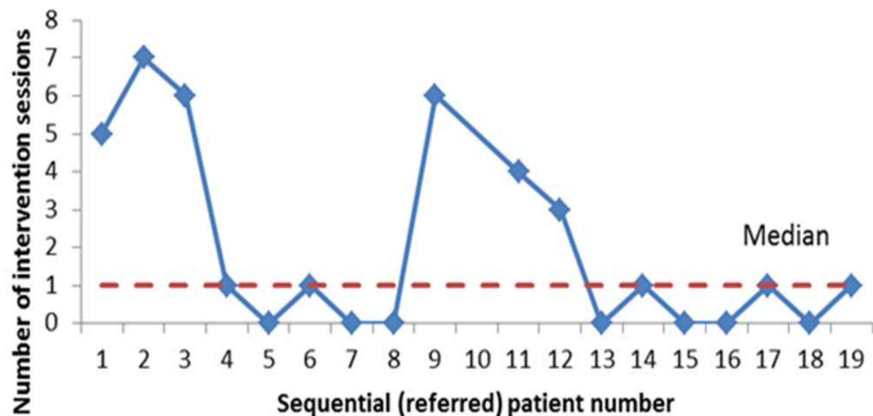
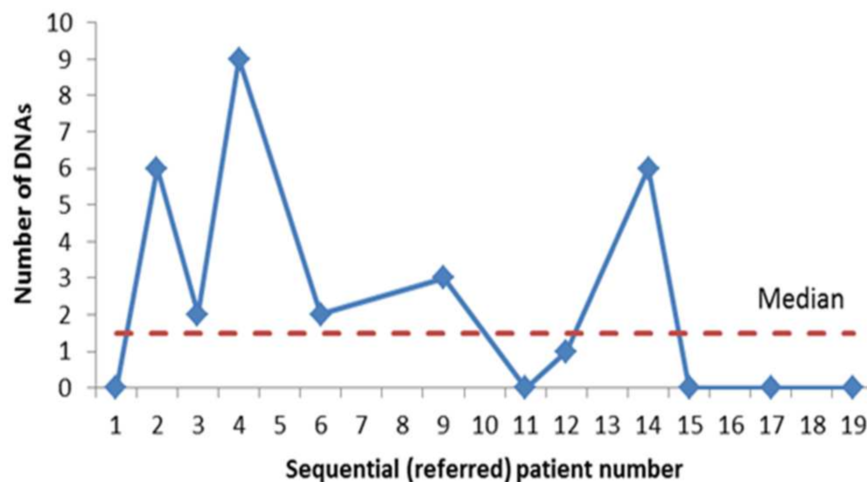
Dashboard

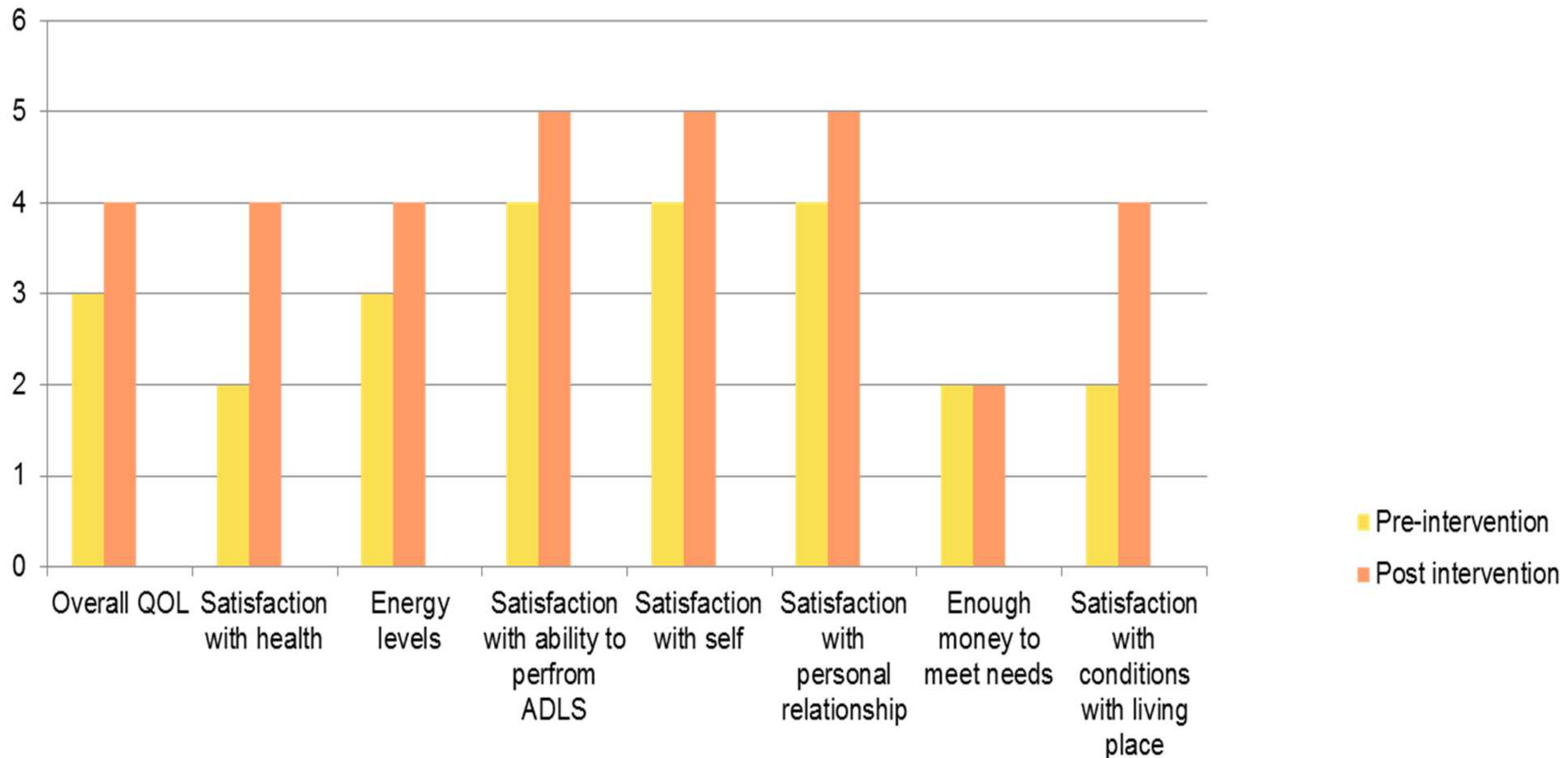






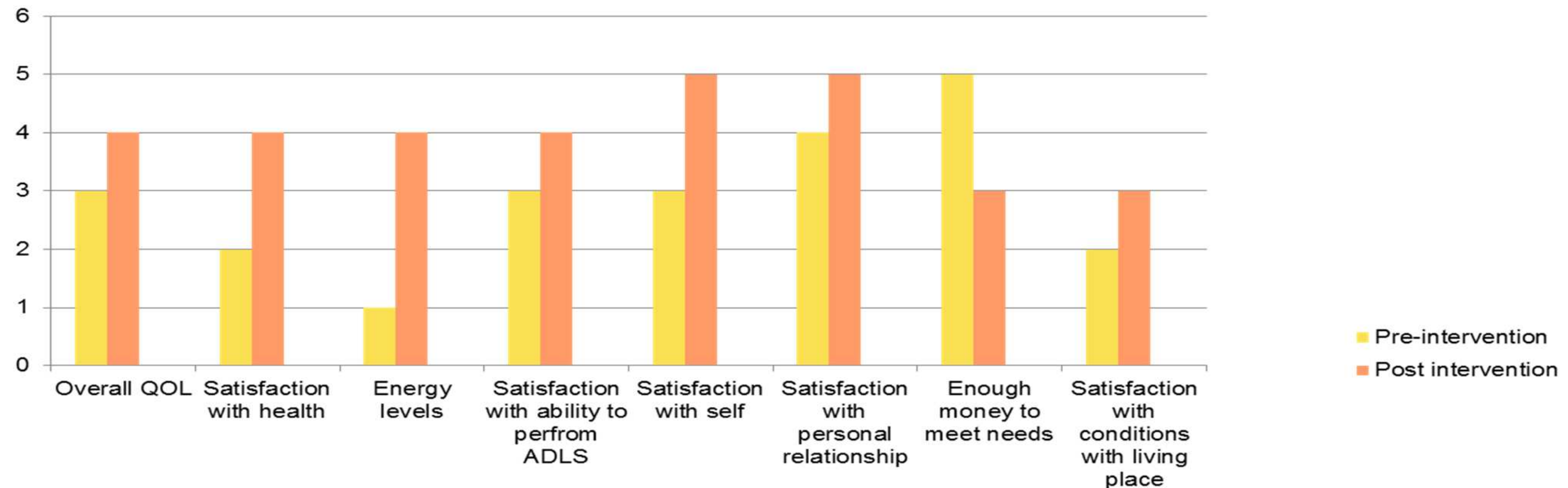


Dashboard



EUROHIS Quality of life measure
Person 1 (See service user story)

Dashboard

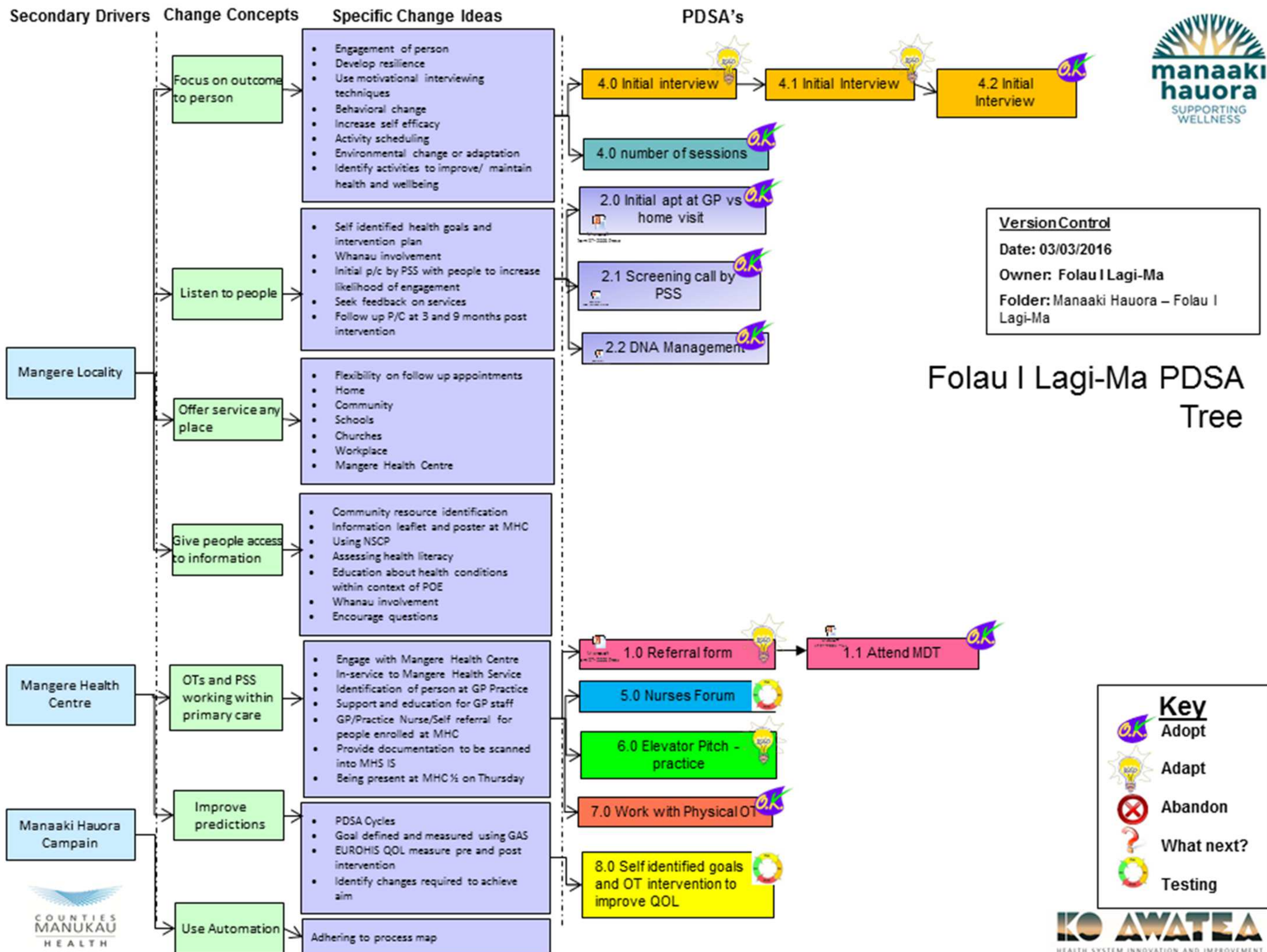


EUROHIS Quality of life measure
Person 2

Feedback from person:

- "Good experience
- Enjoyed it
- Getting low visual aids
- It helped and was a different approach
- Would recommend it
- I am more outgoing
- I sleep better"

Feedback from GP:
"Folau I Lagi-Ma provides practical support today to make tomorrow better."



Secondary Drivers
Change Concepts
Specific Change Ideas
PDSA's
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Mangere Health Centre
Manaaki Hauora Campain
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PDSA Cycles
Goal defined and measured using GAS
EUROHIS QOL measure pre and post intervention
Identify changes required to achieve aim
Adhering to process map
4.0 Initial interview
4.1 Initial Interview
4.2 Initial Interview
4.0 number of sessions
2.0 Initial apt at GP vs home visit
2.1 Screening call by PSS
2.2 DNA Management
1.0 Referral form
1.1 Attend MDT
5.0 Nurses Forum
6.0 Elevator Pitch - practice
7.0 Work with Physical OT
8.0 Self identified goals and OT intervention to improve QOL
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Version Control
Date: 03/03/2016
Owner: Folau I Lagi-Ma
Folder: Manaaki Hauora – Folau I Lagi-Ma
Folau I Lagi-Ma PDSA Tree
Key
Adopt
Adapt
Abandon
What next?
Testing
COUNTIES MANUKAU HEALTH
KO AWATEA
HEALTH SYSTEM INNOVATION AND IMPROVEMENT

Change Package

Secondary drivers (Theory of change)	Change concepts & change ideas tested	Evidence of Improvement
Referral process	• Referral form • Attending MDT • 1:1 liaison with GP and Practice Nurse	• Increased referral rate
Initial interview *Measurement (GAS to COPM),* *Elevator pitch,* *Incorporation of physical health OT (Tim's comments, number of patient's who have had joint input), Use of self identified goals and OT intervention to improve QOL (Eurohis score improvement)*	• Person and occupation centred initial interview to establish self identified health goals	• 5/7 patients who attended initial assessment agreed to have ongoing input (1 of the 2 who did not ,was more appropriate for social work input) • Qualitative feedback sought from one person during PDSA cycle was positive

PDSA’s/Key Learnings

- Need for Physical/Mental health OT combined input whilst both specialties up skill to provide holistic intervention
- CSW/Social role (service area gap i.e have referred one person on, provided some social/CSW intervention)
- OT/Nurse education is an effective combination to improve health literacy/create behavioural change (service user story is example of this)
- Need for face to face engagement with primary care (feedback from GP that this is beneficial - elevator pitch alone did not increase referral rate)
- Preventative care and creating less need for secondary services
- Upon reflection on data associated with engagement and DNA’s- need to go back and finish PDSA’s around relevant change ideas to improve attendance rate

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Risks and associated plan of action

Risks	Plan of action/Resolution
Documentation *(Practice does not want progress notes in their system but legal requirement for practitioners).*	• Not viable to pursue with practice at present (small scale project) • Created shared folder with password protection for clinical notes on W. Drive
No shared system across all services to enable efficient communication	• Push for all services to be using NSCP
Medical decline- changes aim/intervention, threatens accuracy of quantitative data i.e EUROHIS QOL measure	• Refocus goals i.e improving quality of life and promote meaningful occupation in palliative care, use quantitative date (evaluation form, service user story)
Uncertainty of future funding	• Develop a Business Case?

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Highlights

Feedback from Dr Tim Hou and Harriet Pauga (Practice Nurse), Mangere Health Centre:

- *Good feedback from patients*
- *Quick and reactive service*
- *Seen results and things getting done*
- *Utilizing other services in community*
- *Creating health pathway for patients*
- *Service provision is more integrated*

Feedback from recent service user and whanau member:

“I like that things are followed through”

“She always talks about you and how helpful your support has been”
(Sister of service user)

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The 4N Chart ®

	Present	Future
Positive	**Nuggets:** -From two people completed program thus far- both gave positive feedback and had improvements in their QOL score -Good communication and Collaboration between services -Offering both physical and mental health interventions to support people to achieve their goals	**Nice-ifs:** -Evaluation for 3 month and 6 months post intervention is developed to measure whether people are maintaining change -Elevator pitch increases referral and attendance rate -COPM is implemented as more accurate outcome measure then goal attainment scale.
Negative	**Niggles:** -No PSS input due to leave -Need to review process map as intervention sometimes requiring more then 6 sessions -Use of NSCP- difficulty keeping updated without turning it into “note writing”	**NoNos:** -Not focusing enough on PDSAs -Spending large amounts of time attempting to contact people for initial assessments

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