TEAMS STATUS

All 18 teams continue to progress project objectives; collecting baseline data, developing change ideas and concepts, and carrying out testing via PDSA cycles - refer Appendices A and B.

Team highlights:

Brandon Bennett: A number of teams met with Brandon Bennett (Senior Improvement Advisor) during his visit to New Zealand for the APAC forum. Whilst he did raise some concern over the lower than expected number of teams currently undertaking PDSA cycles and presenting data as a regular meeting occurrence, his general comments were positive and reflect that teams are moving, engaged and making progress. Overall feedback from collaborative teams show most found Brandon’s advice and input very valuable in helping to maintain focus on project aims and the direction towards the overall goal of the campaign.

BRITE (Building Responsiveness Into Teams’ Enterprises):

A ‘Community of Practice’ for the campaign has been developed using the Ning platform with links to the Health Navigator and Ko Awatea websites. The aim of this on-line or ‘virtual’ community is to enable the teams, topic experts and others to connect, share ideas and resources, and be updated with articles of interest etc.

The concept is based on social learning theory where people of all levels of experience and knowledge are facilitated to build a living curriculum for the community; the practice of a community is dynamic and involves learning on the part of everyone.

WILL – ENGAGEMENT ACTIVITIES

Masterclasses: Representatives from East Health Trust PHO (David Harrison, Parvin Kapila) and East Tamaki Health Care (Leona Didsbury, Gary Sutcliffe, Merle Samuels, Tasi Ahio and Ula Samau) joined forces to facilitate the Self-Management Education Masterclass held on Wednesday 7th October 2015.

A total of 22 participants from collaborative teams and CMH attended the session where in addition to empowering and informing those working with people experiencing long term conditions, discussions were also held relating to the ‘paradigm shift required to increase self-management opportunities’.

Mangere and Otara Localities Stakeholder Meeting: Experts, health & intersectoral service providers, and community leaders from the Otara and Mangere localities were invited to join the Otara-Mangere Locality Leadership Team in a workshop to explore ways of working together that
could open up new solutions to common issues. This initiative is supported by the campaign to assist with the development of local conditions so that quality self-management support services can be sustained in the short term, and thrive over time within both localities.

IDEAS/OPPORTUNITIES

APAC Forum

APAC Posters: Four posters were submitted to the recent APAC Forum held on 23-25 September at Auckland’s Sky City Convention Centre – refer Appendix C. Sustaining The Gains Across Campaigns submitted as a presentation of the work across all three campaigns won the award for High Performing Organisations.

<table>
<thead>
<tr>
<th>Collaborative</th>
<th>Poster Title</th>
<th>Theme (Category Entered)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owning My Gout</td>
<td>Owning My Gout – A Pharmacist-Led Collaborative Gout Management Service</td>
<td>Transformational Change</td>
</tr>
<tr>
<td>(Rebecca Lawn)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Save your Breath</td>
<td>Save your Breath: Reducing repeat admissions for patients with Chronic Obstructive Pulmonary Disease (COPD)</td>
<td>Values Based Healthcare</td>
</tr>
<tr>
<td>(Ai Sumihira, Larisa Cavit, Alison Howitt)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Hearts Exercise for Life</td>
<td>Taking the Plunge: Aqua Exercise for People With Obesity and Heart Failure</td>
<td>Co-Design</td>
</tr>
<tr>
<td>(Hannah Brown, Sarah Mooney, June Poole, Alison Howitt)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Campaign</td>
<td>Sustaining the gains across campaigns</td>
<td>High Performing Organisations</td>
</tr>
<tr>
<td>(Jacqueline Schmidt-Busby, Diana Dowdle, David Codyre)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

APAC Awards Finalists: The Ko Awatea International Excellence in Health Improvement Awards provided an opportunity to showcase excellence in health improvement and to celebrate best practice in delivering improved, high quality patient care; locally, nationally and internationally.

From the many local, national and international submissions received, three members of the Manaaki Hauora Supporting Wellness Campaign team were chosen as finalists - with Ian Hutchby (Improvement Advisor) selected as the joint winner for the Outstanding Leadership in Quality Improvement category.

<table>
<thead>
<tr>
<th>Team Member</th>
<th>Abstract Title</th>
<th>Category Entered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ian Hutchby (Improvement Advisor)</td>
<td>Building quality improvement capability through quiet leadership</td>
<td>Outstanding Leadership in Quality Improvement</td>
</tr>
<tr>
<td>Danielle Farrell (Project Manager)</td>
<td>ACE-ing it! Transforming acute care for the elderly</td>
<td>Developing a Flexible and Sustainable Workforce</td>
</tr>
</tbody>
</table>
EXECUTION – MEASURES/MONITOR/MODIFY

Measurement: The Manaaki Hauora Supporting Wellness Measurement Strategy has been developed - the final version is expected to be ready for circulation towards the end of October.

To date more than 15,000 individuals have been ‘reached’ (through face-to-face contact) through the work of the collaborative teams, ARI, or via the CMH self-management education programmes. The definitions for quality of social media and telephone reach continue with discussions surrounding how reach will be captured for the non-cohort projects.

Utilising the International Classification of Diseases, 10th Edition (ICD10) codes, a draft data-set report has been produced for the campaign that identifies CMH in-patients with selected long term conditions in the CMH population:

- Asthma
- Bronchiectasis
- Cardiovascular diseases (CVD)*
- Congestive heart failure (CHF)
- Chronic obstructive pulmonary disease (COPD)
- Diabetes
- Gout.

*Although CVD is included in data-set, it has been excluded from current report pending further coding by the CMH public health team.

Conclusions from the initial report indicate:

- There are a total of 32,743 records between fiscal year 2010 and 2015
- Most of patients are acute admission and discharged home
- Conditions are characterised by different age groups
- Overall, the Manukau locality has the highest admission rate
- Diabetes has the highest proportion of inpatients (30%)
- The highest number of bed days is attributed to CHF (30%), diabetes (28%) and COPD (24%) compared to Asthma (8%), Bronchiectasis (6%) and Gout (4%)
- Severity is based on the patient comorbidity level
- The admission rate of each group of LTC is based upon the total admissions for the same year. The admission type includes all types (Acute, Elective and Waiting list). For all admissions from LTC’s, the six conditions selected above represent 4% or 5% per year
IDENTIFIED RISKS
Nil to report.

COMMUNICATION

Learning Sessions 1 & 2 Video: The videos are available to view on the Ko Awatea website and available to view.

Resources:
Community of Practice:
http://manaakihauora.ning.com/

Files, videos and resources including presentations of the engagement session and learning sessions can be viewed on:
http://koawatea.co.nz/project/manaaki-hauora-supporting-wellness-campaign/

CAMPAIGN MILESTONES
Milestones remain on track. Refer Appendix D.

DASHBOARD OF MEASUREMENT
Refer Appendix E. The dashboard comprises:

- Total number of reaches
- Total number of people enrolled in campaign
- New SME leaders trained per month
- Cumulative SME leaders trained
- Monthly enrolments in SME programmes
- Total enrolments in ARI
- Cumulative total ARI patients
- Total monthly EC presentations
## Appendix A: Active projects

<table>
<thead>
<tr>
<th>No.</th>
<th>Project Name</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Advance Care Plans: Pasifika (ACP(P))</td>
<td>By 1 December 2016, increase the number of Advance Care Plans within Pacific communities by at least 100%.</td>
</tr>
<tr>
<td>2</td>
<td>Changing People’s Expectation (ChaPE)</td>
<td>To raise the expectation of people so that they are no longer relatively passive recipients of health care, but understand that they can and should be engaged, proactive participants in their health care decisions – motivated and informed.</td>
</tr>
<tr>
<td>3</td>
<td>Smoke free buffet</td>
<td>To increase the smoking cessation success rate for respiratory patients from 11% to 30% by June 2016</td>
</tr>
<tr>
<td>4</td>
<td>Exercise for life</td>
<td>By December 2015 100 healthy heart and better breathing participants will graduate with a self-management passport to health.</td>
</tr>
<tr>
<td>5</td>
<td>Healing at home</td>
<td>By 1 December 2016, we aim to ensure that at least x high service-reliant patients with long term conditions in the Manukau locality have a personal self-care plan</td>
</tr>
<tr>
<td>6</td>
<td>Helping You Helping Me</td>
<td>By the 31st of December 2015 there are 30 new organisations in the Franklin Community that have signed up to Healthpoint to enable the Franklin Community to access the whole health and social care spectrum to effectively participate in the management of their health conditions.</td>
</tr>
<tr>
<td>7</td>
<td>Huff and puff</td>
<td>We aim to design a reliable screening referral and intervention pathway, for 50 people who smoke aged &gt;35, in the Manukau Locality by December 2015.</td>
</tr>
<tr>
<td>8</td>
<td>Kia Kaha ki te hauora</td>
<td>To support 5000 East Tamaki Healthcare patients with long-term conditions in the Otara locality by 1 December 2016. We aim to engage, activate and connect patients, whaanau and GP clinics within a self-management wheel of support</td>
</tr>
<tr>
<td>9</td>
<td>Ola ilelei - WRAP</td>
<td>By Dec 2016, X number of Service Users will have participated in Living Well: WRAP Programme</td>
</tr>
<tr>
<td>10</td>
<td>Manukau Locality - Diabetes (ML-D)</td>
<td>To identify all those patients with poorly controlled diabetes (two HbA1c &gt;=110mmol/mol for two successive test within 12 months) and ensure each person has ashared management plan to achieve a clinically significant improvement in diabetes control (an average of ? 25mmol/mol) within 12 months. Work in progress</td>
</tr>
<tr>
<td>11</td>
<td>Keep on Moving</td>
<td>We aim to reliably apply a care and management process for the screening and management of joint pain for people newly diagnosed with a long term condition, starting with diabetes in x number of General Practices and wards by 1st July 2016. Work in progress</td>
</tr>
<tr>
<td>12</td>
<td>Owning my gout /&amp;/ Advancing Better Care</td>
<td>To ensure optimal management of gout by engaging ‘x’ patients to participate in gout self-care management via a new collaborative model of care delivered by ‘x’ community pharmacies by 1 Dec 2016</td>
</tr>
<tr>
<td>13</td>
<td>Pacific FME (FanauOla ME)</td>
<td>By 1 December, we aim to improve the health literacy of at least 90% of the people who participate in the Pacific FME programme by the end of each programme attended.</td>
</tr>
<tr>
<td>14</td>
<td>Folau I Lagi-Ma - Journey to Wellness</td>
<td>To work with 30 clients from Mangere Health Centre by the 18th of 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.</td>
</tr>
<tr>
<td>15</td>
<td>Save your breath</td>
<td>To reduce COPD readmissions in Ward 7 by 40% by Dec 2016</td>
</tr>
<tr>
<td>16</td>
<td>Self-Management by All (SeMBA)</td>
<td>To develop an on-line Level 1 course for all health care providers as an introduction to the principles of self management and how to apply this in their everyday practice so that all peope are approached from a self management perspetive and this is embedded in every interaction.</td>
</tr>
<tr>
<td>17</td>
<td>SMILE</td>
<td>x% of patients attending general practices will be offered self-management support by 1 December 2016. Work in progress</td>
</tr>
<tr>
<td>18</td>
<td>BRITE (Bldg Responsiveness into Teams Enterprises - Health Navigator)</td>
<td>team’ to facilitate the building of the required SMS infrastructure by working closely with Campaign Project Managers and Improvement Advisors in supporting the Collaborative Teams’ efforts. In progress.</td>
</tr>
</tbody>
</table>
A Pain In The Big Toe...

Owning My Gout – Developing a Collaborative Gout Management Model

Rebecca Lawn, Ko Awatea. Manaaki Hauora Campaign

Why Gout?

Gout is a chronic condition caused by excess monosodium urate crystal deposition in and around the joints, ligaments and tendons. It causes painful inflammation and swelling, limits function and impacts on quality of life. Gout can be prevented with medicines to reduce urate levels in the blood such as allopurinol. A reduction of the blood urate level to <0.36mmol/L improves clinical outcomes in those that have more than one flare-up per year. Self management support such as dietary advice can also be beneficial.

Local Context:

• There are over 15,000 people aged over 15 years old living with gout in the Counties Manukau Health (CMH) catchment area.
• Gout disproportionately affects more Maaori and Pacific people (2.3).
• CMH has the largest populations of Maaori and Pacific peoples among all the DHBs in New Zealand and these populations are predicted to grow.

Financial Burden of Disease:

• There was an average of 360 hospital admissions (average length of stay 4 days) per year to Middlemore due to gout (primary or secondary diagnosis) between 2004-2008.
• Total estimated cost of admissions due to gout was $1,152,000 NZD per year. This is based on one bed day costing $800. The costs associated with GP visits and pharmaceutical waste cannot be easily quantified, but would be in addition to the above figure.

Intervention And Methodology

The proposed collaborative model for management of gout is a Self Management support initiative and forms part of the Ko Awatea’s Manaaki Hauora Supporting Wellness campaign. The model will be developed using the Model for Improvement by the collaborative partners including:

• Patients
• General Practitioners and Practice Nurses
• Community Pharmacists
• Secondary care clinicians (Eg. Rheumatologist, Clinical Pharmacists)
• Other groups involved in an advisory capacity
• Primary Health Organisations
• Improvement Experts
• Non Government Organisations (Eg.. Arthritis New Zealand)

First Steps

Currently the majority of gout is managed in primary care. Despite the availability of evidence-based guidelines variation exists in the way it is managed. This project aims to investigate the impacts of a new collaborative model of care that enables patients with gout to self-manage their condition.

We got buy in by:

• Gathering data about gout prevalence and its cost to the organisation and presenting a proposal to develop a new model to improve management of gout in primary care to Rheumatologist, Pharmacy Service Manager and Ko Awatea’s Manaaki Hauora Campaign leadership
• Approaching Green Cross Health, who are associated with multiple pharmacies and GP practice’s and presenting the proposal to them. This resulted in them agreeing to collaborate on the project, potentially giving access to numerous GP’s and pharmacies to test the model
• Meeting with a GP, community pharmacist and practice nurses at pilot site and discussing the project and what it involves, and how it could benefit their patients

A pilot practice has been identified where a General Practice and Community pharmacy are co-located. Baseline data from the practice shows that 77% of urate tests done in the past 12 months in diagnosed gout patients were greater than 0.36 mmol/L. This confirms that there is an opportunity to improve gout management. Ethics approval has been gained for this project.

The Theory of Change

The aim of the project is that 90% of patients at “A” practice will be enabled to self manage their condition by December 2015.

Three primary drivers have been identified to facilitate this:

• Activated Clinicians
• Activated Patients
• A collaborative model of care

If this model proves successful there is potential to spread to other practices in 2016

Key PDSA’s

Small scale tests of change, using Plan Do Study Act (PDSA) cycles are underway. Key change ideas identified by the project team for initial testing include:

• Testing an internationally developed gout specific quality of life questionnaire for ease of understanding within the local population (completed). This questionnaire will be used to assess how gout affects quality of life before enrolling in the service and at 6 months.
• Testing the accuracy of a point of care testing device (completed), so the team can be confident in using one in this pilot. It is predicted that using the device will make monitoring urate more accessible for patients, and will allow allopurinol doses to be adjusted by the pharmacist according to a standing order. These 2 ideas will be tested in coming weeks.
• Testing and develop a gout fridge magnet containing key information for preventing and treating a gout attack.
• How Will We Know If It’s Working?

A dashboard of key measures has been developed to allow the team to check if changes implemented have resulted in an improvement in gout management. These include:

Outcome measures:

• Number of patients enrolled in the programme
• Monthly average urate level for cohort (aim to reduce to <0.36mmol/L)
• Number of emergency care presentations
• Number of presentations to General Practice for gout flares

Process measures:

• % of patients collecting prescriptions for urate lowering therapy
• % of patients who have had at least 1 urate check in past 12 months

Expected Outcomes

• Improved patient care through improved concordance with evidence-based gout guidelines
• Improved patient self-management through tailored support
• Improved patient safety through reviews and appropriate urate lowering therapy dosage
• Reduced GP and nurse work hours through optimised care and shifting work-load from GP clinics
• Pharmacists working at the top of practice scope
• Increased integration within primary care (General Practice and Community Pharmacy)
• Increased integration between primary and secondary care
• Increased health literacy across system, health care professionals and patients

First Steps

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Save Your Breath!
Reducing repeat admissions for patients with Chronic Obstructive Pulmonary Disease (COPD)

Context:
Chronic Obstructive Pulmonary Disease (COPD) is an umbrella term for obstructive lung disease, which is the fourth leading cause of death in New Zealand. It is a huge cost to the Health Sector, accounting for about 200,000 GP visits a year (4).

Problem Statement:
Since January 2013, there have been 2896 admissions at Counties Manukau Health (CMH) for patients with a primary diagnosis of COPD. Of these 1331 (46%) were repeat admissions within 12 months.

Challenges faced by the multi-disciplinary team (MDT):
• absence of literature on the MDT model of management
• ineffective communication
• inconsistent post-discharge support

Literature shows that patients' self-efficacy and participation are key to COPD management (1).

Strategy for Change:
The "Manaaki Hauora - Supporting Wellness" campaign uses the IHI's The Breakthrough Series Collaborative Model (2) and the Model for improvement (3) methodology to empower patients to self-manage their condition, and to reduce the risk of a repeat admission once discharged from the acute respiratory ward.

Save Your Breath’s Aim:
To reduce repeat admissions by 40% for patients with COPD discharged from the acute respiratory ward CMH by December 2016.

Understanding Repeat Admissions
A driver-diagram was created to identify the factors that influence a patient’s risk of a repeat admission.

Baseline Measures.
Overall the data exhibits common cause variation. However, there is a special cause signal from Jan-14 to Sep-14 which is greater than 6 points all increasing. This relates to seasonal factors i.e. going from a summer low to a winter high.

Thematic Analysis of Patient Questionnaire
"Hospital kicks me out too soon!"
Overall data exhibits common cause variation. However, there is a special cause signal from Jan-14 to Sep-14 which is greater than 6 points all increasing. This relates to seasonal factors i.e. going from a summer low to a winter high.

Results & Learnings:
We found that patients with COPD tend to have inconsistent support to help manage their complex health issues. From patients’ perspective, a better support network and good communication systems between healthcare professionals are vital to sustain a successful self-management intervention. This is also supported by the literature which suggests COPD self-management is dependent on a level of “buy in” from the patient (1).

Change Ideas & Next Steps
Save Your Breath’s next goal is to develop change ideas based on the results of the current state analysis. Our vision is that our change ideas will empower patients to take ownership of their health condition. These ideas would be developed in partnership with the patients.

Patients expressed that effective communication and understanding of COPD are essential to them being able to manage their condition better and for longer. Therefore the mode of delivery of the self-management intervention will be critical. The change ideas will also shift the current model of ‘working in silos’ to a more collaborative approach amongst the healthcare professionals.

We predict that this project will improve patient health outcomes and hence reduce repeat admissions to the acute respiratory ward at CMH. In future this collaborative model of care could potentially be applied to other chronic health conditions.

References:
A Weighty Concern

Obesity is associated with reduced life expectancy and is a major risk factor for many comorbidities including heart disease. While 30% of all NZ adults are obese (BMI >30), in Counties Manukau Health (CMH) 40% of adult residents are obese with over representation of Maori and Pacific adults compared with other district health boards (50% and 60% respectively).

Heart failure (HF) is a complex clinical syndrome characterised by shortness of breath, fatigue, reduced exercise tolerance and quality of life. It is one of the five main comorbidities at CM Health, HF and Obesity

The link between obesity and HF is well established, with little understood about how best this population can become more fit and healthy. Traditional exercise programmes are recommended for people with HF, however practical limitations restrict safe participation by those with significant obesity.

An alternative programme of exercise was explored and piloted by the Healthy Hearts team as a unique opportunity to address a weighty and heartfelt problem in South Auckland.

Community pool as alternative to gym

The ‘aqua exercise’ concept was explored to meet the unique needs of people with obesity and HF:

- Supervised exercise programmes are recommended in both HF and obesity management. Traditional gyms however are not ideal for people with obesity due to equipment weight restrictions and comfort. A subgroup of potential Healthy Hearts participants were identified as ideal for aqua exercise.

Literature review

Aquatic exercise for people with stable HF has been shown to:
- Improve exercise capacity/tolerance
- Be well tolerated, and safe
- Provide safe and effective alternative for people unable to participate in (traditional) land based exercise programmes
- Result in improved health outcomes

Meeting the needs of consumers

Participants co-designed ‘Aqua Fit’ programme through:
- Focus group to determine participant interest & needs
- Two people/two session/two week trial
- Eight session fixed capacity programme piloted & developed
- Informal group discussions throughout sessions/programme
- Feedback from 11 interviews and written survey responses

Linking with health strategies

Healthy Hearts ‘Aqua Fit’ was instigated to align with:
- NZ Ministry of Health Better, Sooner, More Conveniant approach to health care in the community
- CM Health’s shift towards a localities model; vision to work in partnership with its communities; and focus on innovation
- Auckland Sport and Recreation Strategic Plan 2014-24
- Aucklanders: More Active, More often

Institute for Healthcare Improvement (IHI) methodology

- Programme design and processes evolved through continual small testing and refinement of each component

Launching Healthy Hearts ‘Aqua Fit’

The Programme

- Co-designed with consumers and stakeholders. Launched as a pilot programme in May 2015
- Funded by fly Awaeta’s Beyond 20,000 Days campaign at CMH
- Referrals from CM Health Cardiology team
- Inclusion criteria included stable HF, minimum weight of 140kg, ability to enter/exit pool independently via a ramp
- 14 people assessed. Nine people enrolled in the pilot programme; five people provided with individualised home programme.

The People

- Staff – exercise led by experienced cardiorespiratory physiotherapists trained in aqua exercise; education led by cardiology nurse practitioner. Willing to challenge ‘traditional’ practice culture and keen to innovate
- Participants – people with HF and obesity who wanted to improve their fitness and health through exercise

Healthy Hearts ‘Aqua Fit’ Participants Profile:

- Age: Mean = 52.2, Range = 30 – 74 years
- Ethnicity: 4 Maori, 4 Pacific Island, 1 European
- Weight: Mean = 165kg, Range = 141 – 217kg
- BMI: Mean = 52.2, Range = 44 – 62.7
- Work: Employed, … Not employed
- Distance walked: Mean = 380 – 407m
- Comorbidities: included Osteoarthritis, Sleep Apnoea, Gout, Diabetes

A Promising First ‘Plunge’

Anecdotal evidence indicates that Healthy Hearts ‘Aqua Fit’ was well received, with reports of gradual weight loss, increased confidence and motivation to exercise, and other lifestyle modification changes eg: healthier eating choices and improved medication adherence. Participants attended 76% of sessions offered.

Additional themes included benefits of improved care co-ordination, positive ‘team’ environment, accessible facilities and peer encouragement.

Success of the pilot programme was influenced by: thorough planning and evaluating safety processes including staff credentialing, cultural awareness, logistics i.e. negotiation of pool use, equipment purchase i.e. specialised evacuation board with high weight capacity; liaison with stakeholders, and continual quality improvement.

Participant feedback

- Appreciated: access to health professionals, lively and welcoming environment, variety of exercises and coaching in pool.
- Personal goals were met eg being able to walk dog further, mow lawn without breaks, able to exercise in pool independently

Staff feedback

- Improved staff satisfaction with opportunity to positively engage with people otherwise uninvolved with regular physical activity

Stakeholders feedback

- Supported use of community facilities to link with council values.
- Considered programme worth pursuing as benefit witnessed

Challenges encountered

- Unforeseen pool closures due to maintenance (6 sessions)
- Participant availability for re-assessments (limiting data analysis)
- Time lag between referral and start of programme – some referrals longer in progress
- Limited options for ongoing exercise guidance/support post programme

“Aqua Fit’ in the Future

A second pilot of Healthy Hearts ‘Aqua Fit’ has been funded; commencing September 2015. On completion, further and more detailed evaluation is planned including post-programme:
- Evening reassessment clinics
- Programme viability and capacity, potential participant volume, pool availability
- Optimal programme duration and session format and frequency
- Adaptability to other community pool types and locations

The unique nature of Healthy Hearts ‘Aqua Fit’ programme lends itself to formal research, with potential for multi-centre collaboration.

Options for transition to independent exercise on completion of the supervised programme are currently under review with potential options of, for example, a Healthy Hearts run maintenance group.

Healthy Hearts Aqua Fit, framed by both local and national strategy, offers people with HF and obesity an opportunity to participate in and shape an evidence-based, local and fun exercise programme. Ongoing funding will be sought to continue and expand… allowing more people to take the plunge…!
Reducing hospital demand... ...Holding the gains...

THE PROBLEM: The increasing demand on hospital resources across Counties Manukau highlighted the need for enduring improvements in ways that kept communities healthy.

THE INTERVENTION: "20,000 Days Campaign" launched in October 2011. 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 by reducing hospital bed days by 20,000.

THE METHODOLOGY: Applying the Institute for Healthcare Improvement Breakthrough Series methodology, teams were brought together to use The Model for Improvement to develop independent change packages that would support the implementation of best practice.

The campaigns also engaged with individuals, families/whaanau and organisations across the health sector to inform decision making.

By focusing only on one organisation (CMDHB), the initial campaign managed predicted hospital demand, and enabled the transition from one Campaign into another.

Both Campaigns were designed to encourage CMDHB staff to develop capability in quality improvement.

THE RESULTS: Average Length Of Stay (ALOS) is exhibiting special cause variation as shown by the change in limits and centre line. All of the last 19 months have had a lower ALOS than historically seen.

"There needs to be a simpler way" - "The system is too complex, with patients in and out of hospital, multiple outpatient visits, ...22 clinicians involved."

Professor Harry Rai; Physician

"Last year I went to hospital 28 times" - "By looking after myself and having a better understanding of my condition... I've only been better so far this year!"

George Patient

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

Shannon and Gina Wetere; Patient and Whaanau

THE CONTINUING EFFECTS OF CHANGE:

- Patient/family/whaanau outcomes & experiences
- Engagement across the health sector

Improved:
- Networks and relationships
- Financial savings through days saved
- Reporting on whole system measures
- Evidence informed decision making

Reduced:
- Length of stay
- Re-admissions

Increased:
- Quality Improvement capability across CMDHB

SUSTAINING THE GAINS ACROSS CAMPAIGNS

Jacqueline Schmidt-Busby; Diana Dowdle; David Codyre

(The image contains a page with text and graphics related to the above content.)
## Appendix C: Manaaki Hauora – Supporting Wellness Campaign Milestones

<table>
<thead>
<tr>
<th>Collaborative development, recruitment and engagement</th>
<th>Campaign Milestones</th>
<th>Completion Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Leadership Team (ELT) approval</td>
<td>17 June 2014</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Expert group engagement</td>
<td>July - September 2014</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Leadership group identified</td>
<td>22 September 2014</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Engagement event</td>
<td>24 September 2014</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Campaign project team established</td>
<td>29 September 2014</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Request for Collaborative team proposals</td>
<td>2 October 2014</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Collaborative teams’ proposals due</td>
<td>24 October 2014</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Expert group review proposals</td>
<td>28 October 2014</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Confirmation of collaborative teams</td>
<td>31 October 2014</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

### Phase One
The collaborative – iterative cycles of learning, improving and implementing change

| Learning Session Zero                                  | 21 November 2014 Ko Awatea | ✓ |
| Coaching and support to teams                          | ongoing                    | ✓ |
| First Learning Session                                 | 1 April 2015 Ko Awatea     | ✓ |
| Master classes for topics/ improvement tools           | monthly                    | ✓ |
| Brandon Bennett visit                                  | 6-15 May 2015 23 June – 2 July | ✓ |
| Second Learning Session                                | 24 June 2015 Ko Awatea     | ✓ |
| 4th APAC Forum                                         | 23-25 September 2015       | ✓ |

### Phase Two
Scale up & Spread across Sector

| Third Learning Session                                 | 10 November 2015 Ko Awatea | |
| Coaching and support for holding the gains             | January – November 2016    | |
| How to guides’ completed                               | February 2016               | |
| Goal Achieved                                          | 1 December 2016             | |
## Appendix C: Manaaki Hauora – Supporting Wellness Campaign Milestones

<table>
<thead>
<tr>
<th>Campaign Milestones</th>
<th>Completion Date</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborative development, recruitment and engagement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Executive Leadership Team (ELT) approval</td>
<td>17 June 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Expert group engagement</td>
<td>July - September 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Leadership group identified</td>
<td>22 September 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Engagement event</td>
<td>24 September 2014</td>
<td>✓</td>
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<tr>
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<td>31 October 2014</td>
<td>✓</td>
</tr>
<tr>
<td>Phase One</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The collaborative – iterative cycles of learning, improving and implementing change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning Session Zero</td>
<td>21 November 2014</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Ko Awatea</td>
<td></td>
</tr>
<tr>
<td>Coaching and support to teams</td>
<td>ongoing</td>
<td>✓</td>
</tr>
<tr>
<td>First Learning Session</td>
<td>1 April 2015</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Ko Awatea</td>
<td></td>
</tr>
<tr>
<td>Master classes for topics/ improvement tools</td>
<td>monthly</td>
<td>✓</td>
</tr>
<tr>
<td>Brandon Bennett visit</td>
<td>6-15 May 2015</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>23 June – 2 July</td>
<td></td>
</tr>
<tr>
<td>Second Learning Session</td>
<td>24 June 2015</td>
<td>✓</td>
</tr>
<tr>
<td></td>
<td>Ko Awatea</td>
<td></td>
</tr>
<tr>
<td>4th APAC Forum</td>
<td>23-25 September 2015</td>
<td>✓</td>
</tr>
<tr>
<td>Phase Two</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Scale up &amp; Spread across Sector</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third Learning Session</td>
<td>10 November 2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ko Awatea</td>
<td></td>
</tr>
<tr>
<td>Coaching and support for holding the gains</td>
<td>January – November 2016</td>
<td></td>
</tr>
<tr>
<td>How to guides’ completed</td>
<td>February 2016</td>
<td></td>
</tr>
<tr>
<td>Goal Achieved</td>
<td>1 December 2016</td>
<td></td>
</tr>
</tbody>
</table>
Target 50,000 by December 2016

For those practices that went ‘live’ with the ARI programme in the first quarter (July – Sept 2014), June 2015 represented the final month for them to achieve the 3% enrolment target and therefore become eligible for the outcomes payment hence the increased effort to enrol as many people as possible leading up to this date.
<table>
<thead>
<tr>
<th>Total number of reaches</th>
<th>Total number of people enrolled in Manaaki Hauora campaign programmes</th>
<th>New SME leaders trained per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sum of the number of people enrolled in Manaaki Hauora campaign programmes and the enrolments in SME programmes</td>
<td>Running total of the number of patients recorded by the project teams</td>
<td>The number of new SME leaders trained Source SME quarterly report</td>
</tr>
<tr>
<td>Source - Calculated</td>
<td>Source Manaaki Hauora project monthly report</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cumulative SME leaders trained</th>
<th>Monthly enrolments in SME programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Running total of the number of SME leaders trained</td>
<td>The number of patients enrolled in SME programmes</td>
</tr>
<tr>
<td>Source SME quarterly report</td>
<td>Source SME quarterly report</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New enrolments in ARI</th>
<th>Cumulative Total ARI patients</th>
<th>Total Monthly EC Presentations</th>
</tr>
</thead>
<tbody>
<tr>
<td>The difference between each consecutive months’ total enrolments in the At Risk Individuals programme</td>
<td>The total number of patients enrolled in At Risk Individuals programme</td>
<td>The total number of patients (all ages) who present to Emergency Care per month – source daily pass/fail report with volumes and figures for the 6hours can be ours campaign</td>
</tr>
<tr>
<td>Source ARI monthly report</td>
<td>Source ARI monthly report</td>
<td></td>
</tr>
</tbody>
</table>

**Manaaki Hauora Campaign Dashboard definitions**