APAC FORUM ON QUALITY IMPROVEMENT IN HEALTHCARE
ANNUAL CONFERENCE

AUCKLAND, SEPTEMBER 2013

REPORT

Firstly, I would like to thank the Health Quality & Safety Commission for sponsoring me to attend this event.

The theme of this year's conference was 'Innovate Today: Design Tomorrow'. I was privileged to attend the following sessions.

Healthcare and equity: Why it matters and how to achieve it

This workshop focused on:

- recognising the factors that lead to equity in health care
- understanding the Whānau Ora approach and its relevance to health care for Māori
- appreciating the opportunities for medical practitioners to work within a Whānau Ora framework
- contributing to whānau capability-building by increasing health literacy within whānau and assisting colleagues in Whānau Ora provider collectives.

Professor Sir Mason Durie presented 'Whānau Ora: Flourishing Families'. Professor Durie described 'whānau' as a group with common interest and/or a group that shares a common genealogy, and 'ora' as safety, life and wellness. He talked about Māori families comprising two generational households.

Among health disparities for Māori are disorders characterised by co-morbidities and multiple social and economic disadvantages.

Key to the success of Whānau Ora are:

- establishing a strong relationship between health and family
- bringing multiple government agencies together
- the health sector being well placed to make major contributions to the goals of Whānau Ora.

A taskforce on whānau-centred initiatives was commissioned in 2009–10 and terms of reference developed. The Minister for Whānau Ora, Hon Tariana Turia, led and championed this process. Of the six recommendations made, one that was not adopted was having an independent trust reporting to the Whānau Ora Minister. Instead, the Government set up a governance group. While the group has been relatively successful, some aspects have been challenging, particularly getting a whole-of-government commitment to Whānau Ora principles. Phase 2 of Whānau Ora will include moving towards the original recommendation to establish an independent trust.

Whānau Ora has two goals:

- to deal with the impact of disadvantage
- to build strong capabilities within whānau – wide-ranging and holistic; whole-of-life and living.

The three main features of Whānau Ora are:

1. whānau-centred services
2. whānau integration, innovation and enterprise
3. evidence-based progression; indicators that measure outcomes: best results for whānau.

Provider collectives are well established with regard to whānau-centred services, particularly those between health and social services. To date, 72 whānau navigators have been appointed, people skilled in ascertaining whānau aspirations, mediating whānau tensions and brokering opportunities for whānau with social and education agencies.

After three years, we are starting to see clusters developing among a number of independent providers. A relative lack of capability development factors have been identified, along with challenges for provider clusters, such as how to collaborate without losing identity (ie, developing the alliance model).

Professor Durie spoke of the Whānau Integration, Innovation, Enterprise (WIIE) fund that assists whānau-led development. The fund aims to build whānau capability and strengthen connections. Some examples of use of the fund include health gains, heritage and collective planning.

A broad set of outcome measures are described in the following domains:

1. healthy whānau lifestyles
2. full whānau participation in society, education, economy
3. confident whānau participation in the Māori world
4. whānau economic security
5. whānau cohesion and realisation of whānau aspirations.

Some gains have already been made, for example, increased engagement with vulnerable whānau, improved relationships with whānau, whānau goal-setting, prioritisation of needs, and completing courses and training.

The main challenge is: ‘How can whānau who are languishing become whānau who are flourishing?’ Another challenge is the integration of government contracts (ie, multiple contracts from a range of Ministries).

Several aspects of the health sector have implications for Whānau Ora:

- clinical implications: a whānau-centred approach – health diagnoses AND whānau circumstances; clinical records written for patients and whānau; assessments and case notes form part of whānau health literacy programme; recognising and encouraging potential as well as treating disorders and seizing opportunities for health promotion

- promotion of health literacy: disease, medicines, service and sector literacy; programmes designed for whānau incorporating an understanding of health and management of health and whānau, eg ‘Health Literacy: A Prescription to End Confusion’.
- service implications: linkage, providing medical advice to Whānau Ora providers and assisting with development of outcome measures
- sector implications: promotion of inter-sector collaboration, improving alignments with the health sector, integration of mental health with general health and liaising with regional leadership groups.

Overall, I learned more about Whānau Ora and its implications and opportunities for the health sector; it was a workshop well worth attending.

Keynote speaker: Dan Heath, senior fellow at Duke University’s CASE Center and co-author of *Switch: How to change things when change is hard*

Dan was a brilliant speaker who engaged with his audience right from the start. He opened with the question: ‘What is the world’s biggest challenge?’ Answer: ‘Kids!’

Dan used the analogy of the elephant and its rider to demonstrate the connection between the brain and the emotional factor (and other psychological factors). Dan talked about our tendency to get lost in analysis; to over-complicate things. He referred to a three-part framework for change:

1. direct the rider
2. motivate the elephant
3. shape the path.

The first part involves finding the ‘bright spots’: what is working well and how do we clone it? Dan used the expression ‘TBU’ – ‘True but Useless’. He asked, ‘Are we spending enough time investigating the bright spots?’ He referred to the Counties Manukau DHB initiative ‘Enhanced Recovery after Surgery’ as an example of initiative, spotting a bright spot in Denmark and cloning it. Dan talked about the Kaiser Institution as an outstanding success story due to it looking inwardly as an organisation as well as outward. He quoted the multiple prescribed opioid usage initiative.

The #1 mistake of leading change is to try and motivate people with information/data, Dan said. Information is rarely enough to spark change. ‘See, Feel, Change’. Dan talked about a ‘Lifesaver Award’ for staff who motivate people to do something that detects a life-threatening condition (eg, breast cancer) and asking the patient, ‘What matters to you?’

In terms of ‘shaping the path’, Dan talked about the Stanford University example of ‘Saints and Jerks’. “You are three times more likely to get a jerk with a map to respond than a saint without one,” he said. Changing people’s environment changes their behaviour. Dan referred to fall-proofing hospitals and the presence of more visual/graphic signage that reduced falls in a hospital by 25 percent. He also gave the example of innovation in hand-washing, with sensors on name badges that buzz to remind people to wash their hands.

Finally, Dan talked about the mission of path-shaping and easing the pathway to make change easier. And a final quote: “If you must change, failure is part of the deal.”

Workshop: Looking after yourself to look after others: Mindfulness-based stress reduction and healthcare improvement

Jo Solden (senior clinical psychologist, Critical Care Complex, Middlemore Hospital) and Sue Dykes (clinical psychologist, Mindfulness Auckland) presented this session, which covered:

- defining 'mindfulness' and exploring its place in health care settings
- discussing theoretical evidence for the efficacy of mindfulness-based stress reduction in various settings
- reflecting on the potential contribution of increased mindfulness to joy, work, staff resilience, patient-centred care and patient safety in their own settings.

Jo and Sue run an eight-week mindfulness-based stress reduction group programme. There are two half-hour sessions each week and a 'silent retreat' at the end of the course. There is also an abbreviated course of four two-hour sessions plus an intensive eight-hour session and a follow-up four weeks later.

During the workshop, we did some mindfulness exercises/meditation with a focus on breathing. Jo and Sue talked about the association with emotional intelligence and self-compassion as well as compassion for your patients.

Workshop: Lessons for cross-sector improvement

Joe McCannon and Brandon Bennett (faculty, Institute for Healthcare Improvement) and Judge Ema Aitken presented this session, which covered:

- identifying models of change pursued by different social sectors
- applying successful cross-sector approaches.

A number of successful cross-sector collaborations were discussed and barriers to cross-sector collaboration identified. The speakers covered 'The Glasgow Effect' in Scotland. The question was asked: 'Why do equally deprived UK cities experience different health outcomes?' Key to this is a focus on children. Glasgow had an exciting county-wide vision that covered the life of children in early childhood from antenatal to primary school age.

The common area of care was children. This set the scene for a cross-sector approach, which led to community planning partnerships. Local uniqueness and transferable initiatives gradually brought about meaningful interaction in all sectors.

Judge Aitken talked about the New Zealand justice system and drug courts led by district court judges. These courts focus on addiction issues and handle offenders aged 19–59. There are four stages to a recovery-based approach:

1. picking up pieces of failed lifestyles (treatment-based)
2. assembling a new lifestyle (rehabilitation)
3. aftercare – voluntary work, workshop participation, restorative justice etc
4. self-management, including 12-step programmes, and work and training for families in the community.

New Zealand has followed a US model, led by New York City, with 10 components. A key part of the work focuses on homelessness and the provision of supports for permanent housing. The 100,000 homes campaign identifies all people living on the streets, and rates them based on vulnerability. This campaign has been very successful with much lower recidivism rates than expected. The campaign was launched in July 2010. So far, 66,000 people have been housed. The city has developed a vulnerability index and a cross-sector approach. The campaign employs a housing first approach with wrap-around services. This has led to cross-sector tenacity and leadership, and a shared vision for the welfare of its community.

In this country, judge-led drug courts have been established that focus on alcohol and drug issues and adopt a team approach, including peer support workers. This work is abstinence-based, and involves customised treatment, intensive monitoring and random drug and alcohol testing. It is goal-focused leading to behavioural change. There are incentives for positive change and sanctions for departures from agreed processes. It is also based on mutual honesty.

This is a five-year pilot which started in November 2012. It is government funded and the first of its kind. To date, there have been 64 participants (eight women and 56 men).

Gary Sutcliffe

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