engAGE was developed to better support our aging population.

We knew the way we traditionally supported older people, didn’t necessarily meet their needs - so engAGE was developed and designed to provide a “whole of health system approach to make more effective use of all the available health professional expertise.”


What is engAGE - the detail

engAGE is the innovative, collaborative arm of the Older Person’s Health service at Hawke’s Bay District Health Board, New Zealand.

Our ORBIT team and six engAGE community teams support frail older people to remain independent at home through collaborative, person-centered team work across health sectors in Hawke’s Bay.

Our Vision is that Older People in Hawke’s Bay are creatively engaged to achieve their well-being goals.

Targeted population are community-dwelling people over 65 years or ‘like in age and need’ ie: 55 years and over Māori and Pacifica, in Hawke’s Bay.

Our aims are to:

- Maximise the ability of older people to live independently and age in place.
- Maintain and restore their good health and function.
- Be person-centered and engage older people in decision making.
- Lead integration and coordinated care across the continuum of care.
The Orbit team

Locality-based multidisciplinary teams based geographically around General Practice groupings. The teams meet weekly at general practices and bring together professionals from primary care, hospital Older Person’s Services and a range of community agencies:

- Hospital Older Persons’ Health Services: o engAGE – Allied health, Geriatricians, Gerontology Nurse Specialists o District Nursing, o Clinical Pharmacist Facilitators, o Older Persons’ Mental Health, o Needs Assessment and Co-ordination Services,
- Home Based Support services (care agencies)
- Age Related Residential Care Providers.

A interprofessional rapid response allied heath team based in ED/AAU at Hawke’s Bay Hospital. The team co-ordinates care for frail older people presenting to ED/AAU or requiring a rapid response in the home as a result of acute change in function.

How they work

This is done through comprehensive interprofessional assessment and support planning and co-ordination.

ORBIT accept community referrals direct from primary care and the ambulance service. They were the first team of their kind in New Zealand to match service to demand by adopting a seven day per week extended hours roster. They also lead best practice with new initiatives such as the STEPP program to prevent deconditioning.

To reduce fragmentation, this team also sees some patients under 65 years who would benefit from a co-ordinated response. At present this is 20 percent of their caseload. The team consists of six staff (two Physiotherapists, three Occupational Therapists and one Social Worker) and they use an interprofessional approach to minimise duplication, improve efficiency and improve continuity of care.

The engAGE Intermediate Care Bed (ICB) service

This service provides an alternative to acute hospital care by allowing a temporary stay in an Age Related Residential Care (ARRC) facility for a frail older person who is not well enough to be at home, but does not require hospital care.

Older people can access this service from community via their GP (step-up) or from acute hospital (step-down). Medical care is a partnership between their GP and Geriatrician.

The person is supported to return home with their locality’s engAGE community multidisciplinary team undertaking assessment and goal-setting. The team members work with them during their stay and their progress is discussed at the weekly engAGE meeting with their GP and community agencies.

Barriers to discharge are identified and managed, and home based supports are put into place. The team then follows the older person at home after their discharge to ensure it is successful.

engAGE lives the values of the Hawke’s Bay Health Sector and we are dedicated to leading improvement in the care of older people through interprofessional work, cross-sector collaboration and a commitment to upskilling and education of the workforce.
Impact:

Timeline:
engAGE resulted from a strategy document to address population aging in Hawke’s Bay published in...

A cross sector Steering Group and Working Group formed in 2011 to design the service.


Four further Community Teams launched in November 2015 and full Intermediate Care services began in April 2016.

ORBIT formed in 2010 working 8am-4pm 5 days, and extended to 7am-7pm, 7 days in 2015.

engAGE has transformed the delivery of health and support to older people in Hawke’s Bay. We have improved service quality and staff satisfaction.

Most importantly engAGE has improved the health outcomes of our older people. This is what really matters.

Prior to engAGE services were difficult to navigate for consumers, primary care and clinicians and were slow to respond. GPs felt unsupported and were confused about lines of referral. Older people and families were overwhelmed by the complexity of the system and often struggled in isolation, only coming to the attention of health and social services when they had a crisis, and were admitted to hospital, or felt that they had no option other than moving into Aged Residential Care.

Working together, closer to home is better for consumers and also better for staff and colleagues.

engAGE community teams work with groupings of General Practices and are made up of GPs and Practice Nurses, Allied Health, Gerontology Clinical Nurse Specialists, Geriatricians, District Nurses, Needs Assessment Co-ordinators, Older Persons Mental Health Services, Clinical Pharmacist Facilitators and Care Agency nurses.

Previously, any or all of these clinicians may have been involved in the care of an older person but may not have known the others were involved or who to contact. They would rarely have had an opportunity to meet or discuss issues. Now they meet weekly in a general practice setting.

Working together, engAGE teams have a more accurate picture of an older person’s situation. Care agency staff and district nurses visiting people’s homes bring crucial information about their home situation, which the GP may not have been aware of. These team members are crucial as they identify problems early. Through the engAGE team processes staff work together with the older person to come up with a creative, individualised solution to support individuals. The discussion and development of creative solutions is strongly informed by the GP or practice nurse who know the person well and who will carry on supporting them after engAGE input has finished.

Care agency staff act as “eyes and ears” for the team as they follow up and feed back so changes can be made quickly and crises averted.

Faxed paper referrals to distant departments have been replaced by phone calls and emails between colleagues who support each other to provide the best care possible.
engAGE team members work inter-professionally – the clinician visiting the person carries out a person-centred, holistic assessment and shares this information with the rest of the team, negating the need for multiple visits.

engAGE is an efficient way of working, but more importantly is more responsive and better for consumers, who previously complained that they had to tell their story over and over again to many different people, and then wait for support.

**Patient Story:**
An 86 year old lady with advanced dementia but living at home independently was referred to engAGE by her care agency due to their concerns about how she was managing. The initial interprofessional assessment was carried out by the social worker who was able to gain collateral history from the practice nurse in advance of home visit due to pre-existing working relationship. On this home visit the Social Worker noticed that the lady had a cut on her leg which looked inflamed. Mrs X was adamant that she would not visit the GP. On discussion with the Social Worker, the practice nurse agreed to go and visit the lady at the Alzheimers Day centre (across the road from the practice) and was able to encourage her to come across to the practice where she was seen by the GP, her wound dressed and antibiotics prescribed. This was discussed at the subsequent engAGE meeting where the care agency nurse agreed to increase frequency of home visits to support the lady to take the antibiotics correctly. Additional input included liaison with family and provision of equipment for safety (all carried out by the Social Worker under the Interprofessional model). This proactive approach decreased the risk of this lady becoming acutely unwell and needing hospital treatment.

**Feedback from clients and their families has been positive:**

“It’s wonderful to know that you are... not just a number that has been forgotten about”.

“They did a good job to get Mum to where she is now... It was a very good outcome. Mum is back into a routine now – eating and even managing a bit of gardening.”

**Feedback from staff/stakeholders:**

engAGE has been well received by staff in primary care, community providers, and hospital. Closer working relationships, face to face communication and information sharing have improved system efficiency. Growing group expertise has allowed interprofessional working.

“It is rewarding to hear the positivity that comes from across the sector when talking about engAGE.”

“It has been a privilege to be involved with the engAGE meetings. The enthusiasm is infectious and always at the core is the well-being and best interests of the patient.”
“During the meetings I have learned so much more about medical conditions and possible treatments. I have also learned a lot more about the roles of other health professionals.”

“It has worked. It really has.”

Outcomes:

engAGE is dedicated to continuous improvement and outcome measures are key to this process. Although the service is relatively new, engAGE has already had a significant impact on health outcomes for older people in Hawke’s Bay.

Fewer older people have required emergency department care, indicating that earlier input closer to home by engAGE community teams is preventing crises.

Older people receiving engAGE input had a 20% reduction in ED attendances in the six months following engAGE compared to the six months prior to engAGE.

While the numbers of older people have grown between 2015 and 2016, ED presentations for people over 85 have decreased and there has been a reduction in acute hospital bed days used by this group.

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<th>ED Presentations</th>
<th>2015</th>
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<td>Acute Bed Days</td>
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<td>Change</td>
<td>Population Change</td>
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<td>31463</td>
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Challenges:
For those who have presented to the emergency department a thorough assessment and discharge support plan from the ORBIT team and follow up by engAGE community teams has increased the likelihood of an early and successful return to home rather than an inpatient admission.

engAGE helps others by sharing our service, our journey, our successes and failures. We have been recognised as leaders in our field by other district health boards and by health services overseas, and frequently host visitors from other regions who are keen to learn from us.

engAGE’s culture inspires people to want to work with us. Mentoring and development of our staff are a key part of this culture. engAGE team members are seen as leaders within the district health board and several have key roles in other projects transforming systems of inpatient and community care.

There was a lack of confidence from primary care and a reluctance to give up time to attend engAGE meetings. A strong focus on relationship building at both clinical and management level has been key. A small financial incentive to primary care practices, pro-rata’d according to the number of complex older people they manage, has helped assist practice nurse or GP attendance at meetings.

Conclusions:
Collaborative engAGE teamwork improves the health and increases independence of older people in Hawke’s Bay which is evidenced in reduced ED presentations and inpatient bed occupancy. Significant change from multiple health care providers have been needed and the journey has not been without it’s challenges.

It has taken dedication, drive and strong leadership to get to where we are now, and it will take more of this to continue engAGE’s improvement and expansion.

Supporting change:
Collaborative engAGE teamwork improves the health and increases independence of older people in Hawke’s Bay which is evidenced in reduced ED presentations and inpatient bed occupancy. Significant change from multiple health care providers have been needed and the journey has not been without it’s challenges.

It has taken dedication, drive and strong leadership to get to where we are now, and it will take more of this to continue engAGE’s improvement and expansion.
engAGE is a new way of working.