Entry Cover Sheet
HBDHB-led initiative

Excellence in Provider Collaboration and Integration

Community needs seldom come packaged in line with existing organisation and service structures. People accessing health services do not see "our health care delivery silos", but can feel the impact of them. Working with other agencies, non-government organisations and voluntary networks means breaking down barriers to better respond to community priorities and needs.

Entrants must complete all sections below:		
Title of entry **Maximum of 70 characters** Be specific, eg "A joined up approach to improve the oral health of 13-18 year olds". Title length must not exceed 70 characters.	engAGE MDTs- Cross sector collaboration improves outcomes for frail older people.	
Synopsis of entry	engAGE community multidisciplinary teams (MDT's) are based geographically around General Practice groupings, consist of staff from primary care, Hospital Older Persons'	

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Maximum of 150 words A brief paragraph providing an overview of your entry. Synopsis must not exceed 150 words.	Health Services and community providers and meet weekly in a General Practice setting. Referrals come from primary care, acute hospital and community agencies. Comprehensive interprofessional assessment takes place in the older person's home and creative solutions are developed through team discussion to maximise independence. Comprehensive MDT input improves health outcomes and increases independence, reducing ED presentations, inpatient bed occupancy and readmission rates for older people while improving satisfaction of clients and caregivers. Improved service efficiency, hospital inpatient and ARRC resident costs avoided will contribute to financial sustainability of the service. engAGE has been well received by clients and 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.	
Name of organisation/s **Is entry submitted on behalf of one or a number of organisations?** It is very important that you describe who is involved in this entry. This information is used in promotional materials, acknowledgements and inscribed onto awards, plaques and certificates.	This entry reflects a collaborative piece of work between multiple organisations. These include DHB based services (engAGE, District Nursing, Clinical Pharmacist Facilitators, Older Persons' Mental Health, Options HB), General Practice and PHO staff, Home Based Support services (care agencies) and Age Related Residential Care Providers.	
Contact person Name of person/s who can be contacted in regards to this entry.	Sarah Shanahan (engAGE Team Leader).	
Email of contact person/s.	Sarah.Shanahan@hbdhb.govt.nz	
Phone of contact person/s.	027 3233193	

Service Director entry review and endorsement.	Name:_____ Signature: _____ Date: _____	
Executive Manager entry review and endorsement.	Name:_____ Signature: _____ Date: _____	

Our Organisation:

The engAGE service is part of the DHB's Older Persons Service. engAGE encompasses the engAGE Community MDTs, Intermediate Care Services and the ORBIT (rapid response) team. The engAGE team is made up of Team Leader and Administrator and 16 Allied Health Professionals (Physiotherapists, Social Workers and Occupational Therapists). This team works interprofesisonally and has close links with other DHB services (Gerontology CNS, Geriatricians, District Nursing, Clinical Pharmacist Facilitators, Older Persons' Mental Health, Options HB). We collaborate with community health services- General Practice staff, Home Based Support services and Age Related Residential Care Providers. Our Vision is that "Older People in Hawke's Bay are creatively engaged to achieve their well-being goals". Our mission is to "work in partnership with the older person, their whanau and the community to provide a seamless, responsive service that can be tailored to individual need. The older person will be heard and respected and their right to choice and dignity will always be upheld. We will strive to achieve equity in our community". We live the values of the Hawke's Bay Health Sector and have developed associated actions and outcomes to show how we apply these values to our work with older people.

Provider Collaboration and Integration Initiative:

engAGE improves outcomes for frail older people through collaboration of different sectors and agencies. engAGE specifically addresses issues with services identified by the "Improving Health Services for Older People in Hawke's Bay Strategy- 2011-2016" which were:

- System difficult to navigate for older people, families and clinicians.
- Poor communication between service providers leading to delays in assessment and service provision.
- Lack of service coordination.
- Services working in an acute, episodic model.
- Referrers uncertain about available services.
- Inconsistent follow-up in community for people discharged from hospital.
- Duplication of assessment.
- Lack of geriatrician resources to support primary care.

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engAGE Community Multi-Disciplinary Team (MDT) meetings have been developed with groups of General Practices in 6 areas (Taradale, Napier West, Napier Central, Havelock North, Hastings Health Centre and other Hastings practices). We are working with 20 out of the 24 practices in Napier and Hastings. Meetings take place weekly in general practices and include multiple health professionals who work with frail older people. These groups include GPs and Practice Nurses, Social Workers, Physiotherapists, Occupational Therapists, Gerontology Clinical Nurse Specialists, Geriatricians, District Nurses, Needs Assessment Co-ordinators, Older Persons Mental Health Services, Clinical Pharmacist Facilitators and Care Agency nurses. Referrals come from primary care, acute hospital, ORBIT team, District Nurses and care agencies. Meetings involve team discussion of issues and development of creative solutions to maximise independence of frail older people.
engAGE also provides the opportunity for an older person to access a temporary residential care placement with the support of the MDT to assist them to remain or return to living independently at home (engAGE Intermediates Care Beds).

Collaboration between secondary services traditionally based at the hospital, primary care (the older person's medical home) and Care Agency staff who bring their insight into the person's home situation has proven to be a highly effective approach. 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. Often an older person would need to be sent to hospital in order to quickly access physiotherapy, occupational therapy and social work services. Communication back to primary care was not always adequate and key issues could be missed. engAGE has improved the patient experience by providing more responsive and better co-ordinated assessment and support in the person's own home, in partnership with their own primary care professionals.

engAGE team members work interprofessionally i.e. carry out some aspects of each other's roles, which reduces duplication. The clinician who visits the person at home will carry out an holistic assessment and share this information with the rest of the team, negating the need for multiple visits to an older person. This means the older person does not need to repeat their story over and over again. The engAGE approach is patient centred and supports older people to identify and achieve goals that are important to them rather than imposing the goals of health professionals. engAGE is responsive with wait times of less than a week so intervention before crisis point is possible.

Patient story:

Mary* is a frail 85 year old lady living at home with her 94 year old husband Tom*. She was referred to engAGE by her practice nurse due to difficulty with mobility and with managing the steps at her villa. Mary was unable to go out and felt isolated and depressed. Her goal was to remain living in her own home and to be able to go out to see her friends. She was assessed by engAGE and had input from the team, in collaboration with her GP, over the course of 6 months. Mary received Physiotherapy and Occupational Therapy to work on her mobility and to help her get in and out of the house. The Social Worker linked her with transport assistance and Options and her care agency increased her carer supports to help her maintain her independence. The Geriatrician reviewed Mary's medications and supported her GP with management of her depression.

Over this time Mary was twice able to avoid hospitalisation when her GP and engAGE organised urgent admission into Intermediate Care - first following a fall and then when she developed pneumonia. Mary was able to have treatment and rehabilitation closer to home and to her husband in the more home-like setting of an Aged Residential Care facility. engAGE in-put supported this lady to spend the last months of her life at home with her husband rather than in hospital or in residential care.
* Not their real names.

Benefits and Results:

- Improved communication between service providers. Clinicians have developed positive working relationships and contact each other outside of meetings to get quick access to advice.
- Fewer referrals to specialist services because GPs and Practice nurses can get rapid access to advice from a Clinical Nurse Specialist or Geriatrician.
- Greater staff satisfaction and support. Working with a team gives clinicians the opportunity to share ideas, learn different approaches and get the support of colleagues.
- Better engagement with older people by building on existing relationships e.g. joint assessments or introductions by the clinicians already involved.

Since the roll out of engAGE in November 2015, over 400 older people have been seen by the engAGE community MDTs. A Benefits Mapping process has identified the high level benefits to be achieved by the engAGE service:

- Benefit 1: Needs of older people are met by services that are clinically and financially sustainable.
- Benefit 2: Faster access to appropriate care and support.
- Benefit 3: More effective use of all available expertise and capacity.

Each benefit has specific KPI's. Reporting against these is in its early stages.

Initial indications show engAGE is having a positive impact on ED presentations and acute in-patient bed days for older people when comparing the January- June period for 2016 to the same period in 2015. Inpatient bed days have reduced, with the largest improvement in the over 85's. This is despite population growth in this group.
ED presentations have also reduced in over 85's and have not risen to the degree expected by population growth for over 65's.

Whilst it is likely that other service improvements have also contributed to these outcomes, engAGE has specifically targeted frail older people – the majority of whom are in the over 85 age group with Intermediate Care services and early MDT intervention used to reduce inpatient length of stay and to prevent ED presentations.

HB Population

Population growth over period	65+	85+
Number	1090	140
% growth 2015-2016	3.9%	4.2%

6 months Jan- June

ED presentations	65+	85+
2015	5227	1152
2016	5358	1147
Increase in numbers	131	-5
% change	2.5%	-0.4%

Acute inpatient bed days	65+	85+
2015	15808	4434
2016	15535	4170
Increase in numbers	-273	-264
% change	-1.7%	-6.0%

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Future Plans:

Following evaluation of the service, engAGE will be extended to Wairoa and Central Hawkes Bay, working collaboratively with local providers to best meet the needs of these communities.

After feedback from primary care engAGE has developed a single referral form for multiple DHB services. Frustration was voiced by GPs at having to complete multiple referral forms for engAGE, Options HB, Community Allied Health and Gerontology CNS. The single referral form is being trialled by one GP practice before being rolled out to all groups. This is a step towards a "Single Point of Entry" for all services for older people.

Many lessons have been learned and plans are in place to share these with a poster presentation at APAC and links with other DHBs. One of the biggest recent learnings is that as a DHB moving towards greater collaboration with Primary Care we cannot let processes such as contracting and funding streams impact on the goodwill that exists between providers for working in this way.

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Your organisation	Briefly tell us about your organisation: • How it is structured and the services you provide; • Your workforce – how many people, the different roles/functions they provide; • What is your vision and values? ***Aim to describe your organisation in 200 words or less.***
Excellence in Provider Collaboration and Integration	Describe the provider collaboration and integration initiative that you are entering into the 2016 Hawke's Bay Health Awards: • Be specific and concise; • Describe the collaboration in terms of how it has made a difference to patient experience; • Describe this also in terms of how it has improved outcomes; • Consider including diagrams, photos or patient stories to help illustrate/explain your quality improvement initiative; ***Aim for 700 words or less in this section of your entry.***
Benefits and results	Demonstrate improvement: • The judges are looking for tangible results directly attributable to your collaboration initiative; • Provide benchmark and current data to clearly demonstrate improvement in patient experience or outcomes; • Include any measures or KPIs which you are using to track progress and review impact and effectiveness; ***Aim for 350 words or less in this section.***
Future plans	Demonstrate continuous quality improvement by: • Are there any plans to extend this collaboration and integration initiative? • What other improvement activity has this initiative generated? • Have there been lessons learnt or learnings that can be shared with others? ***Please provide a brief summary of your future plans in 200 words or less.***

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