The Issue.

• Agening population with more complex needs.
• Existing services not well-equipped to meet growing demand.

Impetus for Change.

• System difficult to navigate for older people and families.
• Poor communication between providers leads to delays in assessment and service provision and people “falling between the gaps”.
• Services reactive, not proactive.
• Services working in silos and difficult to navigate for primary care professionals.
• Lack of “patient centered” approach.
• Clients subjected to multiple assessments and asked the same questions repeatedly.
• Lack of geriatrician support for primary care to manage patients more effectively in the community.

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

Mission:
We will work in partnership with the older person, their whanau and the community to provide a seamless, responsive service that can be tailored to effectively in the community.

Action:
• Improving Health Services for Older People in Hawke’s Bay Strategy 2011-2020.
• Cross-sector Steering Group and Working Group developed.
• Pilot phase with one location 2012-2014 and a second in 2014. Roll out in 4 further locations in November 2015.

engAGE Intermediate Care Beds.

• Intermediate Care Beds (ICB) provide short-term placement, up to 6 weeks, in an ARRC facility for medically stable frail older people who are not well enough to be at home, but do not require acute hospital care.
• At the time of an acute change in function due to a minor illness or injury or deconditioning following an acute hospital stay.
• Or for assessment and reability for a person who is on the cusp of requiring permanent placement but wishes to remain at home.
• Older people can be admitted to this service from their own homes or admitted from the acute hospital and receive it from the engAGE MDT in partnership with medical care from their GP.

Impact for Primary Care.

• Single point of access to a responsive service.
• Learning from other disciplines occurs through discussion at the MDT meeting.
• ICB provides an alternative to hospitalisation and a secure setting for elderly people, in the community through acute care and back to home or ICB.
• The same MDT supports the patient at home, in ICB and back to home again.
• Assessment of care agency registered nurses at MDT meetings allows feedback on how patient managing at home and if interventions have been successful.

Impact for Older People and families.

• Wrap around service rather than teams working in silos.
• Shorter waiting times for services.
• Information sharing and locality based teams means not having to tell their story repeatedly.
• Earlier intervention in their own environment.

“Being at home is just huge to Mum. As it is to us” - Daughter.

Impact for engAGE Staff.

• Weekly meeting improves communication and there is less time wasted.
• Relationships have developed across sectors allowing closer collaboration between clinicians who are working with the same people.
• Communication has grown through discussion and information sharing allowing a move to an interprofessional model.
• Creation of an exciting career progression for experienced staff who are involved in developing the service.

“Now I can just pick up the phone. Before, I didn’t know who to talk to I’d spend ages trying to find someone to help. ” - CNS-Gerontologyst.

Case Study.

• Jessie is an 84 year old woman who lives at home alone and has a supportive family.
• She had three admissions to hospital in a month with recurrent diarrhoea.
• During each admission the diarrhoea would resolve with antibiotics but would recur when she returned home.
• She was losing weight, becoming weak and losing confidence to manage at home. Her family were worried and suggested she move to a rest home.
• Jessie was referred to engAGE for help with discharge planning and follow-up.
• Jessie spent 3 weeks in ICB with regular input from Physiotherapy and monitoring of her weight and intake. A family meeting took place before discharge.
• She went home with support from engAGE and a plan for re-admission to ICB if her diarrhoea returned after stopping antibiotics.
• She has remained well and at home with no further hospital admissions.

“l’d much rather be here and have this situation in place thanks to Dr Lucy”. - Jessie.

“The change in her from her last hospital release is just incredible. At home she’s just Mum” - Jessie’s daughter.

engAGE Community Teams.

• engAGE Community MDT meeting weekly in General Practices.
• Geographically based around 6 General Practice groupings.
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Measurement.

• Benefits Mapping Framework.
• Investment Logic Map developed.

Mission.

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