ACKNOWLEDGEMENTS

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A particular thanks to Claire Naumann, Professor Harry Rea and Dr Tim Hou who offered insight into the operations of the At Risk Individuals model of care.

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EXECUTIVE SUMMARY

GOALS OF THE EVALUATION

In response to concerns that people with long term health conditions are not always well supported by proactive or co-ordinated services, Counties Manukau Health (CMH) introduced the At Risk Individuals (ARI) model of care. The ARI model of care provides funding to primary care practices (via Primary Health Organisations) for extended consultations, home visits and other services designed to support patients to achieve their own health goals. CMH commissioned the Health Services Research Centre at Victoria University of Wellington to evaluate ARI, with an emphasis on the extent to which the new model of care is changing the way primary care practices work.

EVALUATION METHOD

The evaluation tested the theory of how ARI is expected to work against the experiences of a purposive sample of staff from primary care practices. Focus groups were held with practice staff in ten general practices randomly selected to cover different Primary Health Organisations (PHOs), different size practices and different localities within Counties Manukau Health. The evaluation was structured to test:

- **The changes in patient behaviours as observed by practice staff.** The evaluation explored the ways in which practice staff thought patients benefited from being enrolled on ARI. ARI involves a process of setting patient-led health goals supported by a Partners in Health questionnaire and the development of an electronically based shared care plan. The expectation is that those individual patients enrolled on ARI achieve their goals and that these achievements improve clinical outcomes.

- **The changes in how general practices operate as experienced by practice staff.** The evaluation examined the circumstances likely to lead to new types of proactive primary care. The term “proactive primary care” is used as shorthand by CMH to signal the expected change away from the generic 15 minute general practice consultation model, towards longer consultations centred on patient led goals for those with long term health conditions.
Changes across the system as judged by practice staff: By resourcing primary care to work in a proactive way, and linking other health and social care services into the orbit of primary care, the expectation was that over time hospital use will decrease. The evaluation probed the ways in which wider system change was thought to be occurring.

FINDINGS

Patients who benefit from ARI have a combination of clinical and behavioural characteristics

Two years into the operation of ARI learning has accumulated over which patients benefit most from ARI. If those enrolled on ARI demonstrate motivation, have a condition that lends itself to a measurable change, and are part of a practice with prior skills in working with psycho-social issues, then staff believe those enrolled are likely to demonstrate increased self-management. If those enrolled on ARI have a condition where it is not obvious what change is needed, are enrolled merely to lower out of pocket costs and are within a practice where the staff are not confident they have skills in working with wider psycho-social issues, then increased self-management is less likely, particularly for complex patients.

Value gained from the time spent with practice staff

From an initial set of suggested mechanisms of how the ARI model of care influences patients to develop new health behaviours, the importance of receiving more practice staff time and working on a patient centred care plan were consistently affirmed as key ingredients. Many stressed it was the power of conversations they had with patients that motivated patient behaviour change rather than a desire to adhere to care plans because patients wanted to be seen as good patients. As explained by focus group participants it was the time involved in sitting with patients and “trying to get them to understand why they need to make changes”, and “it’s the fact of that conversation more than the fact they have made a care plan that matters”.

Variable views on the value gained from reducing consultation costs for ARI patients

In focus group discussions there was a diversity of views as to whether ARI patients valued having less worry about costs. The reason this statement was
included in the evaluation was that those with long term health conditions often suffer from more than one condition, making their care complex and potentially expensive if they need to access primary care regularly. By lowering out-of-pocket primary care costs, the expectation is that patients are more likely to engage with primary care early and avoid secondary care visits that indicate they are not managing their condition well.

Different views on the benefits for patients having less worry about costs were shaped by different starting points for practices with respect to patient co-payments. No one said cost was not an issue, but in circumstances where practices were already working in an environment of free or very low cost consultations, then this was less of a significant change as a result of the introduction of the ARI model of care.

**Uncertainty over whether shared care plans are accessed and used by others.**

Finally, staff were most uncertain that patients were seeing the professionals involved in their care talk to each other as a result of the introduction of ARI. ARI relies on general practices taking more responsibility for co-ordinating care and includes the expectation that the patient goals in the shared care plan are used by all health professionals. The majority of staff in focus groups were not confident that the shared care plans were being accessed by others. That said, hearing from others in the practice, or seeing recent proof themselves that other healthcare professionals were accessing the plans, could be a tipping point to increase confidence that the time involved in drafting electronic care plans was becoming more worthwhile.

**Proactive primary care dependent on the propensity of practices to share information**

A significant part of the change expected from the introduction of ARI is the change in primary care delivery away from purely clinical management of those with long term conditions towards supporting patients to achieve long term behaviour change. As well as resourcing practices for the time needed to motivate health behaviour change, the mechanisms expected to support the longer term goal of encouraging more proactive primary care include: (i) practice nurses taking more responsibility for those with long term conditions, (ii) staff within the practice making more connections with other supports outside the practice to achieve patient goals, and (iii) an increased sensitivity across the practice to plan for the whole enrolled population and not just those who choose to visit.
Different contexts within practices shaped the likelihood these three mechanisms were triggered. The dynamic was not just that it was easier for larger practices and harder for smaller practices (though that played a role). The focus groups revealed that different propensities to share information were a distinguishing feature between practices in the following ways:

- those practices of whatever size who did not hold regular meetings to reflect on what had been learnt implementing ARI, who tried to absorb ARI into their current style of operating and who left nurses to implement ARI in isolation, were less likely to demonstrate an interest in proactive primary care.

- those practices that appointed ARI leads, shared ARI caseloads across nurses and experimented with different ways of “pulling nurses off the floor” to cover the extra time involved, were more likely to demonstrate an interest in proactive primary care. Those setting up ARI explained that their aim is to “create a model that makes doing the right thing easier” and doing the right thing was easier for those practices that already had a collective team ethos.

- those practices that relied on new care co-ordinator roles to act as a bridge between the doctors and nurses in the clinics and the ARI patient, created their own dynamic with advantages and disadvantages with respect to influencing patient behavioural change and sharing information. Information sharing was likely to be strong between the newly created team and the ARI patient, but variable between the team and the doctors and nurses in the clinics.

A whole system approach requires sustained attention across all levels of change

ARI is a complex multi-layered initiative aiming to achieve improvements in outcomes for patients, changes in how general practices operate and reductions in unplanned admissions to hospital emergency care. Practice staff were engaged in a complex balancing act between the need to reach their ARI enrolment target, the need to be confident they were investing time in the right patients (i.e. amenable to change) and managing a capped budget to deliver services to individual patients to support their personalised care plan.
Concerns were raised in the focus groups about the administrative burden imposed by ARI (particularly the problems adapting to the new IT system), but these did not dominate to the extent that practice staff lost sight of the important opportunity being offered to work with patients in new ways. As one focus group participant explained “it is caring for people in the way that we actually trained and aspired to, but never had enough time for”. Practice staff had little trouble with the idea that engaging patients as partners in their care was the key to achieving better outcomes.

The system-wide enablers expected to support ARI were making inroads in some practices, but were still a work in progress in others. Multi-disciplinary team meetings were valued where they were in place, though any further growth is likely to be dependent on practices having a profile of highly complex patients on ARI. While some PHOs and practices had found effective ways to combine their IT systems and were now familiar with how the ARI IT system worked, others were still working through technical issues.

When participants were asked what specific aspects about the way ARI works could be improved or changed there was no one consistent message. Answers fell into three groups:

1. One group wanted more information to sort out specific issues. Recommendations included calls for increased training (particularly IT training) and specific contact points to improve access to advice for complex patients.

2. Another group had ideas for streamlining the ARI process. The suggestions here included ideas of how to simplify the Partners in Health questionnaire, or tailor specific ARI interventions funding to need, rather than the current percentage targets across all CMH practices.

3. A third group identified opportunities to connect ARI with other system wide actions that would make ARI more effective. This included providing evidence that the extended CMH healthcare team was accessing the shared electronic record, and increasing opportunities for a larger throughput of complex patients in multi-disciplinary team meetings.
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CHAPTER ONE: INTRODUCTION

1.1 CONTEXT FOR THIS EVALUATION

The At Risk Individuals (ARI) model of care funds primary care practices in South Auckland to provide flexible, patient-centred support to those with chronic long term conditions. This evaluation explores in what ways and to what extent the ARI model of care is changing the way general practices work in Counties Manukau Health (CMH). To date, 20,776 individuals spread across 115 general practices have been supported through the ARI model of care. The model is based on the theory that high risk patients who receive a shared care plan achieve better outcomes as a result of both: (1) improved self-management and (2) more planned and proactive primary care.

CMH (via Ko Awatea) commissioned the Health Services Research Centre at Victoria University to evaluate the ARI model of care to provide ongoing formative feedback, and to assess the overall impact of the model. The evaluation is nested within a broader set of research activities assessing the impact of the four partnerships in Franklin, Manukau, Mangere/Otara and East (i.e. the Localities initiative) that are working to improve the integration of services across Counties Manukau.

An early analysis of how the Localities initiative was rolling out found that much of the discussion on what would improve outcomes for the local population was cascading outward from the implementation of ARI 1. Consequently, a follow-up, in-depth investigation was requested on the extent to which ARI is changing the way primary care practices work, particularly in light of the interest in encouraging more “proactive primary care”. Proactive primary care encompasses the change expected in primary care delivery away from reactively treating those with chronic conditions when they become ill to working in a proactive way to support people to stay well.
1.2 WHAT IS THE ARI MODEL OF CARE?

Starting in 2014, CMH invested $5.3 million per annum into the ARI model of care. Primary care practices are funded via Primary Health Organisations (PHOs) for extended consultations, home visits, and other services in order to prevent unplanned admissions to hospital, prevent further complications and improve patients’ quality of life. Those enrolled on ARI pay less (or not at all) to access a range of health or health-related services to support them to achieve their own goals. The majority of funding goes towards longer consultations in primary care, but can also include the costs of home visits, prescription co-payments, nurse led clinics and health literacy or self-management interventions such as weight loss programmes.

ARI is a complex, multi-layered initiative seeking to achieve change at a number of levels. For those enrolled in ARI, improved clinical outcomes and self-management are expected as a result of patient-led goal setting using a Partners in Health (PiH) questionnaire and the development of a shared care plan. At the general practice level, changes in the way primary care is delivered are expected through the extended use of nurses and the use of funding to access a wide range of support services. Finally, at the CMH system level, ARI is expected to contribute to admission avoidance, by resourcing primary care to work in a proactive way, as well as linking new health and social-care services into the orbit of primary care services.

At the heart of the change is the belief that small scale changes in how those with long term health conditions are cared for can accumulate into large effects. These small scale changes involve taking into account the everyday realities of patients who have long term conditions, such as diabetes or heart disease, and considering the other risk factors which may be compounding their poor health, such as inadequate housing or low health literacy. The concern is that those with long term conditions use a disproportionate amount of healthcare services which are not always well coordinated, so by working in partnership with those with long term conditions the ARI population is offered more support to better manage their conditions and keep well.

---

1 The Health Literacy Questionnaire was also offered as an alternative to the PiH which a small number of practices chose to adopt as a more accessible assessment tool.
ARI can also be understood as a sequential care process starting with identifying primary care patients with chronic disease, developing electronically-based shared care plans, offering improved co-ordination and culminating in case conferencing for complex patients (see Figure 1).

Figure 1 - A Sequential Care Process

ARI - Proactive Planned Care

Finally, ARI is a key component within CMH’s System Integration initiative which recognises the critical challenges of delivering services to meet the needs of a population of just over 510,000 people (11.5% of NZ’s population), with high numbers of Māori, Pacific and Asian peoples, a youthful population, and high levels of inequalities in health. CMH also has concerns over the ability of its main hospital (Middlemore) to provide sufficient in-patient care and is looking for new ways of treating those with long term health conditions. Key health concerns include diabetes, obesity, heart disease and smoking.
To summarise, ARI is based around targeting patients with the highest risk, improving patient self-management, and increasing care co-ordination between health professionals. Practice staff are resourced to spend more time with patients in order to: (1) make more holistic assessments of patients’ needs and (2) take more responsibility for care co-ordination rather than merely referring patients on to others. In line with the emerging evidence that a whole system approach is needed to manage those with long term conditions, the ARI whole system approach involves requiring primary care to be proactive rather than reactive, encourages the use of community assets through the Localities initiative, and promotes the use of self-management approaches enabled by new electronic infrastructure to share information.

1.3 THE FOCUS OF THE EVALUATION

Whilst self-management solutions have shown benefit in academic evaluations, they have been found to be challenging to implement. Systematic reviews have found small to moderate effects for people with selected conditions and evidence that proactive goal setting can be an effective strategy for promoting self-management. There is limited evidence about the most effective ways to deliver self-management programmes with the implementation of programmes into routine practice highlighted as a significant challenge.

The focus of the evaluation was developed in discussion with those overseeing the roll-out of ARI. ARI sponsors were interested in the following questions:

- Is the ARI model of care generating conversations and questions on how best to manage those patients with a broader degree of psycho-social complexity, i.e. not only those with long term conditions such as diabetes or heart disease, but those whose health might be compounded by other risk factors such as inadequate housing or low health literacy?

- Do practices believe they have the right amount of support to implement ARI? What should be prioritised for the next phase of the ARI roll-out? For example, do practices believe multi-disciplinary meetings will offer further value to achieving the outcomes expected from ARI?

- In what ways are the different Primary Health Organisations’ (PHOs) approaches to implementing ARI shaping how practices engage with the new model of care? What is the experience of information sharing between practices around ARI?
• How does the diversity of ways practices operate (i.e. the overall team-based or outward looking nature of the practice) influence the rate at which more proactive primary care is being developed as a result of ARI?

• What matters about how the tasks are shared within a practice (i.e. between GPs and practice nurses) in order for ARI to work?

To answer these questions, focus groups were held with a purposive sample of staff from ten general practices throughout July and August 2016 (total participants =30). The evaluation applied the realist evaluative approach of testing and refining theories of how an intervention is expected to work, using a set of statements about the way that ARI is expected to deliver value to patients, to practices, and to the CMH system overall. These statements formed the basis of discussions within the focus groups.

A second stage of the evaluation will track patient experiences and outcomes in order to test the gains being made from the perspective of the patients. In this report, attention is focussed on uncovering the views of health professionals on whether ARI is delivering the value expected.

1.4 STRUCTURE OF THE REPORT

The following chapter details the theories of change that formed the starting point of a realist based evaluation. Chapter Three provides a brief history of ARI and its genesis with the broader suite of changes being undertaken by Counties Manukau Health.

Chapters Four, Five and Six provide the results from the focus groups in practices according to how patients are benefiting (Chapter Four), how practices are changing (Chapter Five), and the ways in which the system is re-orientating to focus on primary care (Chapter Six). Chapter Seven pulls the results together to conclude with what works, for whom and in what circumstances.
CHAPTER TWO: THE EVALUATION

2.1 A REALIST EVALUATION

ARI is expected to have multiple effects on an individual patient’s self-management competency, their clinical outcomes and their overall healthcare service use. Thus, as with evaluations of similar complex and multi-layered initiatives, the overall design is a ‘realist evaluation’. The realist approach recognises that not all initiatives are successful at achieving their outcomes in all contexts all of the time, and the approach emphasises identifying ‘what works, for whom and in what circumstances’. This assists decision-makers in identifying what is working well and why; where improvements might be made; and how particular circumstances may influence whether an initiative will achieve its desired outcomes. This in turn enables decision-makers to adapt and better tailor initiatives to different contexts, and assists in the rollout of successful initiatives.

The approach uses a ‘theory-testing strategy’ to unpack the relationships between context, mechanisms and outcomes. Basic ‘theories of change’ are identified, data to identify context, mechanisms and outcomes collected, and the theories of change are then examined in depth for how well they explain the outcomes achieved across different contexts, with the theories being refined from the experiences of those working on or affected by the initiatives. The findings from a realist evaluation pinpoint the configurations [context-mechanism-outcome] needed to sustain an initiative.

2.2 THE THEORIES OF CHANGE BEING EXPLORED

The basic theories of change for ARI are displayed overleaf at the level of patient or micro change (Table One), practice or meso change (Table Two) and CMH macro system change (Table Three). These theories were developed from a review of the ARI set-up documents and semi-structured interviews with those overseeing the roll-out of ARI in both CMDHB and in PHOs (N=6). These initial theories of how the ARI model of care worked were then calibrated against the literature on what is known about the effectiveness of patient self-management programmes, international guidance on how best to deliver integrated care and the history of primary care change in New Zealand.
The research evidence for the type of service changes needed to deliver a whole system approach for those with long term health conditions emphasises the importance of a number of components coming together: components such as, providing a holistic service supporting patients to be independent and resilient; providing named care co-ordinators to provide personal continuity; and building awareness and better communication through shared electronic records. All these elements are incorporated into ARI.

The ARI emphasis on patient centred goal setting aligns with a Health Foundation evidence review that goal setting can be an effective strategy for promoting self-management activity. Behavioural science underscores the importance of making plans that incorporate implementation intentions. ARI shared care plans match advice that achieving a goal often involves more than deciding what to aim for and then working on it. Breaking goals down into manageable chunks and receiving timely feedback along the way can make it more likely that a person will stay on track and ultimately achieve their goal.

Tables One, Two and Three all contain (in the far right hand column) the longer term performance indicators used by CMH to assess ARI performance. The key differences between the tables are the contexts and mechanisms. In different contexts, change involves those individuals with long term conditions behaving differently at the micro level (Table One), those who deliver care in primary care practices behaving differently at the meso level (Table Two), and those overseeing change at the macro level deploying resources differently to re-establish general practice as the central focus of co-ordinated healthcare in Counties Manukau (Table Three). It is these theories of change that were explored in the fieldwork.

Together the following tables form an interlocking logic model of how the ARI model of care is expected to generate better outcomes for patients, practices and the health system.
### Table 1 - Micro Theories Of What Drives Change For Patients

<table>
<thead>
<tr>
<th>C = In contexts where:</th>
<th>M = These mechanisms are expected to be generated:</th>
<th>O = In order to produce these outcomes: Short term (18 months)</th>
<th>Medium term (30 months)</th>
<th>Longer term (42 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients with long term health conditions that are amenable to change agree to be enrolled on ARI</td>
<td>Patients have less worry about the costs involved in managing their conditions</td>
<td>Completed PiH indicate conversations have occurred on how best to self-manage</td>
<td>Patients have improved access to primary care</td>
<td>Reduction in unplanned emergency admissions</td>
</tr>
<tr>
<td></td>
<td>Patients receive more practice staff time to learn how to self-manage</td>
<td>Shared care plans based around patient goals are completed and acted upon</td>
<td>Patients demonstrate increased self-management competency (e.g. scores on PiH show signs of improvement)</td>
<td>Improved clinical indicators including (where relevant):</td>
</tr>
<tr>
<td></td>
<td>Patients improve problem solving by embedding care solutions into their own lives</td>
<td>Interventions funding is used to purchase additional support</td>
<td>Patients have an improved experience and confidence in their care</td>
<td>% of patients with HbA1c&lt;65</td>
</tr>
<tr>
<td></td>
<td>Patients adhere to shared care plans as they want to be seen as good patients</td>
<td>Care plans are electronically accessed and used by all those involved in a patients care</td>
<td></td>
<td>% change of HbA1c in ARI patients</td>
</tr>
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<td></td>
<td>Patients see that the professionals involved in their care talk to each other</td>
<td></td>
<td></td>
<td>% of diabetics with BP systolic&gt;140 for CVD risk 15-19.9%: access to primary prevention dual therapy (statin +BPL)</td>
</tr>
<tr>
<td></td>
<td>Patients receive care that aligns with their cultural practices and beliefs</td>
<td></td>
<td></td>
<td>% of CHF patients on ace inhibitors and beta blockers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>% of COPD patients referred within 4 weeks of discharge to pulmonary rehab programme</td>
</tr>
<tr>
<td>C = In contexts where:</td>
<td>M = These mechanisms are expected to be generated:</td>
<td>O = In order to produce these outcomes: Short term (18 months)</td>
<td>Medium term (30 months)</td>
<td>Longer term (42 months)</td>
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<tr>
<td>Practice staff identify those high risk patients that are amenable to change and offer them an opportunity to be enrolled on ARI</td>
<td>Practices invest in the time to understand patient values and concerns GPs have time freed up as nurses play a more significant role in care delivery Practices make connections with other supports to achieve patient goals (eg social workers, allied health and clinical specialists) Practices benefit from more support Practices plan for the whole enrolled population and not just those that choose to visit</td>
<td>5% of the primary care population are enrolled on ARI PIHs are completed, a goal-based shared care plan is in place and a named care co-ordinator identified for each ARI patient ARI training supports practices to develop high quality shared care plans</td>
<td>Increased capacity of primary care to manage patients in the community (proactive primary care) Evidence of improved sharing of information between primary care and secondary care</td>
<td>Reduction in unplanned emergency admissions Improved clinical indicators as listed in Table 1 General practice is re-established as the central focus of co-ordinated healthcare in Counties Manukau</td>
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2.3 THE FIELDWORK

Interviews with key ARI sponsors and representatives of four PHOs provided initial insights on how ARI had been implemented and what planned proactive care by primary care practices was expected to look like. These expectations were then tested against on-the-ground realities through focus groups in ten primary care practices.
during July and August 2016. Ethics approval for the research was obtained from Victoria University of Wellington’s Human Ethics Committee.

ARI sponsors particularly wanted to understand more from the perspective of those practices not coming to the forums that had been held to gather feedback on the implementation of ARI. To avoid the “usual suspects” in the sample of practices, a bio-statistician developed a programme to randomly choose a sample of ARI practices with the right diversity and balance across different PHOs, the four geographical localities and different size practices (e.g. small, medium and large according to the number of ARI patients enrolled). The goal in developing the matrix was to obtain a diversity of opinion which meant choosing participants with a diversity of characteristics. However, there were some constraints as each PHO is not represented within all Localities and there was not always a wide diversity of practice sizes within each Locality.

To refine the choice even further, key contacts in each PHO were asked to give the names of up to five practices in their PHO who have been extensively engaged with the ARI programme, and up to five practices (for whatever reason) that were not. This distinction helped to uncover the type of contexts that were most influential in supporting the successful adoption of ARI and those contexts which were not. Practices from these initial lists who matched the characteristics in the grid were then approached to participate in focus groups of staff with responsibility for the delivery of ARI. The grid presented in Figure Two displays the final sample based on those practices who agreed to participate. Not all practices in the initial lists from PHOs agreed to participate. In those cases, another practice that met the characteristics in the grid was randomly chosen by the evaluators.

Small practices had less than 200 patients enrolled on ARI, medium size practices had between 200 to 400 patients, and large practices had 400 patients and over. One PHO had developed an integrated care team to work across all their practices, so in this situation two focus groups were held with team members. As displayed in Figure 2 these groups were not linked to a particular Locality in CMH and covered a potential ARI patient population of 5000.
Figure 2 - Focus Group Sample

<table>
<thead>
<tr>
<th>Locality One</th>
<th>Locality Two</th>
<th>Locality Three</th>
<th>Locality Four</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHO A</td>
<td>Small</td>
<td></td>
<td></td>
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<td></td>
<td>Large</td>
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<tr>
<td>PHO B</td>
<td></td>
<td>Large</td>
<td>Medium</td>
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<tr>
<td>PHO C</td>
<td>Small</td>
<td></td>
<td>Large</td>
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<tr>
<td>PHO D</td>
<td></td>
<td>Integrated care team (x2)</td>
<td></td>
</tr>
<tr>
<td>PHO E</td>
<td>Small</td>
<td></td>
<td>Small</td>
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</tbody>
</table>

Those practices who agreed to participate were given the option of deciding which staff needed to be present at the focus group. The focus groups ranged in size from 1 through to 7 members reflecting that smaller practices often only had 1 or 2 members of staff deeply engaged in ARI. A total of 30 general practice staff participated in the groups. The majority of those who participated were practice nurses, though general practitioners, care co-ordinators and public health specialists were also included in some focus groups.

Participants were asked to discuss a set of statements that described the different ways the ARI model of care might be helpful to patients, to practices and to the overall CMH system (i.e. the theories set out in Tables One, Two and Three above), and then group these statements as more or less important from their experiences. The focus group protocol is included in Appendix One.

The focus groups were audiotaped and then transcribed to create a qualitative data set that was entered into NVivo and coded against the initial micro, meso and macro theories of change. The interviews with ARI sponsors and PHO representatives were also audiotaped and transcribed to develop the initial theories of change as well as insights into how ARI implementation had progressed.
CHAPTER THREE: A BRIEF HISTORY OF ARI

The history of an intervention, including the order and pace of implementation, are important pre-requisites for understanding how an intervention works. With that in mind, this section provides a brief history of the implementation of ARI, drawn from the set-up documents, reviews of progress with integrated care initiatives in CMH generally, and insights from those with key implementation roles in PHOs and CMH from semi-structured interviews (n=6). Where relevant, the findings from the focus groups are also included to illuminate how changes were perceived at the grass roots.

3.1 THE GENESIS WITHIN CMH

CMH has had a long running interest in targeting frequent users of secondary and primary care in order to avoid hospital admissions. In 2010, those patients who had 5 or more Emergency Department admissions in a 12 month period were identified as costing CMH $31.5 million, spurring the creation of a Very High Intensity Users (VHIU) programme. In VHIU, integrated multi-disciplinary case management was provided to a group of patients with complex health needs after discharge from hospital. The patients selected were those flagged in the emergency department IT system as having had five or more visits within a year who were then delegated a navigator from secondary care who arranged for any further support as needed.

Degeling’s risk assessment guide was used to provide a holistic assessment and community-based multi-disciplinary team meetings were set up to allow for the discussion of complex patients. Key ideas that shaped the VHIU intervention were then incorporated into ARI, though unlike VHIU, in ARI general practices made decisions on who to enrol to receive support and what support was provided.

The introduction and ongoing operation of ARI has also been supported by a history of work in CMH on changes that keep people well at home. These changes include initiatives encouraging an increase in patient self-management (the Manaaki Hauora Supporting Wellness Campaign), improving the integration of care through the creation of four distinct localities (the Localities initiative), and the launch of a rehabilitation approach within Community Health teams. Collectively, these initiatives aim to reduce pressure on hospital services and improve equity of access and health outcomes.
An earlier report on how the Localities initiative has rolled out since 2011 identified “ARI thinking” as emblematic of the type of philosophical shift from primary care providers that is being encouraged by CMH; a shift aimed at ensuring that patients get “a better experience and better journey” as a result of providers working as a single team and putting the patient who is “at risk” at the centre of the process.

The ARI programme was initially designed to be directly implemented through the Localities initiative, but PHOs successfully argued to be the overseeing body, resulting in an ARI service schedule signed between CMH and five PHOs - ProCare, National Hauora Coalition, Alliance Health Plus, Total Healthcare and East Health Trust. The ARI service schedule explained that ARI was to be managed by the PHOs, with the support of the DHB, and with the plans and goals of each Locality to be taken into account. ARI sits within the context of “alliancing” in the New Zealand health system, whereby DHBs are expected to establish alliances with PHOs as equal partners, though DHBs continue to contract with PHOs. What this means in practice is that ARI is an example of distributed leadership involving a shared responsibility with partners, even though CMH is the designated leader of the service contract.

3.2 FEATURES EVIDENT FROM THE BEGINNING

Given the whole system approach, a multitude of logics are encompassed in the ARI model of care with the following features evident from the beginning:

- An interest in prioritising enrolments to those most at risk of admissions to the emergency department to help reduce demand for secondary care.
- An expectation that patient-led goal-setting using a Partners in Health (PiH) questionnaire, and the development of a care plan, will support improved management by the patients of their long term medical condition.
- A desire to encourage a shift towards a more proactive approach of primary care, where care is co-ordinated between different health and social care professionals, in order to match care to the everyday realities of those with long term conditions.
3.2.1  ENROLLING THOSE MOST AT RISK

To help reduce demand for secondary care, those most at risk of admission to the emergency department were the target group for ARI. A readmission risk algorithm was developed by the University of Auckland to provide a risk score for patients upon discharge from Middlemore Hospital. An earlier study compared the readmission rate between five practices using a tool for identifying patients at high risk of acute readmission (the PARR tool), with those that were not, and concluded that there was a beneficial effect of using the PARR tool as a basis of deciding to intervene with patients at high risk of readmission \(^\text{16}\).

The final ARI service agreement acknowledged the potential of the risk tool, but explained that practices could decide who to enrol using “a CMH agreed predictive algorithm and/or clinical judgement”. Furthermore, before enrolling potential service users into the ARI programme, it was recognised that the responsible primary care practitioner must be satisfied that the person was “amenable to change”. Box One outlines the clinical guidance provided to practices on who to enrol on ARI.

3.2.2  THE IMPORTANCE OF PATIENT-LED GOAL SETTING

Once enrolled, patients complete a Partners in Health (PiH) questionnaire\(^2\) which provides a rapid checklist of areas of self-management that may lead to interventions targeted to an individual’s particular needs. The scale has been psychometrically validated \(^17\) and is part of a wider Australian Flinders Model for Chronic Disease Management. The broader Flinders programme applies cognitive behavioural therapy, problem solving and motivational interviews to work collaboratively with patients to develop individualised care plans. The PiH questionnaire is only one tool within a broader Flinders package, and PHO representatives explained that the PiH tool was selected because of its strengths in uncovering the patient’s own assessment of their condition.

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\(^2\) An option was also provided of using a Health Literacy Questionnaire though this was taken up only by practices within 1 PHO.
### Box 1 - Clinical Guidance for ARI Enrolment

The identification of at risk individuals should be a clinical decision guided by a framework as follows:

<table>
<thead>
<tr>
<th>The patient is amenable to change / their outcome can be changed; and</th>
<th>OR</th>
<th>AND/OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three or more long term conditions (LTCs)</td>
<td>One or more LTC and evidence of non-adherence or unstable diagnostics:</td>
<td>• Non-attendance (GP or OPC &gt;2x) or high attendance;</td>
</tr>
<tr>
<td></td>
<td>• HbA1C &gt; 100 and previously prescribed insulin; or</td>
<td>• Co-morbidities &gt;3;</td>
</tr>
<tr>
<td></td>
<td>• Uric acid &gt;0.36 and previously prescribed allopurinol; or</td>
<td>• Behavioural health condition (e.g. AOD, risk taking behaviour, self harm etc.);</td>
</tr>
<tr>
<td></td>
<td>• Total cholesterol &gt;6.0 and previously prescribed lipid lowering; or</td>
<td>• Medication risk (e.g. polypharmacy (&gt;5 Rx), high risk Rx (warfarin, methotrexate, opioid), medication change;</td>
</tr>
<tr>
<td></td>
<td>• Systolic BP &gt;160 and previously prescribed 2 or more anti-hypertensives; or</td>
<td>• Social risks (e.g. domestic violence, CYF’s involvement, concerns regarding poverty, deprivation, employment, no supports, social isolation, falls risk, ESOL);</td>
</tr>
<tr>
<td></td>
<td>• Diastolic BP &gt;95 and previously prescribed 2 or more anti-hypertensives; or</td>
<td>• Palliative care;</td>
</tr>
<tr>
<td></td>
<td>• INR &lt;1.2 on 2 or more consecutive tests; or</td>
<td>• Frail Elderly</td>
</tr>
<tr>
<td></td>
<td>• BMI &gt; 40; or</td>
<td>• Gestational Diabetes</td>
</tr>
<tr>
<td></td>
<td>• PARR &gt;30%; or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• COPD (measure to be determined</td>
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Flinders training has been incorporated into post graduate training in some New Zealand academic nursing departments, though research has found limited use of the tools involved due to a lack of practice support in terms of organisational capacity (including resistance from colleagues) and resources (particularly the time involved)\(^8\). ARI has a number of features that have the potential to overcome these barriers. Once the PIH questionnaire has been applied, funding is available to implement a Shared Care Plan which outlines the health and related services to be provided. The Shared Care Plan follows an electronic template and overseen by a named care co-ordinator. Once electronically loaded into an IT system, the plan is visible to other health professionals in order to assist in improving the co-ordination of care. Early
negotiations with general practices agreed hospital clinicians and other members of a patient’s care team would be able to see the Shared Care Plan. Furthermore, in order for the ARI enrolment to be valid, the Shared Care Plan needed to be loaded into the IT system.

3.2.3 A MORE PROACTIVE APPROACH TO PRIMARY CARE

ARI is nested within a wider set of changes being made across CMH to re-orient services to primary health care settings, envisioning a future state where primary care is at the centre of new arrangements to support people to stay well in the community. For those setting up ARI, the model of care expected from general practice was described as being less bio-medical and more psycho-social focused, i.e. focused not only on those with long term conditions such as diabetes or heart disease, but on those whose health might be compounded by other risk factors such as inadequate housing or low health literacy.

Another popular image was to describe the importance of ARI heralding the shift away from “five or ten minute visits to the ability to look after people in a much more flexible way”. The written description of what is expected to be different under ARI further refers to the re-establishment of general practices as the central focus of co-ordinated healthcare.

For the majority of the last century the structure of general practice in New Zealand has been characterised as one with a strong tradition of individual professional autonomy with a partial fee-for-service subsidy from the government. Prompted by the provision of a subsidy for practice nurses and a new Commerce Act during the 1980s, moves were made towards a larger more team-based practice structure. During this time, community-led alternatives to primary care services (union clinics, nurse practitioner groups, well women centres and new roles for independent midwives) were also challenging traditional general practice structures.
From 2000, as a result of the Primary Health Care Strategy, significant new funding was provided to support primary care services and reduce the cost to service users of using such services\textsuperscript{19}. The introduction of contracts as an alternative to fee-for-service subsidies from the 1990s resulted in collective organisations such as Independent Practitioner Associations and then PHOs, arising to manage these contracts\textsuperscript{20}. During this time the role of nurses increased and there was evidence of an increase in primary care consultation rates\textsuperscript{21}. Research on the development of PHOs, however, had found little sign of a wider range of health professionals being involved in primary health care service delivery beyond general practitioners and nurses and little attention being paid to enhancing co-ordination\textsuperscript{22}.

More recently, greater policy encouragement has been given to improving co-ordination between primary and secondary care as a way of delivering better care to those with long term conditions and reducing unplanned secondary care use. PHOs receive payments for meeting performance targets that encourage primary care prevention - for example better heart and diabetes checks, better help for smokers to quit, increased immunisation and cervical screening coverage. Nevertheless, as commentateurs have pointed out, there are still weak financial incentives for general practices to give a high priority to the health of the patient population as the current mixed sources and modes of payment generate conflicting incentives that inhibit a strong focus on caring for those with long term health conditions\textsuperscript{23}. While there are a range of providers of primary care and related services that focus particularly on the needs of Māori and Pacific, patient co-payments vary widely. General practices are still paid by their patients for each visit, with large geographic variations in the out-of-pocket payments faced by patients, often unrelated to their socioeconomic circumstances\textsuperscript{23}.

Those setting up ARI described the importance of providers being able to see the bigger picture regarding the change expected in how primary care operates. One interviewee explained that good primary care is already thinking about what they can do beyond a 15 minute consultation, but by being involved in ARI the aim is to “create a model that makes doing the right thing easier”. CMH primary care practices were previously able to access funding for those patients with chronic care needs under a range of disease or person-specific programmes such as CarePlus, High Risk Individuals, and Chronic Care Management. These programmes were subsumed into the ARI model of care, resulting in a generic intervention funding budget ($2.67 million) which allowed practices to purchase whatever services were required to
implement a patient’s agreed shared care plan. The improved flexibility offered by ARI compared to previous programmes was consistently recognised by all those PHO representatives interviewed as a key advantage over the previous Chronic Care Management programmes. The PHOs were responsible for ensuring an equitable process was in place for the allocation of the funding budget, with the potential for funds to go towards a range of activities including: extended consultations; medicine reviews; case conferencing; prescription co-payments; home visits; nurse led clinics; health literacy or self-management interventions; or whaanau ora initiatives. Box Two details the guidance given on where ARI funds could be spent.

**Box 2 - ARI Funding Guidance**

A flexible funding resource that will enable a service user’s care team to facilitate access to health services or health-related services that will support the service user’s agreed and documented Shared Care Plan.

<table>
<thead>
<tr>
<th>Examples of the services that may be purchased under the Interventions Funding include:</th>
<th>The Interventions Funding cannot be used to purchase services or utilities that a person would be reasonably expected to pay (regardless of their health needs, such as:</th>
<th>The PHO may only claim the maximum amounts specified for the listed interventions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Extended consultations&lt;br&gt;• Medicine reviews&lt;br&gt;• Case conferencing&lt;br&gt;• Prescription copayments&lt;br&gt;• Home visits&lt;br&gt;• Nurse-led clinics&lt;br&gt;• Health literacy or self-management interventions&lt;br&gt;• Whaanau ora initiatives</td>
<td>• Bills like electricity, gas, telephone and internet costs&lt;br&gt;• General household fittings, furniture and whiteware goods&lt;br&gt;• Standard electrical goods and consumer products&lt;br&gt;• Goods and groceries&lt;br&gt;• Mortgage payments, rent or rental assistance&lt;br&gt;• Employment services&lt;br&gt;• Fuel&lt;br&gt;• Airplane fares</td>
<td>• Follow-up nurse consult $45 (30 mins)&lt;br&gt;• Follow-up GP consult $45 (15 mins)&lt;br&gt;• Home visit - Nurse $75 (30 mins)&lt;br&gt;• Home visit - GP $75 plus patient co-payment permissible (15 mins)&lt;br&gt;• MDT Nurse $45 (30 min)&lt;br&gt;• MDT GP $45 (15 min)&lt;br&gt;• Care coordination follow up nurse time $45</td>
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The Interventions Funding can be used to purchase goods up to the value of $1,000.00 that are directly required to implement the Service Users Shared Care Plan.

3.3 **ADAPTIVE IMPLEMENTATION**

Three issues strongly shaped the early implementation of ARI: (i) the attention paid to the enrolment target; (ii) the difficulties with implementing the new e-shared care system; and (iii) a preparedness to make a start with the tools available. Between 1
July 2014 – 30 June 2015 each PHO was responsible for training their practices in the philosophy and mechanics of ARI, including the key requirements and processes.

### 3.3.1 Enrolment Targets

With five PHOs responsible for rolling out the ARI programme, the most tangible collective sign that implementation was occurring were the reports back to CMH on the total number of service users enrolled. Enrolment targets for ARI were set for each PHO at 3% of their enrolled population for year one of implementation, with this increasing to 5% at year 3. Figure 3 displays the type of early information used to track progress against these targets as successive waves of general practices came on board with ARI.

**Figure 3 - ARI Enrolment Targets**

ARI was deliberately designed to be flexible, yet a system was needed to allocate funding across the five PHOs and to provide accountability for the funding offered ($5.3 million). The enrolment target of 3% of the practice population was an important pre-requisite to meet public funding procurement requirements, however the emphasis on meeting enrolment targets proved to be of concern when PHOs were perceived as prioritising the importance of meeting the targets over patient need. In the focus groups, it was not uncommon to hear the initial stages of ARI implementation being described as being “all about the numbers” resulting in concerns that the need to enrol patients crowded out more positive messages about
the gains to be achieved from ARI. Chapter Six discusses the implications of this more fully (pages 65-66).
New electronic shared care software was a key part of providing proof patients were enrolled on ARI. Early background research on how best to communicate the changes encompassed by ARI included a large amount of commentary on the likely reception of the new shared care IT system to enrol and track patients. While the IT changes were only an enabler to the bigger changes expected – i.e. the changes in patient outcomes, in how practices operate and how the system managed demand for secondary care – this early report highlighted the potential for IT glitches to colour the experience of practice staff. Practice staff reported they already “felt overwhelmed by emails, numerous IT systems that don’t speak to each other and lots of paperwork”.

Concerns that the e-shared care system was not an improvement on existing systems also turned up as a regular refrain in the list of issues from early feedback in ARI implementation workshops. Not only were there teething problems with the technology of enrolling patients and invoicing for practice time, but interviews with PHOs at the end of 2015 highlighted the ways ARI could be a difficult sell when the first encounter practice staff had with ARI was a complicated new system. As one PHO explained:

“That I guess was the hardest bit, the enrolment probably took the longest. At times up to an hour. Especially if the Shared Care Plan system was stopping or really slow. It was crazy. Providers were just like “look I don’t want to touch it, it’s always crashing on me” ...so we’re trying to keep them motivated and saying it’s just a glitch. A big teething phase. Just keep pushing (PHO representative).”

3.3.3 LEARNING FROM EXPERIENCES

Initial ARI pilots were undertaken with interested practices, but roll out spread quickly as the five PHOs took responsibility for engaging with practices. Representatives of PHOs described a “learning by doing” approach to putting care plans in place:

“We’ve said to practices while you’re starting this and getting the hang of it start with the willing. Start with the ones that you know [you] can work with. As they
Training in how ARI worked was offered initially on a “train the trainer” basis by CMH, followed by the PHOs using the familiar routes by which they engaged with their practices to introduce detailed ARI requirements. These familiar routes included outlining the changes required in newsletters, offering one on one visits and running workshops. Across CMH, the Localities structures were harnessed to communicate changes in some areas (e.g. Franklin), but not necessarily in all. While training was provided, it was not always taken up. As PHO representatives stressed, much depended on how much practices valued and supported professional development for their nurses and how much nurses themselves were prepared to turn up to the training offered. More recently, in support of ongoing quality improvement, practices were asked to review the plans and experiences of up to 10 ARI patients. The results have been a valuable source of insight on what skills are needed to further develop ARI. CMH has developed further training based on the feedback from the practices. Practice staff wanted more on motivational interviewing, health literacy, mental health, care co-ordination and additional ARI learning events.

Using terms such as “baby steps” or “working in pockets” to describe the first year of implementation, the PHOs stressed that for practices, even though the number of patients involved could seem like a relatively small percentage, the work involved was large. While the effort involved in learning how to deliver a good care plan was expected, the PHOs also uncovered challenges in how practices operated:

We underestimated what an impact it would have on their daily processes, [practices] were used to invoicing a certain way for CCM and getting paid a certain way. As well as changing the finances, practice booking times were also affected which required getting the buy-in from everybody within the practice team (PHO representative).

Consequently, one of the gains for the PHOs in implementing ARI has been in engaging more deeply in how practices operate and supporting change where it is needed.
I think it’s helped to see more closely the practices’ model of care. To see how it’s currently running and what it needs to move to. ....it’s been a foot in the door to look at models of care and prompted conversations with the ones that are a bit stuck (PHO representative).

CMH held workshops in September 2014, January 2015 and July 2015 to trouble shoot implementation issues. From a review of the notes from those workshops as well as solutions to IT issues, requests were made for user friendly patient information (including translations) to assist in the process of asking patients if they wanted to be enrolled on the programme. While the flexibility of ARI funding was recognised as an asset, the downside for some was that the sheer flexibility meant practices needed to develop their own thinking on what a tailored programme of support looked like. In follow-up interviews with PHOs, a number mentioned how influential it had been to hear examples at these workshops from other practices on what interventions funding had been used for. As one explained, initially practices were locked into seeing ARI as a way of funding regular quarterly visits by patients, but hearing back from practices engaged in referring patients to other services meant they came back “inspired to do things differently”.

3.4 DECISIONS ON WHO TO ENROL

Practices were given a framework to indicate who should be enrolled on ARI (see Box One), though as discussions in the focus groups revealed, learning accumulated on which patients benefited most. Initially, the need to meet an enrolment target (3% of their enrolled population) and to transfer patients from the previous chronic care management programme dominated the early stages of the roll-out of ARI. By the time the focus groups were run, those practices that had confidently reached their enrolment targets were able to describe the ways they had begun to think about the ideal candidate for ARI. The following chapter presents these results in greater detail, but here a summary is provided of how practice staff experienced the difference between ARI and the previous chronic care management programmes.

When asked to describe the difference between ARI and the previous chronic care management programmes, all participants in the focus groups acknowledged the increased flexibility offered by ARI. ARI was clearly understood to be targeted towards behaviour change and improved self-management and moved away from the prescriptive criteria and quarterly appointments that dominated previous chronic care
management programmes. As one focus group participant succinctly explained, ARI was now about having individuals “manage their own health rather than being managed”.

Practices did not need to fit individuals into prescribed categories when deciding who to enrol, but the downside was that they did need to form their own collective understanding of which patients would benefit most. The difference between the two approaches was described positively in terms of the flexibility of the support offered:

*The Chronic Care before was about filling in forms. Yes ARI is a little bit about filling in forms but it’s mostly about what we can offer our patients (Small size practice participant).*

However, filling in forms did have advantages in that those forms offered a clear prescription on what follow up tasks were required and worked within a well understood IT system i.e.:

*CCM pre populated from Medtech and then it came with a print-out with instructions. CCM was prescriptive but you could print it out, go to the patient and they knew the plan (Small size practice participant).*

The flexibility offered by ARI shone through for those practices that built a clear understanding of the type of needs within their practice as the following quote demonstrates:

*I like the programme because it’s not based on ethnicity, it’s not based on age, or anything. You have people who are highly at risk that are in their 40s, that actually need to be on some form of support programme, but don’t fit into a CCM module. Who don’t fit into other programmes that are run. Therefore this programme is brilliant for that (Large size practice participant).*
3.5 SUMMARY OF IMPLEMENTATION CONTEXT

By the time the fieldwork started in the practices in July 2016, ARI had been in place for two years involving 20,776 patients spread across 115 general practices. As a new model of care ARI had four mandatory elements: (1) a named care co-coordinator, (2) an electronic shared care summary record, (3) an electronic shared care plan and (4) the completion of Partners in Health scale (or the Health Literacy Questionnaire).

As an intervention, ARI does not have a single fixed component or a stable process applied in relatively homogenous settings. With the complexity of five PHOs managing the roll-out, and a desire to give greater flexibility to practices to decide what support to give to those with long term health conditions, ARI is built around the philosophy of giving tools to practices and then allowing them to decide how best to use them.

Reflecting back on the set-up stage, the PHO representatives interviewed identified a number of contexts which could go some way to explain what made implementing ARI easier for some practices and harder for others. These formed the basis of further testing through focus groups and included suggestions that:

- Practice teams with engaged lead nurses had the energy to overcome the time and effort required to learn the new approach (involving new booking procedures, reporting requirements, and new IT systems).
- Practices that were not IT savvy and without PHO technological support found the ARI reporting and shared care requirements a burden to implement.
- Large practices with a team-based culture were more likely to embrace ARI as part of a bigger picture of engaging with outside providers and use the associated ARI interventions funding flexibly.
- Medium and large practices without a team-based culture often left nurses to drive ARI, resulting in care plans being seen as increased administration and interventions funding as merely another way of generating income for the practice.
• Small practices relying on only one to two nurses could easily find they had to do longer consultations with ARI patients (plus the normal practice workload), and when these nurses were less experienced they struggled with implementing ARI.
ARI incorporates many elements of Wagner's Chronic Care model which focuses on linking informed active people with long term conditions with practice teams of health professionals. Evaluations of the Chronic Care Model have found that applying all the components of the model may improve the quality of care for those with different long term conditions, but it is uncertain which components are the most effective or transferable.

In the self-management literature, a wide range of activity is described as self-management ranging from providing leaflets to more active approaches that target behaviour change. ARI sits on the spectrum of more active support and encompasses a diversity of features that have been found to work well to support self-management. These include: (i) involving patients in decision making; (ii) emphasising problem solving; (iii) developing care plans as a partnership between patients and professionals; (iv) setting goals and following up on the extent to which these are achieved by patients over time; (v) promoting healthy lifestyles and educating patients about their condition and how to self-manage and (vi) helping patients to manage the social, emotional and physical impacts of their conditions.

Six statements of the ways patients were expected to gain value from ARI were developed from a review of the ARI set-up documents, and then calibrated against the literature on what is known about the effectiveness of patient self-management programmes, as well as initiatives to help improve care co-ordination. This section presents the results when staff in each focus group were asked how much the following six statements resonated (or not) with what they had observed being valued by patients enrolled on ARI:

1. ARI patients valued the increased opportunity to receive more practice staff time, resulting in an increased understanding about their condition and how to self-manage.

2. ARI patients received more advice on how to embed care solutions into their own lives as a result of developing collaborative care plans, following those plans and then subsequently improving their overall clinical outcomes.
3. ARI patients **had less worry about costs** resulting in more access to primary care and potentially less unplanned use of secondary care services.

4. ARI patients adhered to care plans because they wanted to be **seen as good patients** and demonstrate improved self-management competency.

5. ARI patients received care that aligned with their **cultural practices and beliefs**.

6. ARI patients had improved experience and confidence in their care as a result of **seeing the professionals involved in their care talk to each other**.

When discussing the six statements, practice staff were also given the opportunity to add any further statement of what they thought patients valued. A common addition was to stress the value from having a named connection in the practice which increased continuity of care for patients.

### 4.1 CONSISTENT AGREEMENT THAT ARI PATIENTS VALUE TIME AND ADVICE

Across all six statements the two most consistently endorsed in discussions were: (1) ARI patients valued the increased opportunity to receive more practice staff time and (2) ARI patients receive more advice on how to embed care solutions into their own lives. Focus group participants highlighted the ways in which they observed patients growing to understand more about their condition and increasing their understanding of how to self-manage. These changes were sourced back to the time spent by practice staff building a rapport and harnessing the motivations of those who agreed to be enrolled.

Under ARI, patients had more time with practice staff (particularly nursing staff) than the usual 15 minute consultation. Staff highlighted how these face-to-face interactions meant “patients had their conditions explained to them in detail with different strategies given to overcome any misunderstandings”. For practice staff, the time focused on understanding the patient as a whole rather than just his or her physical issue was an important part of building a rapport with a patient.

There was some discussion on the ways in which the tools made available under ARI supported the process of building rapport. Staff in two focus groups queried whether
the PiH framework was the most appropriate form to capture the views of patients. One used a Health Literacy Questionnaire in preference, while in another focus group staff were concerned the Likert scale in the PiH was difficult for some patients to interpret. In another focus group, a portion of the staff pointed out that they came from a background where they had been trained in the full Flinders suite of tools which included motivational interviewing. Rather than dwell on the tools provided, other focus groups talked less about the mechanics and more about what could be revealed when time is spent asking “what matters to patients”. In practices where nurses were responsible for their own ARI caseload, the conversations sparked by the questions in the PiH and resulting shared care plan were a significant part of building a trusting relationship with patients:

I have been here four years and for me to know every patient that walks in is hard. But I know my ARI caseload. I seem to know each and every one and what we have discussed in our ARI meeting and their goals. I don’t need to bring them up on the system because I know what we have talked to them about...it’s building the relationship with them (Large size practice participant).

When focus group participants reflected on the process of developing the care plan, a number made a distinction between patients valuing the discussion rather than the piece of paper at the end. In making this distinction, staff stressed the power of the conversations in motivating change as the following two quotes exemplify:

They can sit there and talk to you and you really get them motivated. Really you’re just trying to motivate them a lot of the time... some of them.... it’s trying to get them to understand why they need to make the changes and that once they get started they see the benefits, then they’re away. They can be really motivated. I think it’s the time to build up the rapport and get them to trust you (Small size practice participant).

Although we do offer them copies of the care plan and access to the care plan and we talk to them about the care plan, ...the plan itself doesn’t really catch their imagination, but what we talk to them about ... that can involve an increase in capability to comprehend and embed solutions .. if you talk to somebody about what diabetes is and how their blood sugar goes up and how their diet and exercise might actually work to control that. They have time to comprehend that ...it’s the fact of that conversation and that interaction more than the fact they have made a care plan that matters (Large size practice participant).
Two years into the operation of ARI, the lived experience of implementing ARI had sharpened the sense of the type of patient ARI worked well for, and those it did not. In summary, participants explained the ARI worked well for patients who were motivated, had a condition that lent itself to a measurable change, and could work well for those with wider psycho-social issues (though this was not universally experienced). Each of these is discussed in more detail below.

**ARI works well for those patients who demonstrate motivation but does not necessarily work well if the driving motivation is to simply lower out of pocket costs.**

If ARI was sold to potential patients on the basis of lower costs or “free visits”, focus group participants reported experiences of getting them in for the initial hour and then a drop-off in ongoing involvement. A later section of this report discusses how the experiences of patients was mediated by the different starting points with regard to out-of-pocket costs across practices in the sample. Some practices had a long history of offering free or low cost services to their enrolled population which then shaped their views on the increased advantage being offered by ARI of lower costs for more extended consultations. Practices with a history of higher co-payments described making nuanced judgements on which patients would transfer from the previous Chronic Care management programmes. The decision to offer enrolment on ARI was a combination of clinical need, motivation and financial need, i.e.:

> I think we have got the [the enrolment criteria] down now. If they are starting to come into the practice a bit more often and need more intensive time and encouragement from us we are enrolling them. We are also using it for short term things…people that need Cognitive Behavioural Therapy that cannot afford it otherwise and health psychologists…resources that they would not have been able to tap into financially otherwise (Small size practice participant).
ARI works well for those with conditions that lend themselves to a measurable change but does not work well for those whose condition merely needs monitoring.

Contrasting the experience of previous chronic care management programmes, which paid for a patient’s health to be monitored, participants stressed the importance of identifying and working on a measurable change in collaboration with a patient. Some conditions lent themselves more clearly to a measurable change, which became apparent when nursing staff recounted situations where they wanted to challenge a request by others to enrol a patient on ARI.

*Often you get referrals from the doctor and they’ll go, ‘oh he should be on ARI’ and you look at the patient and he has actually he’s got all these things in place. What are we actually going to be doing for him other than a social chat? (Large size practice participant).*

Conditions linked to diabetes were regularly mentioned as the type of condition that allowed staff to have an impact, with staff reporting they are seeing real “turnarounds”, particularly when patients are first diagnosed and need to make lifestyle changes. Others noted that ARI was also valuable in the later stages of diabetes when more care was required as a result of renal failure. Staff stressed the importance of not just monitoring a condition but working to influence a change:

*If I [as a nursing care co-ordinator] don’t think I can make a difference it doesn’t matter if they can pay for it or not. I don’t really see the point. Just because putting them on the programme will let them check their healthcare provided by the doctor. We can’t actually impact their health, then what is the point? If I’m not doing something for them, then what is the point of filling the care plan? That’s just a waste of my time (Large size practice participant).*

ARI can work well for those with wider psycho-social issues though there is a limit to what primary care can do.

Those practices in areas with high health and social needs strongly appreciated the flexibility embedded in ARI. Participants in these focus groups stressed the power of being able to adapt ARI to fit the complexity of conditions they saw and the opportunity to adapt their response to “what matters to the patient”. Box Three provides some examples of the type of cases raised to demonstrate
this point. Nevertheless, much still relied on patients’ willingness to be enrolled in the first place. Practice staff were sometimes able to draw on the skills they have developed in dealing with transient populations, but could still find that being enrolled in ARI was not the solution for those patients who were time poor, had transport issues or wider issues in their lives:

\[
\text{It doesn’t work for those who do not want to be on the programme. They have to consent. They have to be willing to change. We cannot make it work one-sided. It has to be in partnership with them to work. We will enrol some and see if we can build a rapport with them. If it is not working out for them and us we are dis-enrolling them (Large size practice participant).}
\]

Moreover, being placed on ARI is not a magic bullet:

\[
\text{What tends to happen is [our staff] will receive a phone call from the hospital saying “this patient is not using our services and is not attending our clinics and is very non-compliant - put them on ARI”... We look into the patient’s file and we will quickly find that this patient is not the ideal patient to be on ARI.}
\]

\[
\text{What makes them not the ideal patient?}
\]

\[
\text{They don’t meet the specifications. When Counties first gave it to us there were two specifications. One - is the patient willing to improve their health and well-being? Only then do you enrol into ARI. Well clearly this patient that has been referred by secondary care is not interested. If we ask the patient the patient says I am not interested. They are not quite ready. We cannot willy nilly enrol anyone and everyone into ARI also knowing there is a capped volume and there is a limited amount of funding available to wrap around services and interventions (Large size practice participant).}
\]

Not all practices were confident they had either the skills or support to offer care to those on ARI with wider psycho-social issues. Most could see that the intent of ARI was to be as flexible as possible to allow services to be wrapped around complex patients, but concerns were voiced that: (1) for mental health issues the services to wrap around may not exist; and (2) there is a limit to what primary care can do if individuals are not engaged in their own health. To illustrate the latter point, staff in these practices would highlight their experience of intractable cases where “the guy that really needs it is not going to do it no matter what we do” or “what is happening at home is somewhat the territory of social welfare rather than primary care”.

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4.2 VARIABLE RESPONSE TO “LESS WORRY ABOUT COSTS”

In discussion in the focus groups, there was a diversity of views whether ARI patients valued having less worry about costs (statement 3). The reason this statement was included in the evaluation was that those with long term health conditions often suffer from more than one condition, making their care complex and potentially expensive if they need to access primary care regularly. By lowering out-of-pocket primary care costs, the expectation is that patients are more likely to engage with
primary care early and avoid secondary care visits that indicate they are not managing their condition well.

When asked if they agreed ARI patients valued having less worry about costs, there was variation in the importance attached to this statement according to the fees charged by practices in the first place. Not surprisingly, those practices who already charged low fees (under $20 or less) were less likely to rank this as a \textit{significant} advantage for ARI patients, though being able to reassure patients there would not be any costs for services provided beyond practice consultations (e.g. self-management programmes) was important. Those practices who charged between $20-40 or over $40 for each enrolled adult could see a significant advantage to their ARI patients who did have less worry about costs, particularly the elderly population who were on a fixed income and “could not afford to keep coming back in”. Figure 4 displays the breakdown of the different charging regimes within the sample.

\textbf{FIGURE 4 - BREAKDOWN OF CHARGING REGIMES WITHIN RESEARCH SAMPLE}

<table>
<thead>
<tr>
<th>Locality One</th>
<th>Locality Two</th>
<th>Locality Three</th>
<th>Locality Four</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PHO A</strong></td>
<td>Over $40 adult enrolled (2 practices)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>PHO B</strong></td>
<td></td>
<td>Less than $20 adult enrolled</td>
<td>Between $20-$40 adult enrolled</td>
</tr>
<tr>
<td><strong>PHO C</strong></td>
<td>Less than $20 adult enrolled</td>
<td></td>
<td>Between $20-$40 adult enrolled</td>
</tr>
<tr>
<td><strong>PHO D</strong></td>
<td>Less than $20 adult enrolled</td>
<td>Less than $20 adult enrolled</td>
<td></td>
</tr>
<tr>
<td><strong>PHO E</strong></td>
<td>Less than $20 adult enrolled</td>
<td>Less than $20 adult enrolled</td>
<td></td>
</tr>
</tbody>
</table>

One focus group participant more familiar with the United Kingdom’s National Health Service highlighted the ways in which thinking about costs had to be factored into caring for those with long term health conditions in New Zealand:
I am not used to thinking about the cost to patients and [ARI] makes me feel less guilty as I tend to get people back a lot and I forget that this is a cost to them...this makes it easier to think I need to see you a fair bit and they are not going to be paying as much (Small size practice participant).

Staff in practices that saw less worry about costs as a significant value to ARI patients could find themselves needing to juggle the desire to lessen the worry about costs for patients with the desire to be assured that ARI support was going towards a change in health status. As outlined in the previous section, the ideal ARI enrollee needed to demonstrate a motivation to change rather than to simply want to lower out-of-pocket expenses. In the focus groups, concerns over what costs were legitimate to cover under ARI revealed some uncertainty over whether, for example, costs to cover taxis to clinics or free flu vaccinations were likely to lead to a measurable change in health status. Clear parameters of what costs could be covered by ARI were presented in the ARI service schedule and were summarised earlier in Box Two.

4.3 VARIABLE RESPONSE TO ALIGNMENT WITH CULTURAL PRACTICES AND BELIEFS

Each PHO was advised to consider Māori health and cultural safety in their delivery of ARI and, furthermore, Question five on the PiH asks patients to indicate on a scale from “never” through to “sometimes” and then “always” that “I am able to deal with health professionals to get the services I need that fit with my culture, values and beliefs”. When asked to comment on whether ARI patients valued receiving care that aligns with their cultural practices and beliefs, most staff referred to the insights they gained from answers to this PiH question, although there were differing levels of confidence in the answers, from the uncertain, e.g.:

I find that one hard to explain to people what that actually means to them. I know that with some patients I certainly try to explain what was meant by cultural practices and beliefs (Medium size practice participant).

...to those who were confident they could use the answers to offer the opportunity to align patients with health professionals who understood their cultural values and beliefs, e.g.:

Some of our nurses have the same ethnicity as some of the patients. We have a mental health team within our network that have psychologists and health coaches and those health coaches are also for different ethnicities. We try and align them with the patient’s ethnicity (Large size practice participant).
Those practices with high Māori or Pacific populations clearly outlined the importance of adapting ARI to recognise whaanau approaches to care:

*With respect to our Pacific patients we understand that individuals are not individuals. So we often ask for family members to come in to be part of conversations. Especially the ones who do the cooking, and the shopping, and the transporting. We know our patients reasonably well in that respect, but I think having at risk individuals isn't really a Pacific or Māori world view though I guess it can be the door in to some families (Small size practice participant).*

Another focus group discussion linked the advantage ARI provides in allowing more time with the patient to the opportunity to understand the ARI patients’ perspectives on the world. In circumstances where “care coordinators” implement ARI then the role can act as a bridge between the patient and the doctor as the following participant outlined:

*If you explain that you need to eat healthily to someone from another culture it could mean something different...for Pacific Island, Indian, Asian ...all the cultures in South Auckland they might take a different meaning away, ...for some of them it might mean they need to take traditional medicines while the doctor is actually saying you need to go for a walk to lose weight (Large size practice participant).*

**4.4 UNCERTAINTY OVER HOW CARE PLANS ARE USED**

ARI is not solely a self-care management programme, but also relies on general practices taking more responsibility for co-ordinating care for service users. Each ARI patient is allocated a named shared care co-ordinator and provided with a shared care plan electronically accessible to all health professionals, in the expectation that ARI patients would experience greater confidence in the co-ordination of their care. The ARI training materials emphasised that confusing and conflicting messages could be avoided if the patient goals in the shared care plan were used by all health professionals. However, when focus groups were asked if they thought patients were seeing the professionals involved in their care talk to each other, the majority were not confident the shared care plans were being used as expected.
Two focus groups were particularly concerned that plans were not being shared within the practice resulting in “the doctors having no idea what the patient’s goals are” leading to concerns that ARI is just a paper-based exercise:

   I start to think who in the practice looks at them? We only do it to update it, because we have to update it. I don't think the doctors go in and see ‘oh what’s this patient’s goal’, what are we trying to achieve here? I don’t think the doctors are accessing the care plans much. I might be wrong but I get that impression (Medium size practice participant).

Three other large practice focus groups pointed to variable engagement within the practice in engaging in care plans between doctors: some doctors for example expressed a view that “they only have 15 minutes to spend with the patients so they cannot actually do everything in the care plan”.

Others were more confident about communication within their practice, but expressed concerns whether those outside the practice were accessing the plans as expected. Some recognised that not everyone across CMH had been able to electronically access the plans, though messages that this could be changing were filtering through. Occasionally a participant was able to give others an example where someone had placed a message within a plan as proof things were improving as evident in the following focus group dialogue in a medium-sized practice below:

   P1: I think those who use E-shared care know about it and use it. Those who don’t, don’t currently. I suppose it’s just beginning.

   P2: For a whole year nobody looked at it.

   P4: Now they’re assuring us that it is often looked at in the hospital.

   P3: The needs assessment coordinator, you know. They look at it regularly and the district nurse. Somebody came from the hospital and she is doing her best to educate others. She said they do all know how to look it up. She’s promoting it more and more.

   P2: What I wish is when your patients go off to a specialist nurse clinic I wish they would write on the care plan.

   P3: I can’t say that I’ve had anyone add to my plans.

   P4: I’ve had task messages sent to me saying can you do this.
Another aspect of care plans that also raised a diversity of views was the suggestion that ARI patients were more likely to adhere to care plans because they wanted to be seen as good patients. This statement was included as a synthesis of the factors most likely to influence the adoption of self-management included the patient’s desire to please clinicians and be seen as good patients and also emerged from interviews prior to finalising the statements. Across all the focus groups, this was regularly questioned as something that patients valued when compared alongside the statements stressing the opportunities for patients to have more staff time, lower costs or tailored self-management advice. Staff often stressed there are “no good or bad patients” and what was more important was working with the patient’s own goals. The following quotes illustrate the nuanced ways staff worked to motivate patients to achieve change within the context of what each solution meant to each patient in their own daily life and routine:

A good patient ... I don't even think there is such thing as a good patient. I congratulate them on whatever change they have made, for example the diet fizzy instead of regular fizzy. She was buying 50% less sugar juice as well (Small size practice participant).

I can think of a patient who was having lots of hospital admissions. He kept being discharged and then very quickly going back into hospital. I talked about this when he came on to ARI. He said [he] never feel[s] that [he has] the opportunity to get well before he’s back having to manage himself .... He was subsequently admitted to hospital and he did have a period of rehabilitation. I wasn’t able to tell whether that was because somebody looked at the care plan or he got brave enough to say. I think that what happened is that he was able to verbalise his wants so he had rehearsed that in his mind and then had the words to express it to somebody else (Large size practice participant).

A few staff noted situations where patients had agreed to be on ARI “to please their doctor”, but when staff attempted to work on a care plan they found patients were not engaged.
4.5 DIFFERING VIEWS ON “AMENABLE TO CHANGE”

The guidelines on who to enrol referred to the importance of selecting patients who are “amenable to change” when describing who benefits from ARI. Focus group participants teased out how they appraised the level of patient interest in identifying goals and working towards a change. They looked for someone whose goal was not just to be healthy but who had something specific they wanted to change about their health. One noted that timing an individual’s ARI involvement after they had a major illness, or had been in hospital, could be a key moment to engage patients on a new path to recover well and self-manage.

No-one interviewed in the focus groups had a confirmed percentage breakdown of the different types of conditions of their ARI enrolled population. However, when asked about the type of long term health conditions they believed they were having the most success with the following were noted: diabetes patients who wanted to lower HbA1c; those with high BMI who wanted to lose weight; those who wanted to stop smoking; and those needing to make changes as a result of various forms of heart disease.

Those with mental health issues, those requiring palliative care and the frail elderly were also regularly mentioned by some practices. What was interesting was that other practices expressed uncertainty over whether these groups fitted a category labelled “amenable to change”. For example, when considering the frail elderly, one participant explained how she was not sure how the goals of these patients fitted the ARI criteria as it was not clear how they were going to improve:

> What I find is that some of the ones really where you’re basically trying to maintain them at home, they’re not going to improve. They’re in their 90’s, their kidneys are not suddenly going to start functioning again. A lot of those I find quite hard, because there is not a lot other than making sure things are in place for them to actually stay in their own home. That’s usually their goal to be independent and stay in their own home. There is not a lot you can actually do for them in terms of having a goal they need to try and meet or improve on. Some of those are a bit hard (Large size practice participant).
Another example comprised palliative care patients. One participant explained that:

*While personally I don’t have a problem using ARI for palliative patients so we can provide as many services as we can in the community but this is a patient that is clearly not going to improve* (Large size practice participant).

Two practices gave examples of ARI enrolments initially based on age. One practice started the transition to ARI by enrolling all those over 70 in their practice, but this was having mixed success as:

*A lot of them are really well people that don’t actually need it. We’re missing out on some of the ones that do need it. We’re so focused on doing all these care plans and updating them* (Medium size practice participant).

Another practice included those patients over 13 years of age who had long term health conditions so they could make their appointments free and lessen the cost burden on the parent as well as “accessing other support that they may not have been able to access privately”.

4.6 SUMMARY

Those enrolled on ARI are expected to demonstrate increased self-management competency, have improved access to primary care, and feel more confident that the professionals involved in their care are talking to each other. From the perspective of the health professionals implementing ARI, most of these outcomes are being achieved under certain conditions. Practices were given a framework to indicate who should be enrolled on ARI, though over time learning has accumulated on which patients benefit the most.

If those enrolled on ARI who demonstrate motivation, have a condition that lends itself to a measurable change and are part of a practice with prior skills in working with psycho-social issues, then staff believe those enrolled are likely to demonstrate increased self-management. The two key mechanisms that “cause” this outcome are the increased time spent by practice staff in building a rapport with patients and the skills they apply in harnessing the motivations of those who agree to be enrolled.
If those enrolled on ARI have a condition where it is not obvious what change is needed, are merely enrolled to lower out-of-pocket costs and are not part of a practice confident they have skills in working with wider psycho-social issues, then increased self-management is less likely, particularly for complex patients.

Staff in practices reported they needed to juggle the desire to lessen the worry about costs for patients with the desire to be assured that ARI support was going towards a health status change. In contexts where practices had a long history of low co-payment charges then staff were less likely to see a reduction in worry about costs as a significant advantage for those on ARI. Based on their experiences of dealing with individuals with complex co-morbidities and a transient lifestyle, staff in these practices would report that the barriers to accessing primary care were more complex than cost barriers, though being able to offer an assurance that any further services to achieve a shared care plan were free of costs was important.

ARI relies on general practices taking more responsibility for co-ordinating care and includes the expectation that the patient goals in the shared care plan are used by all health professionals. The outcome expected is that ARI patients have an improved experience and confidence in their care as they see the health professionals involved talking to each other. When focus group participants were asked if they thought patients were seeing the professionals involved in their care talk to each other, the majority were not confident the shared care plans were being accessed by others. That said, hearing from others in the practice, or seeing recent proof themselves that other healthcare professionals were accessing the plan, could be a tipping point to increase confidence that the time included in drafting care plans was becoming more worthwhile.
CHAPTER FIVE: WHAT DO PRACTICES GAIN FROM ARI?

Those implementing ARI were aware from the beginning that implementation requires a paradigm shift among health care professionals who have traditionally been trained to take control of, and responsibility for, acute health problems. For those overseeing ARI, the approach heralds a shift in primary care from “five or ten minute visits to the ability to look after people in a much more flexible way”. The expectation was that general practices would show signs they were becoming more outward looking as they develop comprehensive care for complex patients and connect with services “other than those they provide in their practice”. The term used by CMH to encapsulate this change is “planned proactive primary care”.

Internationally, studies suggest that the type of changes encompassed in the ARI model of care require a supportive general practice environment in terms of professional training, financial reimbursement, and an understanding of the constraints of how practices operate. Six statements of the ways practices are expected to gain value from ARI were developed from a review of the ARI set-up documents and the literature. Staff in each focus group were asked how much the following statements resonated (or not) with what they had experienced in their practice:

1. We are **resourced for the time** it takes to develop care plans and follow up with complex patients.

2. Within the practice, the general practitioner’s working day is freed up as **nurses now play a more significant role** in delivering care to practice patients with long term health conditions.

3. **ARI training** has exposed us to the potential of a structured collaborative process that empowers patients to take an active part in decision making on their condition.

4. We now have **working contacts with social workers and other community and allied health workers** and can therefore engage differently with patients with complex needs.

5. We feel better supported to help patients with complex needs because we have **improved access to and support from secondary care**.
6. Within our practice discussion has been prompted on what else could be done to improve the overall health of the practice population, rather than just those who choose to visit.

In the previous chapter, focus group participants held fairly consistent views about the ways in which patients gained value from ARI. When considering how practices gained value, there was a much more diverse set of views according to the size, location and dynamics of the practices involved. Two contexts particularly shaped views on the extent to which ARI had supported practices to deliver more planned proactive primary care:

1. The differences between how practices organised themselves to implement ARI. Figure 5 presents the break-down of the sample between (i) those practices who absorbed ARI into their current style of operation; (2) those practices who adapted to cope with ARI; and (3) those practices who significantly changed how they operated (Figure 5).

2. The potential for the existing relationship between nurses and doctors within a practice to facilitate progress in some circumstances and hinder progress in others. Those practices without a team-based culture for example often left nurses to drive ARI, resulting in care plans being seen as merely increased administration.

5.1 THE IMPACT OF HOW DIFFERENT PRACTICES ORGANISED THEMSELVES

Health professionals often complain time pressures get in the way of providing the type of personalised care they would like to be able to deliver. The expectation was that by resourcing practices for the time involved in filling in the PiH, developing the shared care plan and offering ongoing interventions, practice staff are able to overcome these time pressures and grow their capacity to deliver planned proactive primary care. When focus group participants discussed if they agreed that they were now resourced for the time it takes to develop care plans and follow up with complex patients, responses varied.
The five practices who absorbed ARI into business as usual were normally small-to medium-size practices. If practices are smaller it is not unexpected that it may be harder to absorb the time involved in ARI even though more resources are being made available. Two of the five practices who had absorbed ARI into business as usual reported problems finding the time to support ARI. One reported an absence of allocated time to ARI due to being a walk-in clinic resulting in “no support from the rest of the staff because it is another extra job in a very busy day”. Another medium-size practice also reported struggling with incorporating the work into their normal routine, explaining that while they had training to highlight the difference between ARI and CCM:

... when you try and put the training in practice you just couldn’t as there was not time and you just couldn’t allow an hour every week to see a patient for six weeks and spend that time to get the goals and achieve them (Medium size practice participant).
The other three practices that had absorbed ARI into business as usual were more likely to agree they were resourced for the time involved, often because they had already been doing this work and were now getting paid for it. What characterised these three practices, despite their small size, was the strength of team dynamics they could draw on, built from past experiences delivering care to those with long term health conditions. Staff highlighted the ways they found shortcuts to cope with the administrative demands, for example:

*I just do it when I can. I try and do it. When I’m seeing... after I’m seeing them actually. I try and spend time with them writing on a piece of paper and try and do most of the computer stuff after they have gone* (Small size practice participant).

That said, concerns were raised from those staff who had many years’ experience working with those with long term health conditions that they “now did more administrative work today than I have ever done in my career”.

Discussions in one small practice noted that it can be logistically difficult to pass on patients to the one-to-two nurses in the practice whose time is increasingly booked up. Nevertheless, the practice has found a way to split ARI responsibilities between the general practitioners who initiate the process and the nurses who follow up and agree specific goals and develop a care plan. As they explained “when it started it was one of the huge issues in our head where were we going to get the time to do all this but it has worked”, as now:

*As a doctor I can say OK book 30 minutes with me and I spend that time with the patient and then pass onto the practice nurse ...it doesn’t reduce the time I spend having the nurse involved but it increases the quality of what patients receive* (Small size practice participant).

Three larger practices reported adapting to ARI demands by appointing nurse leads, sharing ARI caseloads across nurses and experimenting with different ways of “pulling nurses off the floor” to cover the extra time involved. These staff were also able to draw on a team-based approach to delivering care in partnership with the doctors in the practice. As one focus group participant reported, ARI gives staff the time to do the things they should be doing as care providers:
The idea of ARI, sometimes you have this [thrown] back at you from contacting people [and] talking about the programme. They say isn’t that what you do anyway? Or isn’t that what you should be doing anyway? In that sense it is caring for people in the way that we actually trained and aspired to, but never had enough time for. It does bring us back to that point. Really the whole thing that it gives us is the time to do the things that we’re wanting to do (Large size practice participant).

While ARI did involve more work for the nurses, with the right team dynamic they were able to argue for changes to the way the practice allocated time:

*When it first started we were all lost...we did not know what to do ..but now as we are going ahead it is more work for us but we are getting more time allocated to do that work as well. We are getting set times. As it is going when we do need more time we are speaking out and we are getting an allocation (Large size practice participant).*

One of the PHO representatives noted the business realities for practices in taking on ARI as nurses “are able to see patients at the same time as GPs, so that increases [practice] revenue”.

Finally, one PHO took the opportunity to embed a group of ARI care co-ordinators within an integrated care team with significant responsibility for the operation of ARI across 20 clinics. The integrated care team comprises up to 25 members (with 7 care co-ordinators and 5 clinical family navigators). Two focus groups explored the experiences of this purpose-built team who took responsibility for co-ordinating the care of ARI patients and connecting patients with in-house wellness support for mental health issues, physical fitness, home visiting, and health coaching through six week self-management programmes. Those undertaking the care co-ordination role were a mix of nurses, public health specialists and overseas doctors awaiting registration in New Zealand.

The team reported a process of enrolling patients initially over the phone to gain consent to be enrolled, followed by a PiH undertaken by the nurses and doctors in the clinics (though these could also be done over the phone if the doctors did not have enough time) and scheduled phone follow-ups to check in on goals. A further option
was to connect with Clinical Family Navigators who could also go into a patient’s home to do a PiH.

The focus groups reported pros and cons of undertaking part of the process over the phone. Language barriers could arise and were addressed by calling on specialists from the wider integrated care team. The team was often asked to prove they had bona fide links and “could sound like a business trying to sell a new policy or scheme”. Once a relationship had been built, the regular follow-up phone calls played an important role in making the care plan a live document and motivating patients. As one described their role:

...we are like the helpful buddy of the patient who is a bit lost with their care management plan, so we come in and might hear that they are a bit lost with what the doctor suggested. So we say what about this? would you like to go here? and we get their consent to refer to a dietician for example, or to an internal self-management course (Large size practice participant).

5.2 THE IMPACT OF A TEAM-BASED CULTURE

ARI expands the role of primary care nurses, offering opportunities to enrol patients and substitute for general practitioners in routine appointments, run clinics to help monitor and inform patients and undertake more in-depth care co-ordination. International evidence indicates that primary care nurses can provide care of an equal quality to general practitioners for most people with long term conditions at a lower cost, though nurses need adequate training, technological support and time in order to be most effective.

While one focus group indicated that as a result of ARI general practitioners are using nurses more, this was not a universal experience. Again, many stressed the existing relationship between nurses and doctors within a practice carried over into ARI: an existing relationship that could facilitate progress in some circumstances and hinder progress in others. For example, when asked if they thought the general practitioner’s working day was freed up as a result of nurses now playing a more significant role, one participant stressed this was par for the course:
I think we had already mastered it. We were already doing it. I've worked in several different practices and it all depends who is running the ship as to how much interest the GPs show in engaging with the nurses ....we've got [number] GPs that come and go here. You’ll have a selection of them who are not interested in even sharing their patients with you because they ... That’s just their nature. Fine, so be it. Then you’ve got eight of the other ones that actually want you to do the work. It depends a lot on the team dynamics within a practice (Large size practice participant).

Another participant in another practice lamented how little discussion there was between nurses and doctors in the clinic overall. For this participant implementing ARI brought this problem into sharp relief as ARI clearly needed a team based ethos:

*I think [ARI] would be a very good programme in a clinic that works as a close team and has regular meetings as it is designed to encourage more time between staff and patients* (Small size practice participant).

One group discussed that while practice meetings were held at the beginning of implementing ARI, since then there has been little discussion about ARI, a situation which led them as a group to query how doctors coming into the practice were briefed on ARI. It was not uncommon to hear reports of a diversity of interest and engagement between doctors within a practice. A number spoke of the need to counter the initial impression of ARI as a complicated electronic system with examples of particular successes with patients that would then inspire a new understanding about ARI between general practitioners and nurses. General practitioners themselves could also be looking to engage other general practitioners in large practices. As one explained:

*Within [the practice] some doctors are aligned to it and aware of it to the extent that when the care co-ordinators are in the clinic they will facilitate that and do a hand off with the care coordinators whereas others are totally inert and just working in their own silos. It is a problem for me because I want to train them to change their mind set to try and say this is better for your patient and better for the organisation* (Large size practice participant).

When reflecting on the ARI training offered, staff often looked for recognition that those delivering the training understood the realities of working in primary care. One participant stressed as a nurse the training was excellent but noted there was nothing very general practitioner specific. Across all the focus groups, staff acknowledged ARI
training was useful for communicating the importance of working collaboratively with patients to deliver care plans. Some struggled with the level of detail required to be recorded in the shared care plan explaining that they went through a cycle of “learning to say more until they learnt less was needed”. Furthermore, as mentioned previously, once electronically loaded into the system staff wanted an assurance others were accessing and using the plans.

5.3 ARE PRACTICES THINKING DIFFERENTLY?

The hope was that ARI would act as a prompt for practices to think more about their general population and not just those who choose to visit. As others have stressed, general practitioner training has a limited focus on understanding and managing population health with more attention paid to one-to-one consultations. When asked to reflect on whether practices were making broader changes in how they thought about their practice population three practice focus groups gave examples of how they were considering mental health peer coaching programmes, increasing contacts with other care professionals, and broadening their understanding of other services available locally. The 25 strong integrated care team developed by one PHO was applying ARI funding to a wide range of activities including home visits, blood tests at home as well as health coaching, cognitive behaviour therapy, mindfulness programmes and physical fitness support. Rather than making external links, however, these were being made in-house.

Four practices mentioned that a key advantage offered by ARI were the increased contacts with other care professionals (i.e. allied health, social workers, dieticians, clinical psychologists, podiatrists). One participant noted that a particularly useful offshoot of the ARI training was an increased awareness of the other services available locally. Those practices that signed agreements with different services to be part of the ARI were also clear that ARI had increased the working contacts they have with social workers and other health professionals. While the hope had been that the shared care plan would be the vehicle by which co-ordination between health professionals would improve, it was the face-to-face relationships that stood out as the ways in which those working contacts were improved.

Not all practices were confident ARI had prompted change. When considering the practice population as a whole, a number pointed to the attention already being given
to reaching population targets (i.e. better heart and diabetes checks, better help for smokers to quit, increased immunisation and cervical screening coverage). When considering whether they agreed with the statement that “within our practice discussions have been prompted in what else could be done to improve the overall health of the population”, staff were more likely to link these developments to the population health performance incentives overseen by PHOs than ARI.

When asked if the practices felt better supported to help patients with complex needs because they had improved access to and support from secondary care, the results across all the focus groups were mixed. Those practices with strong links to the VHIU team or Locality-based multi-disciplinary team meetings acknowledged the improved support they were getting from secondary care. However, practices in other Localities were much less confident they could point to improved access and support from secondary care. Some expressed concerns whether those in secondary care knew about ARI explaining that “it would be interesting to know in hospitals if the nurses even know what ARI is”.

5.4 SUMMARY

To summarise, ARI is more likely to increase the capacity of practices to manage patients in the community in circumstances where practices choose to organise themselves differently to deliver ARI, or when practices were able to build on a prior team-based culture for managing those with long term health conditions. The dynamic was not just that it was easier for larger practices and harder for smaller practices (though that played a role). The focus groups revealed that those practices of whatever size who did not hold regular meetings to reflect on what had been learnt from implementing ARI, who tried to absorb ARI into their current style of operating and who left nurses to implement ARI in isolation, were less likely to demonstrate an increased capacity to manage patients in the community.

When asked if they thought the general practitioner’s working day was freed up as a result of nurses now playing a more significant role delivering ARI, focus group participants acknowledged that nurses were playing a significant role but were less likely to source this directly back to the introduction of ARI. Where the existing relationship between nurses and doctors within a practice was strong, this was being harnessed to facilitate progress but the introduction of ARI itself was rarely a trigger to introduce a new understanding between nurses and general practitioners. That said,
there were examples where practices built an improved understanding of how to split tasks between managing long term conditions (nurses) and managing acute episodes (doctors).

Finally, there was evidence of improved information sharing between primary care and secondary care and between health and social care. The examples given linked this to the creation of personal links – i.e. putting names to faces when referring – rather than the use of electronic links.
CHAPTER SIX: CHANGE ACROSS THE SYSTEM

In CMH’s annual plan, the ARI model of care is described as a key intervention in the System Integration programme and is expected to “prevent unplanned admissions to hospitals, prevent future complications and improve the patient’s quality of life” 2. The System Integration programme, in line with international developments, reflects a desire to re-balance the health system towards meeting a changing pattern of need generated by increased numbers of people with long term health conditions, and using the technological opportunities becoming available to foster professional team working and to encourage those with long term health conditions to be active participants in their own care 23. The subsequent move away from a reactive, disease-focused fragmented model of care towards a proactive, holistic and preventative model involves a whole system approach that requires various components to be in place in order to be successful 3. The previous two chapters explored the changes required to support individual ARI patients to develop the confidence and competence to self-manage, and to support primary care practices to develop new ways of working. This chapter considers the changes needed across the system to support these micro and meso level changes.

Focus groups were asked to reflect on the extent to which they agreed or not with the following statements:

1. We participate in more multi-disciplinary team meetings to better support complex patients.

2. Technological IT support is now available to enable the sharing of information on patients with long term health conditions.

3. Opportunities have increased to co-ordinate and connect with other practices in our Locality.

4. Primary Health Organisation support has helped us deliver more planned proactive primary care.

5. We are seeing a reduction in unplanned admissions to Middlemore Hospital for our at risk patients.
6.1  LOOKING BEYOND THE PRACTICE

One of the success measures listed for ARI in an early CMH PowerPoint is that multi-disciplinary team meetings (MDTMs) are occurring “within general practice cluster networks to support care planning for complex patients”. The representation of ARI as a sequential care process (see Figure One page 11 ) also highlighted the role of these meetings as the culmination of the ARI care process, particularly for complex patients whose care plan would benefit from the input of hospital specialists and/or community care providers. As one of the ARI sponsors explained, if general practices are to be re-established as the central focus of co-ordinated healthcare, then they will need to deal with more disciplines than those within “their own four walls, so multi-disciplinary team meetings are a route to start having these conversations”.

PHO representatives stressed that much about engaging with MDTMs was “practice dependent” with larger practices often already undertaking their own internal MDTMs. One PHO representative explained that while secondary care was open and ready to respond to requests for MDTMs, practices can choose not to engage because:

*They just don’t have time to spend an hour talking about a few patients. I think a lot of that is down to not having experience with good MDTs and with not having that amount of downtime. There is obviously less revenue produced for that time period. Some practices don’t feel they need it particularly and are doing ok. Some of the larger practices do their own MDTs. One of practices has a community team so they already have a lot of social work support and other kind of support (PHO representative).*

Focus group participants were asked whether they now participate in more multi-disciplinary team meetings as a result of ARI. Practices in two Localities said “yes”. They were engaging in more MDTMs and the nurses involved stressed that these meetings were a good opportunity to learn more about the individuals in their ARI caseloads. The following example was given to describe the power of new relationships being formed in one locality:

*A patient came with an acute episode so we put together a care plan to put her on proper medication. I addressed this at the locality MDT meeting and [the specialist] had her on his radar. I raised her a couple of times as she was going in and out of Middlemore like a yoyo. The specialist said clinically it looks like it is at end stage so can you arrange to go out and meet the whaanau and look at oxygen therapy and pulmonary rehabilitation. By the time we orchestrated that
(and it happened quickly in six weeks) the specialist was surprised as on assessment she was alert and doing more than her clinical indicators signalled to him (Small size practice participant).

One participant pointed out that the numbers of patients discussed at every MDTM could be small given the size of their overall ARI patient population, so questioned whether the throughput was sufficient for the resources spent. Others in the same Locality were more positive and clearly took advantage of these meetings to strategise over complex patients, though rather than the culmination of the ARI care process, the discussions could be an alternative for those patients who do not do well on ARI as:

...they can be carried over to the locality home healthcare team (via MDTs). The people I present to the Locality B MDTs are the ones where we have exhausted our own resources...these are our complex patients (Small size practice participant).

Practices in another Locality had MDTMs that pre-dated ARI so were less likely to indicate that they believed the introduction of ARI had resulted in more meetings. In the final fourth Locality, no mention was made of historical, nor ARI-inspired, MDTMs. The comments from these practices indicated there was “a less of a need in this Locality”, with “corridor meetings” happening internally and other connections with allied health being made over the phone.

6.2 ENABLED BY INFORMATION TECHNOLOGY

From the beginning of the roll out of ARI, new electronic shared care software was an important plank in enabling the sharing of information between health professionals and providing proof patients were enrolled on ARI. The earlier section on the features that characterised the first years of ARI highlighted the IT teething problems in the initial roll-out. Internationally, despite one-off successes, IT issues are regularly cited as one of the biggest challenges for those looking to deliver better services for people with long term conditions. The same is true of other New Zealand initiatives. The problems experienced by ARI at the start were confirmed again in the focus groups as participants highlighted problems with respect to different IT systems “talking to one another” and unfavourable comparisons with the perceived simplicity of the previous
CCM system. The description below vividly illuminates the “double handing” some staff were experiencing:

You start with the ARI requirements then go into Medtech and then into [PHO E] claiming system otherwise you don’t get paid... you have to be seen to be documenting aspects into Medtech and then back to ARI... three different IT programmes (Small size practice participant).

There was a difference between the different technological starting points across PHOs. One PHO had invested in a tailored ARI recording system which was ultimately not compatible with the system adopted across all CMH. The result was improved communication across their own clinics/practices but poor connectivity with secondary care. Other practices in different PHOs had found effective ways to combine their systems and were now clearly familiar with how the ARI IT system worked, though as one GP explained “I don’t do the paperwork I hand it over to the nurses”. The importance of evidence that the electronic shared care plan was being used given the time invested in creating and loading the electronic shared care plan was an ongoing frustration. The quote below is a good example of the frustration with patchy take-up, while at the same time recognising improvements were occurring:

I just keep saying it and others are the same. Not everybody is using it. We have patients that are under the district nurses, who have got no idea and we don’t get updates about what is happening with our patients. Hospice are quite good and they update it. But if someone goes to emergency department and they want something done we might be waiting a week for discharge summary. Things don’t happen. It should be easy because it’s on the computer and they have access to it. Or specialists could send a message, or the GPs be able to send a message. Again I’m the only one in the practice with access to it. You’ve got to apply for access as well. Some of the pharmacies are using it so that’s good. You can see that they’ve gone through the medication plan with the patients and explained what the medication is for (Small size practice participant).

6.3 THE MESSAGES HEARD

Another vision for the system changes expected to be prompted by ARI was that opportunities would increase to co-ordinate and connect with other practices in each of the four specific Localities. When this was explored in the focus groups, apart from the connections encouraged through MDTMs, there were few examples given of new connections with other local practices. PHOs successfully argued to be the overseeing
body for ARI, despite an earlier expectation that ARI would be directly implemented through the Localities initiative, so some of the opportunity to profile ARI as a change that supported new local connections was muted.

One of the arguments made by the PHOs as to why they should be the overseeing body for ARI was that they would be providing the skills to make it work. Interviews with PHO representatives responsible for ARI implementation acknowledged the complexity of the task, particularly around ensuring IT systems were compatible. As the following discussion highlights, the skills provided by PHOs in implementing ARI were centred on knowing their practices:

*We were not given any evidence for why ARI was created the way it was but we did know that GPs had voiced their opinion that with CCM it was very very structured and there were limits to how long they could see a patient. That was the only thing we were given in the beginning to go out and sell this.*

**What did you use to sell it?**

*We have very close relationships with our practices, so for our PHO it is like a big family, so we were going in with the following messages: things are changing, this is a flexible pool of funding, we are looking at the patient now holistically and what else can you do to help them. You can give the patient intensive work over 6 months and see them once a week. Another selling point was that this was a nurse-driven initiative (PHO representative).*

While knowing your practices was a help, there was much about the ARI change process that was daunting in its reach and required PHOs to do more than communicate how to access a new funding source. When focus group participants were asked how they were supported by PHOs, it was not uncommon to hear that PHOs offered help (i.e. explaining how the new IT system worked), but practice staff occasionally expressed concerns they were not always given the correct information, that reaching enrolment targets dominated the early messages, and that more training would have been valuable.

Participants in one focus group, for example, were of the view that if they failed to reach their enrolment target then the “practice misses out on funding” which led them to express concerns that “patients are put on ARI that don’t necessarily need to be on
it”. Another focus group reported the initial pressure from their PHO was so strongly focused on meeting the enrolment target that this led to similar concerns that “the [PHO] want us to become more about money than the patients”. The quotes above were from practices linked to different PHOs. A third focus group in a different practice which belonged to another PHO further outlined the downside of the attention being paid to reaching targets in terms of building collaboration with other practices:

We are a very large practice and we get compared with stats from the next practice down the road, that only needs a target of maybe 30 people enrolled to reach 3%. We need 243 more to reach our percentage. I think what happens is they put data out there that obviously PHOs are wanting to try and drive everyone…. You almost get a bit competitive. You’re actually not liaising with them [other practices]. You’re thinking on how you can improve to look better in the percentage mark (Large size practice participant).

6.4 UNPLANNED ADMISSIONS

Discussions with those overseeing the roll-out of ARI in CMH acknowledged the long time lag before a reduction in unplanned admissions to Middlemore Hospital would be seen as a result of ARI. The expectation was that patterns of service use would change as patients engage more frequently with primary care professionals resulting in fewer crisis and in-patient admissions. Reviews of the impact of self-management programmes provide some support for this expectation 3, though results across studies can be complicated as a wide range of initiatives can described as self-management ranging from those relying on the provision of more information to those actively targeting behaviour change and care co-ordination.

Focus groups were asked about the extent to which they thought their practice was seeing a reduction in unplanned admissions to Middlemore Hospital for their ARI patients. All stressed they had no definitive data for their enrolled population so could only rely on what they had observed. A number struggled with how they would judge whether a hospital admission could have been avoided and were cautious in agreeing or not agreeing with the statement that “we are seeing a reduction in unplanned admissions to Middlemore Hospital for our at risk patients”. One focus group discussed how feasible it was to expect such an outcome reflecting that the patients on ARI are more likely to have problems that will cause them to be admitted at unexpected times:
We [primary care] are doing everything we possibly can so you cannot tell us it is our fault that people are coming into hospital – the demand has increased but you cannot say it wasn’t because we are not doing enough to prevent it...you can do everything you can to make that risk as low as possible but you cannot change that risk (Small size practice participant).

One practice was confident ARI patients were now coming to see the practice first before going to hospital, though they stressed there would always be those individuals whose instinct was to go to hospital first. Another practice said they had observed “select” examples where an individual had increased their confidence on ARI and was now less likely to go to the hospital. Another gave an example of how building the confidence of patients can avoid the crisis visit in the middle of the night “as panic is less likely to set in as the patient has managed their health well for the last seven days and doesn't need, for example emergency oxygen”.

Other focus group participants pointed to the complexities of reducing the use of secondary care given the overall characteristics of particular enrolled populations, i.e.

*No our patients frequently don’t come in until it’s too late and they have to go to hospital. There is no other option. Even though you can give them all the education in the world they will still do their own thing (Small size practice participant).*

...and the importance of individuals believing they have a right to hospital care:

*When you say a long term plan is to get you out of hospital, they kind of think you’ve grown a couple of horns. ....They don’t really get it (Large size practice participant).*

An earlier small scale analysis concluded there was a beneficial effect on acute admissions from an early prototype of ARI which compared the readmission rate between five practices using an early tool for identifying patients at high risk of acute readmission 16. Ideally, larger scale analyses are needed to track whether the readmission rates of ARI patients are reducing though this will be complicated by the breadth of patients enrolled, agreement on what is an unplanned as opposed to a planned admission for an ARI patient, and the multiplicity of other initiatives across CMH seeking a similar outcome.
6.5 SUMMARY

This chapter explored the extent to which practice staff were experiencing the system wide changes of (1) electronic health records being regularly used by the extended healthcare team; (2) an increase in the number of MDTM; and (3) general practices working more in local clusters.

With respect to the increasing use of electronic health records, aligning IT systems across five PHOs and across secondary care has been problematic. Where gains have been made, particularly in providing evidence that the extended healthcare team is accessing shared electronic records, these have built confidence that the time invested in creating and loading a shared care plan is worthwhile. When staff have not seen any evidence other healthcare professionals are accessing shared care plans, confidence can be dented.

Similarly, MDTMs are a “work in progress”. Where they are in place, often prompted by concurrent initiatives seeking to improve the care provided to complex patients, they are clearly valued by practice staff. In situations where practices have introduced clear ARI caseloads for nurses, they offer opportunities for greater professional development and understanding around ARI patients. Compared to the high numbers of ARI patients at any one time (up to 20,776 have been enrolled) these meetings can only discuss the care of a small fraction. Any further growth in the number of MDTMs is likely to be dependent on practices having a profile of highly complex patients on ARI.

In tandem with the introduction of ARI, the Localities initiative has been seeking to co-ordinate and connect with other practices in each of the four specific Localities. When this was explored in the focus groups, apart from the connections encouraged through MDTMs, there were few examples given of new connections with other local practices, though a few staff mentioned new relationships that had been forged by ARI training.
CHAPTER SEVEN: CONCLUSION

The aim of this evaluation is to assist ARI decision-makers to identify what is working well and why; where improvements might be made; and how particular circumstances may influence whether ARI will achieve its desired outcomes.

Following the realist approach of distilling initial theories on how the ARI model of care was expected to work, three tables at the beginning of this report revealed how ARI is a complex multi-layered initiative aiming to achieve change at (1) the micro or patient level to improve clinical outcomes for those with long term health conditions; (2) the meso or practice level as part of the establishment of general practice as the central focus of co-ordinated healthcare across Counties Manukau; and (3) at the macro system level to reduce unplanned admissions to secondary care.

The focus groups tested these initial theories resulting in refined explanations of how the ARI model of care is achieving its hoped for outcomes. These are summarised in updated tables at the end of each of the following sections.

7.1 MICRO THEORY OF CHANGE

Practice staff engaged well with the key ideas of how patients benefit from ARI, particularly the increased opportunity to receive more practice staff time which was perceived to lead to an increased understanding about their condition and how to self-manage. While tools were made available to support this process (e.g. the PiH, the shared care plan template), the focus group participants routinely stressed the power of motivating change through conversations with patients and the major benefit of having the time to have those conversations. Practice staff had little trouble with the idea that engaging patients as partners in their care was the key to achieving better outcomes.

From the perspective of those delivering ARI, the contexts where individuals were most amenable to change were those where the individuals demonstrated motivation to change, had a long term health condition that lent itself to a measurable change, and were enrolled in practices used to dealing with a higher degree of psycho-social complexity.
Conversely, the contexts where it was more difficult to build a rapport and motivate change were those where patients enrolled on ARI had a long term health condition where it is not obvious what change was needed, had been enrolled merely to lower out of pocket costs, and were not in a practice confident they had skills in working with wider psycho-social issues. In those circumstances an increase in self-management was less likely, particularly for complex patients.

The initial mechanisms theorised as the way the ARI model of care influences patients to adopt new health behaviours include: (i) patients receiving more practice staff time to learn how to self-manage, (ii) patients improving their ability to self-manage as a result of embedding care solutions into their daily lives, (iii) patients adhering to care plans because they want to be seen as good patients, (iv) patients receiving care that aligns with their cultural practices and beliefs (v) patients having less worry about costs of care and (vi) seeing the professionals involved in their care talk to each other.

When these mechanisms were tested in focus groups, practice staff consistently agreed that ARI patients value the opportunity to receive more staff time (i) and as a result improve their ability to self-manage (ii). There was a more variable response that patients adhere to care plans (iii) because they want to be seen as good patients, with many stressing the power of conversations with patients in motivating patient behaviour change rather than a desire to comply with the views of healthcare professionals. Other studies have identified that how health providers perceive people’s capability to adapt and grow can affect decisions to spend appointment time discussing lifestyles changes with patients. If health providers question the potential for patients to change, it is more likely (given time pressures) providers will decide in that moment not to engage in prevention discussions. ARI creates an environment where these discussions are more likely to occur across all providers using patient centred goals.

There were variable views on how much patients receive care that aligns with their cultural practices and beliefs (iv) with much depending on the initial experience of the general practice in working with distinct cultural communities. Equally there were variable views on the significance of the reduction of worries about primary care costs (v) in the light of different starting points for practices with respect to patient co-payments. No-one said cost was not an issue, but in circumstances where practices were already working in an environment of free or very low cost consultations, then
this was less of a significant change as a result of the introduction of the ARI model of care.

Finally, staff were most uncertain that patients were seeing the professionals involved in their care talk to each other as a result of the introduction of ARI. ARI relies on general practices taking more responsibility for co-ordinating care and includes the expectation that the patient goals in the shared care plan are used by all health professionals. The majority of staff in focus groups were not confident that the shared care plans were being accessed by others. That said, hearing from others in the practice, or seeing recent proof themselves that other healthcare professionals were accessing the plans, could be a tipping point to increase confidence that the time involved in drafting electronic care plans was becoming more worthwhile. Since the focus groups were held ARI sponsors report that the utilisation of care plans by secondary care staff is increasing. Care plans are now being accessed approximately 950 times per month.

**TABLE 4A – UPDATED MICRO THEORIES OF WHAT DRIVES CHANGE FOR PATIENTS**

<table>
<thead>
<tr>
<th>C = In contexts where:</th>
<th>M = These mechanisms are expected to be generated:</th>
<th>O = In order to produce these outcomes: Short term (18 months):</th>
<th>Medium term (30 months):</th>
<th>Longer term (42 months):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals enrolled in ARI demonstrated:</td>
<td>Consistently generated mechanisms:</td>
<td>Completed PiH indicate conversations have occurred on how best to self-manage</td>
<td></td>
<td>Reduction in unplanned emergency admissions</td>
</tr>
<tr>
<td>- a motivation to change rather than an interest solely in lowering out of pocket expenses</td>
<td>Patients receive more practice staff time and learn how to self-manage through conversations</td>
<td>Shared care plans based around patient goals are completed and acted upon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- had a long term health condition that lent itself to a measurable change rather than a condition that required being monitored</td>
<td>Patients improve problem solving by embedding care solutions into their own lives</td>
<td>Interventions funding is used to purchase additional support</td>
<td></td>
<td>% of patients with HbA1c&lt;65</td>
</tr>
<tr>
<td>- were enrolled in practices used to dealing with a higher</td>
<td>Less consistently generated mechanisms:</td>
<td>Care plans are electronically accessed and used</td>
<td></td>
<td>% change of HbA1c in ARI patients</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>% of diabetics with BP systolic&gt;140</td>
</tr>
</tbody>
</table>
7.2  MESO THEORY OF CHANGE

ARI is being implemented by five PHOs who play a significant role in communicating between CMH and local general practices. Taking responsibility for ARI represents a significant step in taking responsibility for the larger change of re-establishing general practice as the central focus of coordination of healthcare in CMH and delivering proactive primary care. The size of change required was larger than anticipated:

*I think nobody, not just our PHOs, I don’t think anybody estimated the amount of change that was required. I don’t think the change management within the practice was supported. I think we could have done better with that. That was probably as much as anything a timing thing. We went from the pilot with a couple of practices to it rolling out. The time to develop more for individual practices - because obviously each practice is different - was limited (PHO representative).*

Those setting up ARI explained that good primary care is already thinking about what they can do beyond a 15 minute consultation, but by being involved in ARI the aim is to “create a model that makes doing the right thing easier”. While concerns in the focus groups were raised about the paperwork involved, and the problems adapting to new IT systems, the findings from the focus groups reveal these did not dominate to
the extent that practices lost sight that the ARI model of care represents “time to do
the things we are wanting to do”, the things “we actually trained and aspired to but
never had enough time for”.

ARI offers considerable flexibility to practices on how they implement the ideas in
ARI. With this flexibility comes an increased responsibility to run a general practice in
ways that create a strong team dynamic as information regularly needs to be shared
about ARI patients. At the beginning of the evaluation, ARI sponsors asked “how does
the diversity of ways practices operate (i.e. the overall team based or outward looking
nature of the practice) influence the rate at which more proactive primary care is
being developed as a result of ARI”. This evaluation has found that this diversity has a
significant influence.

The mechanisms expected to support the longer term goal of encouraging more
proactive primary care include: (i) being financially resourced for the time needed to
motivate patients (ii) giving practice nurses more responsibility for those with long
term conditions, (iii) making more connections with other supports outside the
practice to achieve patient goals (iv) planning for the whole enrolled population and
not just those who choose to visit (v) benefiting from improved access to and support
from secondary care.

When considering how these mechanisms are triggered it was clear different contexts
within practices shaped the likelihood that practices are delivering more proactive
primary care. The dynamic was not just that it was easier for larger practices and
harder for smaller practices (though that played a role). The focus groups revealed
that different propensities to share information were a distinguishing feature between
practices in the following ways:

- those practices of whatever size who did not hold regular meetings to reflect on
what had been learnt implementing ARI, who tried to absorb ARI into their
current style of operating and who left nurses to implement ARI in isolation,
were less likely to demonstrate an interest in proactive primary care

- those practices that appointed ARI leads, shared ARI caseloads across nurses
and experimented with different ways of “pulling nurses off the floor” to cover
the extra time involved were more likely to demonstrate an interest in proactive
primary care. Those setting up ARI explained that their aim is to “create a
model that makes doing the right thing easier” and these practices had a collective ethos that supported the implementation of ARI

- those practices that relied on new care co-ordinator roles to act as a bridge between the doctors and nurses in the clinics and the ARI patient, created their own dynamic with advantages and disadvantages with respect to influencing patient behavioural change and sharing information. Information sharing was likely to be strong between the newly created team and the ARI patient, but variable between the team and the doctors and nurses in the clinics. The ARI patient’s ongoing motivation to change was supported by the regular ongoing connections made by care co-ordinators. In these situations the ARI engagement clearly became more than the creation of a care plan. However, the care coordinator team did not always have the credentials and understanding that arose from the connection between the clinic and ARI patient. This became the most obvious when the initial approach to offer enrolment on ARI was made over the phone.

When asked if they thought the general practitioner’s working day was freed up as a result of nurses now playing a more significant role delivering ARI, focus groups acknowledged that nurses were playing a significant role but were less likely to source this directly back to the introduction of ARI. Where the existing relationship between nurses and doctors within a practice was strong this was being harnessed to facilitate progress but the introduction of ARI itself was rarely a trigger to introduce a new understanding between nurses and GPs. While ARI did involve more work for the nurses, with the right team dynamic they were able to argue for changes to the way the practice allocated time. In smaller practices it was possible to find ways to distribute tasks so GPs managed acute episodes and initial consultations and then passed patients over to practice nurses to manage longer term follow up and co-ordination.
### Table 5A Updated Meso Theories of What Drives Change for Practices

<table>
<thead>
<tr>
<th>C = In contexts where:</th>
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<th>Longer term (42 months):</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practices take advantage of an earlier propensity to share information and a collective team based ethos.</td>
<td>Consistently generated mechanisms: Practices have increased confidence they are resourced for the time needed to motivate health behaviour change. Practice nurses have increased confidence in their responsibility for those with long term health conditions.</td>
<td>5% of the primary care population are enrolled on ARI. PIHs are completed, a goal-based shared care plan is in place and a named care co-ordinator is identified for each ARI patient. ARI training supports practices to develop high quality shared care plans.</td>
<td>Increased capacity of primary care to manage patients in the community (proactive primary care). Evidence of improved sharing of information between primary care and secondary care.</td>
<td>Reduction in unplanned emergency admissions. Improved clinical indicators as listed in Table 1. General practice is re-established as the central focus of co-ordinated healthcare in Counties Manukau.</td>
</tr>
<tr>
<td>These are practices that: -hold regular meetings to reflect on what has been learnt implementing ARI rather leave nurses to implement ARI in isolation. -experiment with different ways of “pulling nurses off the floor” to cover the extra time involved including: appointing ARI leads or care coordinators and sharing ARI caseloads.</td>
<td>Less consistently generated mechanisms: Practice staff make more connections (often initially face-to-face) with other supports to achieve patient goals (e.g., social workers, allied health and clinical specialists). Practices are more sensitive of the need to plan for the whole enrolled population and not just those that choose to visit. Practices benefit from improved access to, and support from, secondary care.</td>
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</tbody>
</table>

5% of the primary care population are enrolled on ARI. PIHs are completed, a goal-based shared care plan is in place and a named care co-ordinator is identified for each ARI patient. ARI training supports practices to develop high quality shared care plans. Increased capacity of primary care to manage patients in the community (proactive primary care). Evidence of improved sharing of information between primary care and secondary care. Reduction in unplanned emergency admissions. Improved clinical indicators as listed in Table 1. General practice is re-established as the central focus of co-ordinated healthcare in Counties Manukau.
7.3 MACRO THEORY OF CHANGE

The system-wide enablers expected to support ARI were making inroads in some practices, but were still a work in progress in others. The system-wide enablers included expectations that: (i) information relating to the ARI patient would be visible to everyone involved in their care via an electronic health record; (ii) relationships between secondary care and primary care and between health and social care would be deepened as a result of multi-disciplinary team meetings; (iii) that PHOs and CMH would take collective responsibility for reducing unplanned admissions to secondary care; and (iv) Localities would forge stronger links between local general practices.

Multi-disciplinary team meetings (MDTM) were valued where they were in place, though any further growth is likely to be dependent on practices having a profile of highly complex patients on ARI. While some PHOs and practices had found effective ways to combine their IT systems and were now familiar with how the ARI IT system worked, others were still working through technical issues. Aligning IT systems across five PHOs and across secondary care has been problematic. ARI is expected to support the improved sharing of information as a result of: (1) practices realising they needed to make connections with other supports to achieve patient goals, and (2) the opportunities provided by the electronic health record to share information across an extended healthcare team. The first was more likely to be triggered than the second. Examples were given by staff of the creation of new links between primary care and other health professionals in the focus groups but these were more likely to be sourced back to the creation of personal links – i.e. opportunities through ARI training, MDTMs, or other workshops to put names to faces - rather than to the use of electronic links.

While for those who work at a system level there is an interlocking logic between re-establishing general practice as the central focus of co-ordinated healthcare across Counties Manukau, reducing unplanned admissions and improving clinical outcomes though increased self-management, this is not always evident for those staff at the grassroots. Practice staff were engaged in a complex balancing act between the need to reach their enrolment target, the need to be confident they were investing time in the right patients (i.e. amenable to change) and managing a capped budget to deliver services to individual patients to support their personalised care plan.
The early ARI prototype concentrated on enrolling those patients most at risk of unplanned admissions to secondary care using a risk algorithm. However, as more and more practices came on board, this more planned approach gave way to a more fluid approach. No one in the focus groups mentioned applying a risk algorithm. Practice staff placed much more emphasis on interpreting what “amenable to change” meant in practice and the need to reach enrolment targets when deciding who to enrol.

In tandem with the introduction of ARI, the Localities initiative has been seeking to co-ordinate and connect with other practices in each of the four specific Localities. When this was explored in the focus groups, apart from the connections encouraged through MDTMs, there were few examples given of new connections with other local practices, though a few staff mentioned new relationships that had been forged by ARI training.

**Table 6A – Updated Macro Theories of What is Driving Change Across the CMH System**

<table>
<thead>
<tr>
<th>C = In contexts where:</th>
<th>M = These mechanisms are expected to be generated:</th>
<th>O = In order to produce these outcomes: Short term (18 months)</th>
<th>Medium term (30 months)</th>
<th>Longer term (42 months)</th>
</tr>
</thead>
<tbody>
<tr>
<td>System enablers (IT system, MDTMs, Localities) dovetail well with the diversity of PHO and local experiences</td>
<td>Information relating to the ARI patient is visible to everyone involved in their care via an electronic health records</td>
<td>Alliance Leadership Team successfully promotes changes associated with early intervention and planned, proactive, patient-centred care</td>
<td>Electronic health records are used by the extended healthcare team</td>
<td>Reduction in unplanned emergency admissions</td>
</tr>
<tr>
<td></td>
<td>Relationships between secondary care and primary care and between health and social care are deepened</td>
<td>An increase in the number and size of multi-disciplinary team meetings</td>
<td>Increase in numbers of locality-based multidisciplinary team meetings co-ordinating care for complex ARI patients</td>
<td>Improved clinical indicators as listed in Table 1</td>
</tr>
<tr>
<td></td>
<td>PHOs and CMDHB take collective responsibility for reducing unplanned admissions to secondary care</td>
<td></td>
<td>GP clusters are evident with deeper connections across practices in local areas</td>
<td>General practice is re-established as the central focus of co-ordinated healthcare in Counties Manukau</td>
</tr>
<tr>
<td></td>
<td>Localities forge stronger links between local general practices</td>
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</table>
7.4 SPECIFIC AREAS FOR IMPROVEMENT

ARI sponsors asked for advice on whether practices believe they have the right amount of support to implement ARI and what should be prioritised for the next phase of the ARI roll-out. Box Four displays a summary of the answers given in focus groups when staff were asked what aspects about the way ARI works could be improved or changed. The answers fell into three groups. The first group wanted more information to be made available to sort out specific issues, the second group suggested streamlining the ARI process in various ways and the final group highlighted opportunities to connect ARI with other interventions that would create opportunities for ARI to be more effective.

**Box 4 - Summary Answers To "What Aspects About The Way ARI Works Could Be Improved Or Changed"**

<table>
<thead>
<tr>
<th>Increase information</th>
<th>Change ARI operating parameters</th>
<th>Improve systems around ARI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve access to PHO – for example the nurse can call PHO to obtain a faster reply to concerns over how the IT system works.</td>
<td>Re-consider whether Partners in Health questionnaire needs to be mandatory.</td>
<td>Increase the opportunities for IT systems to connect with the existing IT platform used by practices.</td>
</tr>
<tr>
<td>Increase IT training so the IT system is better understood. This should involve making it easier for doctors to see the care plan.</td>
<td>Simplify the exit Partners in Health questionnaire to ask “since being enrolled on the ARI programme, do you feel that your knowledge has increased in medication management, and overall disease knowledge?”</td>
<td>Initiate more multi-disciplinary team meetings to ensure a larger throughput of complex patients.</td>
</tr>
<tr>
<td>Appoint a designated secondary care support who is sympathetic to primary care dilemmas who can be contacted directly about complex cases.</td>
<td>Tailor ARI funding caps to the risk profile of the practice population instead of the current universal percentage targets across all CMH practices.</td>
<td>Provide evidence that the extended CMH healthcare team is accessing shared electronic records.</td>
</tr>
<tr>
<td>Increase feed-back loops on whether ARI patients are going less to Middlemore Hospital.</td>
<td>Increase size of fund in order to cover more mental health costs (such as CBT) and extend green prescriptions beyond 6 weeks.</td>
<td>Consider introducing more opportunities for working with groups of similar ARI patients who support each other through peer networks.</td>
</tr>
</tbody>
</table>
7.5 NEXT STEPS

The ARI model of care involves a whole system approach to manage those with long term conditions and achieving change is difficult and requires sustained attention.

This report explored the extent to which practice staff were reasoning and behaving in the ways expected from the introduction of the ARI model of care. Further research is needed to:

- Understand patient views and experiences. While practice staff identified ways they thought patients were motivated to achieve their health goals as a result of the new model of care, ideally these need to be tested against the experiences of patients themselves.

- Investigate the administrative data being collected to form a richer picture of the type of patients being enrolled on ARI. ARI Sponsors report that ARI tools will be developed to enable clinicians to work effectively with specific patient cohorts covering: complex families, child health, diabetes, frail elderly and self-management support. The increased flexibility that is a hallmark of ARI could be matched with a deeper understanding of the size of different patient cohorts currently being funded by ARI.

- Track whether the readmission rates of ARI patients are reducing. This will be complicated by the breadth of patients enrolled, agreement on what is an unplanned as opposed to a planned admission for an ARI patient, and the multiplicity of other initiatives across CMH seeking a similar outcome.
REFERENCES


APPENDIX ONE FOCUS GROUP PROTOCOL

Introduce topic  We want to gather your views on the extent to which the At Risk Individuals (ARI) approach is changing the way your practice works. We want to understand how ARI is being implemented so we can improve the experience for future patients, and provide advice on how practices can be best supported going ahead.

Introduce process  We have some statements that describe the different ways the At Risk Individuals programme might be helpful to patients, your practice and the overall system. I want us to discuss these and group them as more or less valuable from your experiences to date.

Before we start I want to explain that:

I would like to hear from all of you – what you say will be used anonymously and you will not be identified.

One advantage of focus groups is that you can hear what others think and respond.

You do not all have to agree.

The information you provide is very important to build up a picture of how the ARI is working from the perspective of your practice.

I would like to check that you have previously read the information sheet and signed the consent form.

Explain the following:

I would like to audio-record the focus group

I have not started the recorder yet

Please avoid identifying people by name so we can maintain anonymity

We will anonymise all data so your comments cannot be attributed to you

Does everyone understand?

Do you have any questions?

Thank you
1. Tell me about your experiences with introducing the new At Risk Individuals approach in your practice?

2. What stands out for you as the difference between the ARI programme and other previous programmes seeking to provide support for primary care patients with complex needs?
   
   *Probe for what kind of evidence members were made aware of to explain why it was created the way it was.*

3. Talk me through the process you have used to decide which patients to enrol?

4. From what you know of the experiences of patients within each of your PHO practices, does the ARI programme work for every at risk patient?
   
   *Probe for If yes why, if not why not?*

5. The ARI programme is expected to deliver value in a number of ways (to patients, to practices and to the overall system).

   I. What have you observed as being experienced and valued by patients to date?

   *Hand out the following statements and ask one group member to read one out and comment on what they have observed.*

   a. Patients are able to obtain support to manage chronic long term conditions without worrying about the costs involved.

   b. Patients receive more practice staff time and increased advice from practice staff on how to self-manage their condition.

   c. Patients experience an increased capability to comprehend and embed solutions into daily practice as a result of the development of a care plan.

   d. Patients adhere to care plans because they want to be seen as “good patients”.

   e. Patients see that the professionals involved in their care talk to each other.

   f. Patients receive care that aligns with their cultural practices and beliefs.
II. What is being experienced and valued by your practice to date?

*Hand out the following statements and ask one group member to read one out and comment on what they have observed.*

g. We are resourced for the time it takes to develop care plans and follow up with complex patients.

h. We feel better supported to help patients with complex needs because we have improved access to and support from secondary care.

i. We now have working contacts with social workers and other community and allied health workers and can therefore engage differently with patients with complex needs.

j. Within the practice the GPs’ working day is freed up as specialist nurses now play a more significant role in delivering care to practice patients with chronic long term conditions.

k. ARI training has exposed us to the potential of a structured collaborative process that empowers patients to take an active part in decision making on their condition.

l. Within our practice discussion has been prompted on what else could be done to improve the overall health of the practice population, rather than just those who choose to visit.

III. What bigger changes are you observing across the system as a result of ARI to date?

*Hand out the following statements and ask one group member to read one out and comment on what they have observed.*

m. We participate in more multi-disciplinary team meetings to better support complex patients.

n. IT support is now available to enable the sharing of information on patients with chronic conditions.

o. Opportunities have increased to co-ordinate and connect with other practices in our Locality.

p. PHO support has helped us deliver more planned proactive primary care.
q. We are seeing a reduction in unplanned admissions to Middlemore Hospital for our at risk patients.

6. Anything else that is an important part of the experience of the ARI approach that you have observed?
   *Are there are other statements we need to create?*

7. To what extent has ARI changed the way you work as a practice?

8. How would you group the statements we discussed earlier as less valuable or more valuable?
   *Suggest they physically assemble them in order.*

9. Finally looking ahead is there anything about the way ARI works that could be improved or changed?