At Risk Initiative (ARI) Counties Manukau Health (CMH)

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Summary

This case study describes the learnings to date from an initiative where a care coordination approach was introduced in primary care for patients identified as being at risk of not being able to manage their long-term conditions.

Background

CMH like the rest of New Zealand is facing the significant challenge of a growing and ageing population, and rise in long-term conditions, such as diabetes and heart disease. CMH want to integrate services and systems across the health and social care spectrum and empower their healthcare users to keep themselves well and at home and prevent trips to hospital. CMH has started to re-orientate their health system around primary and community care. This has resulted in a number of projects, campaigns and improvement initiatives taking place across the district.

One such initiative is the At-Risk Initiative (ARI) which like several other of CMH's programmes is underpinned by a strong philosophy around patient centred integrated care. The ARI approach is a strengths-based way of working, delivering planned proactive care to defined groups of patients, using goal based strategies and supported by care planning.

ARI, along with other CMH initiatives, is clinically led and supported by management. The aim of the programme is not to create a new system but to make the patient's journey through the current system smoother and less fragmented.

General Practice teams identify patients the teams believe would benefit from the programme and once enrolled patients have:

1. **a designated care coordinator** responsible for working in partnership with the person 'to understand what matters to them' and support them in the development of their goal based in the e-shared care plans as well as monitor progress in consultation with other providers of health and social services. The care plan will be developed with input from care team members such as SMOs, community nurses, and allied health, all of whom can secure message each other and the patient through the e-shared care record

2. **a Partners in Health assessment** to support the development of a goal based care plan

3. **an electronic summary health record and care plan** will be available to healthcare teams through their existing patient management systems so that key information relating to the patient is visible to everyone involved in their care.

The case for change was easy to make. The clinicians working across the district understood their patients' experiences and issues relating to poor coordination and the complex multi-sectorial interventions. The programme started in July 2014 and as at the end of June 2016 20,119 patients have been enrolled.

The funding pool for ARI was drawn from a number of sources including CarePlus and the old chronic care management budget. Funding to the practices was done on the basis of need using the CarePlus algorithm. The ARI budget at practice level allows for differing levels of interventions to patients based on need and determined by the local practitioner, usually the practice nurse. Additionally, each practice has a flexible funding allocation which can be spent at the practice team's discretion.

The process of reporting and claiming funds has been designed based on trust, and efforts have been made to reduce the administrative burden to practices.

ARI is underpinned by a philosophy of looking at the patient as a whole, using structured shared care planning. This is important for the CMH population as so many patients have multiple comorbidities and social issues. A Localities approach (a group of local practices working together) allows for services to be developed around a cluster of practices, which can see the local need and opportunities. For example, in the Mangere Locality, clinicians identified a lack of social workers in their area. Practices contacted local NGO providers who employed social workers, who now work alongside the practices, to support ARI multi-disciplinary teams (MDT) for each cluster of practices.

MDT membership is usually made up of a Care Coordinator, GP, pharmacist, specialist support (SMO or nurse specialist) and community team members.

Care coordinator, is a function rather than a role. Most of the care coordinators are practice nurses who receive additional training and support for their new function.

Learnings

Important to have strong support from clinical sponsor (Dr Harry Rea), and strong clinical leadership (Dr Tim Hou).

Providing change management support for practices in the form of identified funding to enable practices to release staff for training, time for whole of practice planning etc. In Year 1 every practice had 15% of total budget allocated for change management and it was up to each practice to decide how that money was spent.

In Year 2 every practice had 10% of budget allocated to quality improvement. Each practice has a quality improvement plan around care planning. Care plans have been audited and patients have been interviewed by the practice. Changes have been identified and included in the improvement plan.

Training is based on expressed need – what the practice teams say they need rather than having it determined for them. The training topics dates, times and venues are all listed on the integrated care website.

Each PHO has a facilitator to support change and ongoing improvement.

There is a need to think flexibly and look at the programme through an improvement lens. Do your homework around an IT enabler. Electronic care planning is fundamental to the success of the approach and IT functionality and integration issues can be challenging.

Steal shamelessly and learn from others. Put local flavour on what others have done and credit the source where appropriate.

Experience so far is generating discussions around what the new workforce might look like. In addition to the array of clinical skills and expertise needed; there is significant potential to develop a 'new' workforce building on work currently carried out by community health workers, kaiawhina and peer support workers.

Results to date

Early data indicates that the programme is having a positive impact on inpatient episodes and ED attendance.

The Flinders Partners in Health scale is being used as part of the care planning process. Early indications based on the follow up data at 6 months show that patients perceive the programme positively.

Information and Integrated care stories of change can be found on CMDHB website.

http://www.countiesmanukau.health.nz/about-us/performance-and-planning/integrated-care/planned-proactive-care/