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Quigley, Rachel, Russell, Sarah, Harvey, Desley, and Mann, Jennifer (2021) ***OPEN ARCH integrated care model: experiences of older Australians and their carers.*** **Australian Journal of Primary Health, 27 (3) pp. 236-242.**

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https://doi.org/10.1071/PY20203

1 OPEN ARCH integrated care model: Experiences of older Australians and their carers

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5 Rachel Quigley[A,B] , Sarah Russell[A,B] , Desley Harvey[A, C] and Jennifer Mann[A,D]

6 A. Cairns and Hinterland Hospital and Health Service, PO Box 902, Cairns, Qld,
7 4870
8 B. College of Medicine and Dentistry, James Cook University, PO Box 6811,
9 Cairns, Qld, 4870
10 C. College of Healthcare Sciences, James Cook University, PO Box 6811, Cairns,
11 Qld, 4870
12 D. College of Public Health, Medicine and Veterinary Sciences, James Cook
13 University, PO Box 6811, Cairns, Qld, 4870

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15 Corresponding author:
16 Rachel Quigley rachel.quigley@jcu.edu.au

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29 **Abstract**

30 There is world-wide recognition of the need to redesign health service delivery with a
31 focus on strengthening primary health care and aligning health and social care through
32 integrated models (Goodwin, 2014). A defining feature of integrated models is improved
33 patient and carer experience of care. This study explores the experiences of older persons
34 and their carers enrolled in a unique model of integrated care that provides a specialist
35 geriatric intervention in the primary care setting for older adults with complex needs in
36 Far North Queensland. A qualitative exploratory descriptive design using semi-structured
37 interviews was used to address the study aims. Seventeen older people and nine carers
38 participated. Data were analysed inductively, guided by the principles of thematic
39 analysis. Three themes emerged: *Getting by, Achieving positive change,* and *Improving*
40 *and maintaining the OPEN ARCH approach.* Findings indicate that enablement models
41 of integration can be successful in activating positive change towards independence for
42 the older person with complex needs. Understanding patients' and carers' experiences is
43 essential to comprehensive service evaluation.

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54 **Introduction**

55 An ageing population, with an increasing number of older adults with complex
56 care needs, continues to challenge health system capacity. Coordination of care for this
57 cohort is often suboptimal, with patients receiving reactive, acute, episodic and
58 fragmented care (Mann et al., 2020, Kuluski et al., 2013). Suboptimal care compromises
59 health and quality of life, produces unsustainable carer demands, and has significant cost
60 implications for the health system (Lawless et al., 2020, Mann et al., 2020). There is
61 world-wide recognition of the need to redesign health service delivery with a focus on
62 strengthening primary health care and aligning health and social care through integrated
63 models (Goodwin 2014). Integral to these initiatives is that care is person-centred with
64 appropriate services coordinated around the needs of the person and their carers (Mann
65 et al., 2020, Mastellos et al., 2014, Spoorenberg et al., 2015).

66 To date, most integrated care model evaluations have focused on clinical
67 outcomes such as nursing home and hospital admissions, physical function, and health
68 service utilisation. This study explores the older persons' and their carers' experiences of
69 care which has been identified as being a defining feature of integrated models (Mastellos
70 et al., 2014). The OPEN ARCH model emphasises a person-focussed approach (Mann et
71 al., 2020) and as such provides an opportunity to evaluate this integral component of care
72 experience. The aim of this study was to explore older persons' and their carers'
73 experiences of the OPEN ARCH integrated model of care in Far North Queensland,
74 Australia.

75 **OPEN ARCH Model of Integrated Care**

76 OPEN ARCH (Older Persons ENablement And Rehabilitation for Complex Health
77 conditions) is a model of care for community-dwelling older people with complex needs.

It provides specialist geriatric assessment, comprehensive planning, and care coordination for older people with complex conditions at risk of hospitalisation, institutionalisation, or functional decline (Mann et al., 2020). Older persons are referred from General Practice (GP) and assigned an Enablement Officer (EO) (nursing or allied health professional), and Geriatrician. The model aligns Geriatric specialist care with that of the GP, with the older person being seen by the Geriatrician within primary care, facilitating sharing of medical records and case conferencing with the specialist, GP, and EO. A full description of the model has been reported previously (Mann et al., 2020). OPEN ARCH is also being assessed for effectiveness through a stepped-wedge randomised controlled trial (RCT). This trial is described in more detail elsewhere (Kinchin et al., 2018).

Complex interventions that involve social or behavioural processes are difficult to explore using quantitative methods alone (Bleijenberg et al., 2015). Qualitative input from service users can have a bearing on how implementation of new services progresses, and can inform success (Harvey et al., 2016). The aims of this study were to: (1) describe the experiences and impacts of the OPEN ARCH model of care from the perspective of the older person and carers; and (2) identify how the implementation of the OPEN ARCH model of care could be improved.

Methods

Design and setting

A qualitative exploratory descriptive design using semi-structured interviews was used to address study aims. The study was conducted in a Hospital and Health Service in regional Queensland, Australia. Ethical approval was obtained from the Far North Queensland Human Research Ethics Committee (HREC/17/QCH/104 – 1174).

Participants and recruitment

Older person

Eligible participants were community-dwelling adults aged >70 years, and Aboriginal and Torres Strait Islander people aged > 50 years, who were participants in the OPEN ARCH RCT and had been receiving the OPEN ARCH intervention for 6 to 9 months. Participants had been identified by their usual GP as frail, at risk of imminent functional decline or hospitalisation, and with chronic conditions and complex care needs. Residents of residential aged care facilities or those already receiving specialist Geriatrician intervention and/or care coordination were excluded.

Carer

Participants were informal carers (aged >18 years) of eligible older people.

The recruitment process involved two steps. EOs identified eligible participants from the OPEN ARCH RCT and provided them with verbal and written information about the study. EOs obtained verbal consent from potential participants to forward contact details to the research team. Consenting participants were then contacted by the research team and given further information about the study and an invitation to participate. All participants signed a consent form before the interview.

Seventeen older people and nine carers were recruited. Table 1 details participant demographics.

Data collection and analysis

Semi-structured interviews were conducted in the participants' own homes by members of the research team (RQ, SR, DH) who had no prior clinical contact with the

124 participants. Interviews guides comprised open-ended questions relating to participants' 125 experiences and impacts of OPEN ARCH on their health and wellbeing, as well as 126 recommendations for improving the service. Participants were also asked to reflect on 127 their experiences of ageing prior to, and after OPEN ARCH. With consent, interviews 128 were recorded and transcribed verbatim by an independent transcription service.

129 Data were analysed inductively, guided by the principles of thematic analysis 130 (Braun and Clarke, 2006). Three researchers (RQ, SR, DH) read and coded one older 131 person and one carer interview each. Through discussion and interrogating the data, a 132 coding framework was developed. One researcher (RQ) then coded the remaining 133 transcripts utilising NVivo Version 12 (QSR International) software to manage the data. 134 The framework was modified by agreement, where gaps were identified, and new codes 135 were required. Data were classified and sorted by one researcher (RQ) before all authors 136 discussed and interrogated the data further to derive themes and sub-themes.

137 **Findings**
138
139 Three themes emerged. *Getting by* exemplifies how the older persons and their carers 140 perceived managing the changes associated with ageing prior to contact with the OPEN 141 ARCH program. *Achieving positive change* illustrates the experiences of OPEN ARCH 142 and the changes then implemented. *Improving and maintaining the OPEN ARCH* 143 *approach* elucidates on participants' suggestions for improving the service and how 144 participants perceived the transition into and out of the service. Representative extracts, 145 labelled as either Older Person (OP) or carer (C) in chronological order of recruitment, 146 are included.

147 ***Getting by***

148 Participants discussed health status and day to day functioning of the older person prior
149 to engaging with the OPEN ARCH program. Overall, both older persons and carers were
150 resigned to how they were managing at home:

151 *I think we were managing ok. We're certainly deteriorating in what we can do*
152 *and we've certainly slowed down a lot from previously … between the two of us*
153 *we do alright but really one depends on the other a lot of the time and, you know,*
154 *I think we were ok. (OP7)*

155 Many older people accepted reduced function as a normal or inevitable part of ageing:

156 *Well I can't do anything now. I used to be able to cut the lawn, but I can't*
157 *anymore. I can pick a cup up with a lot of trouble but, you know, I'm alright.*
158 (OP6)

159 Carers also accepted decline:

160 *He was having difficulty getting into town and going to shops and things and not*
161 *walking around fast … I bought a walker… I bought that so that we could go into*
162 *town and I'd push him around in town, so he doesn't have to walk.* (C1)

163 The expectations of many of the participants centred on functioning at a basic level to
164 achieve the day-to-day requirements needed to remain living at home:

165 *I'm still on my own and I'd rather be on my own than in a home or anything, you*
166 *know. I want to stay here. I've been here for twenty years and I don't want to go*
167 *anywhere else so as long as I can stay here and get some services, I'll be alright.*
168 (OP3)

169 For some participants, this sense of resignation was reflected in coping with the changes
170 without seeking help:

171 *Well we really thought that we were handling ourselves fairly well because [older*
172 *person] could still get around, even though she was going from a walking stick to*

173 *a walker, but we've always prided ourselves how we've managed everything by*
174 *ourselves and we really never thought that we needed assistance.* (C5)

175 In many cases, there was a point of realisation that outside help may be of benefit. For
176 many participants, reliance on personal networks was an acceptable means of filling in
177 gaps of unmet need:

178 *I've got friends, and there's two; they were my main ones… they know me… You*
179 *know they've been doing my shopping and that.* (OP10)

180 For most participants, a sentinel event such as a hospitalisation, change in health status
181 or change in the carers' capacity to manage triggered the realisation that they were no
182 longer able to manage with the current level of support:

183 *I was at the stage that I said to my family, "I can't do this anymore" because I*
184 *have been suffering from vertigo for over a year and four months. And I've been*
185 *doing everything because I'm actually [older person's] carer. And so I'm doing,*
186 *the yard work. I'm doing everything, maintenance, everything, cooking,*
187 *everything. And I've been doing that for about five years, and, I just said to him I*
188 *can't do it anymore.* (C4)

189 *Getting by* also signified a lack of consideration of future planning for potential increased
190 needs and in self-management:

191 *I did think, you know, that I, because I didn't know what facilities were available*
192 *to me as, you know, a pensioner and to be honest with you I never bothered to*
193 *look*. (OP8)

194 Participants became aware of the need for help as the older persons' health declined, but
195 were at a loss knowing what was available or how to access it:

196 *In a way we were in the dark. We didn't know, we didn't know what we didn't*
197 *know and we didn't know what there was to help us.* (OP2)

198 For those participants who were linked into aged care services prior to OPEN ARCH, the
199 experience of accessing services had been confusing and for some, unsuccessful:

200 *I find it very complicated and very disheartening because nothing happens. And*
201 *the whole thing is very hard for older people to understand…we've been assessed*
202 *about four times. We've asked – been asked all the same questions, and we've*
203 *answered them as much as we could because I – I personally find the whole system*
204 *very hard to understand.* (C7)

205 For many with existing services, the experience was one of tolerating unsatisfactory
206 service arrangements or gaps in having their needs met:

207 *Well, I had physios coming in…. all of a sudden, they just stopped, didn't come*
208 *back again. And well, how can I go up to the hospital to see the physio because I*
209 *can't drive, I had a stroke. And the podiatrist stopped coming. I had podiatrists*
210 *come home to cut my toenails and all that, they just stopped…[I] Didn't know why*
211 *they stopped.* (OP17)

212 ***Achieving positive change***

213 All participants, to varying extents, described positive outcomes of participating in the
214 OPEN ARCH program. Many participants felt the program had provided reassurance
215 about the medical care the older person was receiving from their usual GP:

216 *…what they [OPEN ARCH] were doing, they were just making sure that our*
217 *doctors were doing the right thing, prescribing the right medicine.* (C7)

218 For many, the OPEN ARCH team enhanced the care provided by the GP through access
219 to geriatric specialist advice in addition to their GP's care:

220 *he [Geriatrician]'s invaluable. He puts a different perspective on things that we*
221 *won't get from anywhere else.* (C3)

222 Having a specialist team working in conjunction with the GP promoted a feeling of
223 holistic care and many participants valued being part of the wider team that came together
224 under a person-centred approach:

225 *I think that probably the best thing that's come out of it, is that it's put Dr*
226 *[Geriatrician] back on our team - that we have now got ... There's a team and I*
227 *felt like, you know, he's [older person] not going to fall through the cracks.*
228 *Because we're in and out of hospital for bits and pieces and it's more*
229 *collaborative, definitely.* (C3)

230 For many participants, there was a sense of being listened to as an individual by the OPEN
231 ARCH team and hence feeling valued:

232 *He [Geriatrician] sat there and he listened as if you are not just a patient…you*
233 *left there feeling "oh my god, he's somebody that has listened".* (OP16)

234 Importantly, for many, being given the time to talk without being rushed was significant:

235 *They [EO] were great. They were absolutely marvellous, you know, because you*
236 *need somebody that you can talk to and tell your troubles to and know that they're*
237 *not going to laugh at you and sort of deride everything you say…They were great,*
238 *you know, they would listen to me go on and on and on.* (OP3)

239 Several participants expressed how OPEN ARCH facilitated communication between
240 themselves and their GP, and service providers:

241 *[EO] would ring the [GP] that deals with me, and her being medically trained ...*
242 *you know, a nurse and that, she can have that discussion with him. And, you know,*
243 *she's part of my care plan.* (OP10)

244 Then in turn, receiving feedback from the discussion between the GP and Geriatrician:

245 *Most beneficial was Dr [Geriatrician], and [EO] in [case conference] and then*
246 *feedback [to older person] what we're getting through the doctors, which is good.*
247 (OP16)

248 OPEN ARCH built on the existing trust that the participants had with their GP. Many
249 older people consented to the program because their GP had recommended it:

250 *I'm happy with the way OPEN ARCH works. I would never doubt [GP]'s*
251 *recommendations.* (OP8)

252 Participants noted that their care became more seamless as the shared records facilitated
253 the passing of information between GP and specialist, who were collocated in the GP
254 practice:

255 *He [Geriatrician] had access to the medical history on the [GP] system…It made*
256 *a difference for his knowledge about us.* (C1)

257 The co-location within the GP practice, as opposed to seeing a specialist at a busy
258 hospital, was advantageous for many. Reasons included being located closer to home,
259 less waiting time to see the specialist, and familiarity with the environment and practice
260 staff:

261 *[OP with dementia] is familiar with the [GP] environment,... And it's a good*
262 *environment to get in and out of. It was really, really good because we went in*
263 *there. He knew exactly where he was going. He didn't get anxious or confused or*
264 *anything. We just walked into another office, sat down where we would normally*
265 *sit down, and had the consult. So that was a pretty big thing…It was a familiar*
266 *environment, comfortable* (C3)

267 OPEN ARCH was valued for providing relevant aged care system information including
268 eligibility and availability of services and supports:

Until they [OPEN ARCH] came along, you know, there was a lot of things out there that I never, never knew that was available and what was on offer. (OP10)

Participants valued assistance with choosing appropriate service providers, being linked into allied health and nursing services, having assessments for services organised, and being provided with assistance with paperwork for such things as Carers Allowance and Enduring Power of Attorney:

[OPEN ARCH] just came on the scene. I think I felt that was a means by which we could really get connection to the you know ... Well, certainly to all the Aged Care. (OP11)

One participant likened the connecting work that the EO facilitated as putting the pieces together: *She [EO] was able to link in and put what plug belonged in what socket.* (OP10) This co-ordinated care approach contrasted with prior experience:

What did I do before this [OPEN ARCH]? I was trying to manage it in bits and pieces. Whereas I now think it's more coordinated. (OP2)

For several participants, OPEN ARCH created a safety net by guiding the older person through the system:

When I say safety ...I don't mean physical safety. That ongoing safety of where do you go from here? Like I'm seventy-eight, [OP]'s ninety-one. Oh what's next you know you're ... where do we go? So if I hadn't had them [OPEN ARCH] that team helping find different ways of well staying in the home, getting access to services that I didn't know I think it would have ... I'd have been in a really bad place (OP2)

From the carers' perspective, they experienced reduced carer burden as services and supports for the older person were initiated:

293 *I haven't got all that responsibility of him on me. So if [OP]'s not well, she [nurse*
294 *from the service provider] will either organise a doctor's appointment, or*
295 *otherwise, I'll ring one and, you know, and she'll take him to the doctors and*
296 *things like that.* (C4)

297 Participants described the advocacy role that the OPEN ARCH team provided
298 which played a critical role in achieving improved quality of life. EOs advocated with
299 service providers to secure equipment and more optimal care:

300 *I think she [EO] was a good advocate in that she got onto things and got them*
301 *moving with the package provider.* (C3)

302 *I've got a payment ... that comes in .... I didn't know about that until [EO] told*
303 *me ... she said, you know, you have money here. The government has sent you*
304 *money here… [EO] said to me use it while you can. The money is there use it. So,*
305 *I got a chair and a mobility scooter… I got myself a walker…Then came the bed*
306 *and walker, ... they sent me a hospital bed. (OP17)*

307 For many participants, OPEN ARCH provided them with the confidence to seek out
308 services and supports and liaise with providers for more appropriate care:

309 *I'd be pretty confident to just phone up aged care [My Aged Care] or someone*
310 (OP1)

311 Participants placed importance on the personal skills and characteristics of the
312 clinicians. Specifically, clinical knowledge, communication skills, efficiency,
313 compassion, understanding, respect and empathy were perceived as critical in ensuring
314 their needs were met:

315 *[EO] saw that I was going down, deteriorating. I've lost all my body, my muscle*
316 *mass. And that I'm continuing to lose weight…so I'm getting weaker and weaker*
317 *just about every week. And I'm trying to hang out as, as much as I can to be*

independent. But [EO], she saw what was happening…[EO] being a nurse she could see that, … the struggle that I was in. (OP10)

Participants also expressed the importance of OPEN ARCH supporting their individual goals. This reinforced how important it was that the team were responsive to the older persons' and their carers' needs and provided them with an opportunity for fulfilling their goals:

I've looked at OPEN ARCH as being part of that stepping stone of getting that help and also you're going to be living a better life, because… [OPEN ARCH]– is giving you an opportunity of deciding "hey, family can't push me into a nursing home". If I'm – even if I can't do everything, I can still live a life that to me is healthier, because you're not up to a nursing home. (OP16)

For many participants, OPEN ARCH generated an awareness of the need to plan for increased service provision in the future:

I think it's made me think more about my old age and what the future could hold if I live long enough and that's a point, where there's two of us, we can manage. If one passes on, what sort of difficulty will the other encounter in the future. (OP7)

Improving and maintaining the OPEN ARCH approach

Not all participants referred by their GP felt that this was an appropriate program for them. These participants had not identified a current unmet need themselves, and did not have concerns regarding future planning:

I think I'm too independent for [OPEN ARCH], I mean why should I be wasting their time when there are other people? (OP15).

341 The transition out of OPEN ARCH also was problematic for some participants,
342 who expressed a continued need for ongoing management and co-ordination of services
343 beyond the OPEN ARCH program timeframe.

344 *I think it would be good [to carry on with OPEN ARCH] actually. It would be*
345 *good because one of the things that intrigues us both, [OP] and I, is with the little*
346 *cracks starting to appear in our physical, and I suppose mental, wellbeing, how*
347 *many of those things are to be expected and you just have to live with them as an*
348 *oldy, or how many of them are things should and would be treatable? I find that*
349 *to be a rather interesting dilemma because you don't know ... We all get aches*
350 *and pains and you get up some days and things aren't as good as they should be*
351 *and what's normal? That's the area that a Geriatrician would work I think.*
352 *What's normal and what's abnormal? So I think that sort of thing would be useful.*
353 (C2)

354 For some participants, there was confusion about the program itself including eligibility,
355 program outline, and aims:

356 *I didn't know whether this [OPEN ARCH] was a continuing program or whether*
357 *it was just for a period of time.* (C1)

358 Ironically, for some participants, services instigated through OPEN ARCH, created
359 additional administrative burden of dealing with new service providers:

360 *We've actually had so many visitors from My Aged Care coming about getting us*
361 *onto a package, and every now and again if we ask them for something they send*
362 *out an occupational therapist or a nurse ... We begin to wonder where are they*
363 *all from? We've got to think, you know.* (OP7)

364 For some participants, more frequent contact with the EO would have been
365 welcomed: *I'd probably like to see a little bit more interaction from [the] Enablement*
366 *Officers* (C3).
367

368 **Discussion**

369 This qualitative study has provided insight into the experiences of older persons
370 and their carers enrolled in a specialist geriatric model of integrated care, provided in a
371 primary care setting for older people with complex needs. The three themes, *Getting by*,
372 *Achieving positive change,* and *Improving and maintaining the OPEN ARCH approach*
373 provided evidence not only for the participant experience of the OPEN ARCH program
374 itself, but also a changed perspective towards positive ageing and the associated impact
375 on quality of life. This study is consistent with the findings of Kuluski and colleagues
376 (2019) of what constitutes good practice in integrated care, in that participants valued
377 being listened to, having a trusted 'go-to' person, being able to more easily access
378 services and supports, having more control over health management and feeling safe
379 whilst achieving increased independence. However, by exploring how participants
380 managed before receiving OPEN ARCH, the findings of this study provide a more
381 nuanced understanding of the impact of an enablement model of integrated care. The
382 OPEN ARCH model facilitated a change in participants' perceptions of ageing and health
383 management, and this shift in attitude extends previous understanding of the impact of
384 integrated models. Furthermore, this study provides useful information concerning the
385 development and implementation of integrated models of care for older people with
386 complex care needs.

387 Many older adults viewed decline as an inevitable part of ageing and were
388 therefore not actively seeking to engage in preventative care or address issues around

389 health and social care and loss of independence. These findings resonate with other
390 research that describes ageing stereotypes and the perception that it is normal for physical
391 health and function to decline considerably as we age, leading to an unwillingness to seek
392 or use preventative health care (Andrews et al., 2017, Levy and Myers, 2004). A strength
393 of OPEN ARCH was in actively challenging those stereotypes and promoting a positive
394 approach to healthy and successful ageing. Furthermore, OPEN ARCH reduced
395 perceptions of the hardship of ageing through the management, support, and advocacy of
396 a team approach that led to tangible improvements in functioning and in quality of life.

397 Participants described the difficulty they had in locating and accessing services.
398 Prior to OPEN ARCH involvement, most participants turned to personal support
399 networks for assistance. This aligns with previous research that found many older persons
400 rely on the advocacy of family members to negotiate with health and social systems to
401 access the supports they require (Sarris et al., 2020, Funk et al., 2019). As with other work
402 in this area, participants in this study who had approached formal services previously,
403 found that accessing services was problematic, as participants struggled to navigate
404 through system complexity (Funk 2019). However, OPEN ARCH increased participants'
405 knowledge of services and facilitated the navigation of the aged care and health care
406 systems. The benefits of case managers and patient navigators has previously been
407 reported (Carter et al., 2018, Manderson et al., 2012).

408 Findings also highlighted some of the strengths of the integrated model of care.
409 Consistent with other literature in this area, participants emphasised the collaborative or
410 team approach to care and valued the GP as central to their ongoing health management,
411 highlighting the role of primary care as a key intervention point (Grol et al., 2018, Mann
412 et al., 2020).

413 The relational aspects of the OPEN ARCH model and the skills and attributes of
414 team members were also emphasised. Participants appreciated the time taken to explore
415 their needs and felt valued as an individual. This is consistent with findings from
416 Zonneveld, Raab and Minman (2020) who identified values of trust, person-centredness,
417 empowerment, and respect as integral aspects of integrated care. A fundamental feature
418 of successful integrated care lies in the potential to improve care experience through
419 strengthening person-centred care rather than in placing value on improvement in health
420 outcomes (Rijken et al., 2019).
421 Participants appreciated the availability and ease of access to a specialist and
422 acknowledged health improvements as a consequence of specialist input. Improved
423 patient outcomes, including reduced risk of hospitalisation, when Geriatricians provide
424 care in the community in collaboration with GPs, has previously been reported (Fenton
425 et al., 2006).
426 OPEN ARCH was not seen as beneficial by all participants. Some identified areas
427 that could be improved. This included the need for smoother transitions in and out of the
428 service, which could be addressed through clearer, consistent explanations of the program
429 both by the GP and OPEN ARCH clinical team. Also raised was the limitation of OPEN
430 ARCH being a time-limited program, which in itself created dilemmas with transitioning
431 out of the service where participants wished to remain in the service. For some
432 participants, the result of increased services was further administrative work associated
433 with service provision contributing to the burden of care. The capacity to manage this
434 workload needs to be incorporated into care plans, as this could further add to the burden
435 of managing care needs (May 2014).
436 This study had some limitations. As this study was part of a larger RCT, some
437 participants felt they were too well and independent and therefore not suitable for OPEN

438 ARCH. This highlights the need for refinement in the eligibility criteria so there is more
439 of a targeted, case finding approach. The cross-sectional nature of the study also resulted
440 in participants only being followed up at one point in time. Further research into outcomes
441 to see if impacts were sustained over time, as well as optimal length of service delivery
442 would be of use.
443
444 **Conclusion**
445 Overall, this study has provided valuable insights into the experiences and impacts of a
446 unique model of integrated care involving colocation of specialist geriatric and GP
447 services in a primary care setting from the perspectives of the older person and their
448 carers. Participants valued a model of care that features collaboration and coordination
449 between co-located specialist geriatric and primary care. This study has shown that a
450 model of integration that fosters enablement and facilitates a shift towards independence
451 engages older people in their care. It also highlighted the importance of relational
452 attributes for clinicians in the delivery of integrated models. Examination of the older
453 persons' and carers' experiences are a vital component of development, implementation
454 and evaluation of new models of service delivery.
455
456
457 Conflict of Interest
458 Jennifer Mann is a member of the OPEN ARCH service delivery team.
459
460 Acknowledgements
461 We thank all the clients of OPEN ARCH and their carers, and our GP partners who
462 participated in the pilot of this new service. Thanks to members of both the OPEN
463 ARCH Research and Project Steering committees. We also acknowledge and thank the

North Queensland Primary Health Network (Out-of-Hours Care program) and the Queensland Health Clinical Excellence Division (Integrated Care Innovation Fund) for their financial support of the wider OPEN ARCH program. The qualitative component of this project did not receive specific funding.

489

490 **Table 1. Demographic characteristics of participants**

491

	Older adults (n=17)	Carers (n=9)
Age (years)		
Mean	83	80
Range	69-94	58-89
Gender		
Male	9	2
Ethnicity		
Caucasian	15	9
Aboriginal	1	
Torres Strait Islander	1	
Has a carer	7	
Relationship of carer to older person		
Spouse		8
Child		1
Length of time in caring role (years)		
Mean		6
Range		1mth-13yrs

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