

Care Plus Formative Report



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BACKGROUND TO THE RESEARCH

The Ministry of Health has implemented a pilot of the Care Plus initiative in six Primary Health Organisations (PHOs). CBG Health Research Limited has been contracted to provide an evaluation of the Care Plus Pilot.

As a part of the evaluation, the Ministry of Health requested a report that describes the process of setting up Care Plus for the PHOs piloting the initiative. The following report describes the findings of a formative evaluation conducted with three Auckland PHOs.

RESEARCH OBJECTIVES

To understand the processes involved in setting up and implementing Care Plus from a PHO perspective.

RESEARCH DESIGN

SAMPLE

Three Auckland PHOs were selected to complete the formative qualitative evaluation. At the time of the formative interviews (September 2003) one PHO had started implementing Care Plus with their practices; the other two PHOs were planning to commence at the end of the month.

RECRUITMENT

Each PHO was contacted by telephone and invited to take part in a 1.5 hour interview with an experienced health researcher at a time and date convenient to them. The PHOs were sent a semi-structured interview guide before the interview.

DATA COLLECTION

The interviews were all completed at the PHO premises in the month of September 2003. All discussions were recorded with the permission of the participants. Interviews were guided by a discussion guide to ensure that all relevant topics were covered. The interviews lasted one and a half to two hours.

DATA ANALYSIS

The recorded data was openly coded, i.e. examined, compared and categorised. Each category of information was coded onto a framework that contained all of the major areas outlined in the discussion guide (appendix 1). The coded frame was sent to the respective PHO for validation of the interpretation of the information given during the interview. The coded frames were then used to create the report.

KEY POINTS

The Care Plus pilot was seen as an opportunity to see how the Care Plus criteria would apply to real practice populations, and of the practical issues in implementing a care planning approach. It was not regarded as a trial of a replacement for the High Use Health Card (HUHC).

Several possible reasons why HUHC patients, who may be eligible for Care Plus, might not be transferred were suggested:

- It may be administratively easier to renew the HUHC than start Care Plus
- Practices may prefer the security of receiving direct HUHC funding, rather than receive funding from Care Plus through their PHO
- Some practices might renew an HUHC, rather than transfer to Care Plus, as this could achieve the same level of practice funding for less clinical work.
- Not all HUHC patients can be classified as high need (12 retrospective visits does not always equate to past or current high need) and therefore may not benefit from Care Plus
- Patients transferred to Care Plus could lose Pharmacy HUHC subsidies

The capped amount for HUHC and Care Plus is seen as adequate. It is anticipated that the first one percent of Care Plus patients will be easy to identify through the practice staff's experience and knowledge of their patients but the remainder may be more difficult. PHOs do not anticipate exceeding the financial cap and will employ risk management models.

Risk management of the capped amount for HUHC and Care Plus will be completed at a PHO level, across the entire PHO (or participating practices) population. One PHO is planning to initially focus on a practice allocation with the provision to later redistribute across the entire population if there is wide variability in Care Plus enrolment rates. The former risk management approach appears to have been adopted to facilitate the trial of Care Plus in practices with an existing high percentage of HUHC.

It is anticipated that meeting the first criterion (six visits) for Care Plus patients will be easy to identify through the Practice Management Software (PMS) systems and practice staff's experience and knowledge of their patients.

While practices will receive some guidance as to the common chronic conditions that should be considered for inclusion in Care Plus, any disease coding lists will not be presented as exclusive. Patients with other less common conditions will be accepted into the programme.

PHOs have provided and will continue to provide a guide for the selection of patients to each practice but the patient selection is at the discretion of the practice team. Part of the selection process involves an intangible element of clinical knowledge and judgement to decide which patients would most benefit from a care planning approach.

PHOs are tracking enrolments, either by paper-based or electronic systems, as they happen.

The concept of Care Plus has been welcomed and is liked by practices but early feedback is that some practices have concerns that the funding for reviews is inadequate.

Some practices view Care Plus as legitimising the current practice of discounting for high need patients.

All of the PHOs have made provision for a project co-ordinator and/or clinical nurse specialist to oversee the implementation of the pilot at a practice level. PHOs' early experiences of setting up Care Plus support this being a valuable step in establishing the initiative in practices. The set up and establishment of Care Plus was thought to require:

- Communication of the concept to GPs and Practice Nurses (PNs)
- Identification of a person who will be responsible for Care Plus within each practice
- Practice staff training to
 - Use identification methods
 - Set up care plans
 - Manage the overall Care Plus patient portfolio
- Sharing of ideas on methods of identification, patient approaches, and care plan tips between practices via the resource co-ordinator
- Support to maintain identification systems and management of the Care Plus patient portfolio

Commencement of the pilot in the winter months has led to a slow uptake by practices.

Common problems that have been encountered to date:

- Nurses taking too much time to complete the care plans
- Practice staff perception that reviews will involve the same amount of work as the original care plan set up.
- Issue of loss of pharmacy co-payment in a transfer of HUHC to Care Plus

It was occasionally reported that patients may prefer to have unlimited subsidised visits (as with the existing HUHC) without any care planning.

Pharmacy reviews of patients who transfer from HUHC to Care Plus, and are taking a large number of medications, may offset the loss of the pharmacy HUHC subsidy, by identifying eligibility for the pharmacy prescription subsidy.

Care Plus is viewed as fitting with moves to increase the specialisation of practice nurses, patient self management and population based health. It was positioned as complementing other services such as hospice care and district nursing.

EVALUATION AREAS

Some process evaluation areas, listed below, were suggested during the course of completing the formative evaluation:

- Measure the number of patients eligible for Care Plus within each practice
- Contrast and report practitioner selection of Care Plus patients with reference to each criteria
- Understand the methods employed by practice staff to select potential Care Plus patients, in particular, the use of “head held” patient lists (that is, lists of patients which are held only in a practitioner’s head, not written down anywhere)
- Examine the HUHC population with respect to expiry date of the card and assessment of any transfers or failure to transfer to Care Plus
- Measure the time involved in care plans, recall, reviews, patient identification and management of the Care Plus portfolio
- Identify the use, if any, of hospital and Emergency Department (ED) admission list and disease code guidance to identify Care Plus patients
- Assess the number of home reviews for terminally ill patients
- Examine practice attitudes and PHO approaches towards risk management inherent in the capped percentage
- Investigate the practice incentives for, and barriers to, transferring HUHC patients to Care Plus
- Investigate the intangible elements involved in the discretionary decision-making by practitioners as to the selection of Care Plus patients and who will most benefit from Care Plus.

QUALITATIVE FINDINGS

INFORMATION PROVIDED TO THE PHOS

All of the PHOs were in the process of developing Care Plus contracts which, at the time of interview, had yet to be signed. One of the PHOs had been provided with a Care Plus Ministry of Health (MoH) proposal and communications outlining eligibility criteria and the various considerations for the transfer of HUHC patients to Care Plus. This PHO noted that they had been extensively involved with the evolution and development of the Care Plus concept since its proposal by the Independent Practitioners Association Council (IPAC) to the Ministry of Health. The remaining two PHOs had received Care Plus service schedule documents from their respective District Health Boards (DHBs). They noted that the main communications regarding Care Plus had been via IPAC, other PHOs involved in the Care Plus pilot and DHBs.

For supporting quotation please refer to Table B, quote 1, Table C quote 1 and 2

The information that had been shared between the PHOs, MoH and/or DHBs and IPAC was deemed to have been comprehensive and had been used to inform the PHO plans for the implementation of Care Plus. It was noted that the MoH documentation had been slow to emerge and that this had delayed the pilot start from the proposed February 2003 commencement. One PHO noted that late communications regarding funding plans for Community Services Card (CSC) and non-CSC patients had proved problematic to the planning of a risk management strategy.

For supporting quotation please refer to Table C, quote 3

PHO staff perceived that issues relating to the integration of HUHC, CSC, the original IPAC proposal with Care Plus plans and funding considerations were responsible for the documentation delays. Concerns were relayed about practices capacity to start implementing Care Plus during the winter months when their workload is typically high.

For supporting quotation please refer to Table A, quote 1.

Despite the slow start, PHOs said that they had been preparing and priming their practices for the commencement of Care Plus. One of the PHOs ran the National Health Index numbers (NHIs) of the PHO enrolled patients through hospital databases to identify patients who had been admitted. Another PHO had requested an up-to-date list of CSC and HUHC holders within their enrolled population from HealthPAC. The CSC and HUHC register that was initially returned was not correct. This caused delays in the PHO's plans to implement the Care Plus pilot.

For supporting quotation please refer to Table B, quote 2

Further preparation saw one PHO incorporate a change in their governance structure to add in a clinical board to oversee and support the implementation of Care Plus. Delays in the start date of the pilot were thought to have afforded this PHO the opportunity to gather more information about HUHC trends under the capitation model.

For supporting quotation please refer to Table C, quote 4

Care Plus was explained to be a care plan approach to patient care that will integrate a multidisciplinary team approach, specialisation for practice nurses, regular care reviews and the development of patient self management. It was described as an approach that aims to improve the health of the population and brings a timely relationship between care plans and illness that will encourage practices to increase the quality of care available to high need patients.

*For supporting quotation please refer to Table A, quote 4 and 5,
Table B, quotes 3,4,11,
Table C, quote 5*

The management of the capped percentage for Care Plus and HUHC was regarded as an area that required some attention in the evaluation. The capped enrolment for Care Plus was not considered to be a limiting factor for the pilot. It was anticipated that most practices would not reach the cap and/or the PHO would stay within the quota using various risk management approaches.

*For supporting quotation please refer to Table A, quote 8,
Table B, quotes 5 and 17,
Table C, quotes 6 and 14.*

Two of the PHOs were taking or planning to take a total population approach to afford Care Plus patient selection in practices that already have a high percentage of HUHC (up to five percent in some practices). One of the PHOs had opted to use a practice allocation approach with provision for redistribution of Care Plus places, between the participating pilot practices, depending on variability in uptake of places.

For supporting quotation please refer to Table A, quote 15.

It was expected that alerting practices to the capped amount could predispose some of them to take an unrealistically conservative approach. It was thought that there were practices who would wish to keep a percentage available for new patients. Similarly, it was noted that some practices would work towards achieving the maximum amount to fully utilise the allocated resource.

For supporting quotation please refer to Table A quotes 16 and 17.

Interpretation of the eligibility criteria

1. Has had six or more primary health care visits in the past six months (including emergency department visits);

The PHOs were, or anticipated, assisting practices with this criterion by obtaining from the DHB a list of patients who had had an emergency department visit. One of the PHOs said that this criterion would most likely be used to set up Care Plus patient identification systems within its practices. It was advised that practice staff usually have a “head held” list of patients who would meet this criteria.

For supporting quotation please refer to Table A, quote 2, Table B, quote 6, 7, 8

2. Has had two or more acute non-surgical admissions in the past 12 months;

Similar to ED admissions, the PHOs were, or anticipated, assisting practices with this criterion by providing lists of patients who had been admitted to hospital. Lists had been or were being obtained from the DHBs.

3. Has a terminal illness (defined as someone who has advanced, progressive disease which is no longer responsive to curative treatment and whose death is likely within 12 months);

PHOs advised of various service initiatives that are or have been developed, such as a policy which encourages patients who wish to die at home to do so under the care of the GP team. It was noted that Care Plus would complement some of the approaches and would afford the opportunity for practice staff to create and review care plans.

For supporting quotation please refer to Table B, quote 9

4. Has two or more chronic conditions, defined as follows:

- **they have a significant burden of morbidity**
- **they create a significant cost to the health system**
- **there are agreed and objective diagnostic criteria**
- **continuity of care and a primary care team approach has an important role in management;**

All of the PHOs had guided, or were proposing to guide, the GP team in selecting patients under the chronic conditions criteria. It was noted that any chronic condition lists provided by the PHO would be reference guides rather than exclusive inventories. It was further explained that patients with other chronic conditions, who were deemed by practice staff to be likely to benefit from a care planning approach, would be welcomed into the programme. The following conditions were considered common and have been or will be provided as a guide to the practices:

1. Asthma
2. Diabetes (insulin and non-insulin dependent)
3. Chronic obstructive airways disease
4. Heart disease (One PHO specified codes for ischemic heart disease, hyperlipidaemia, hypertensive disease and heart failure)
5. Depression

For supporting quotation please refer to Table A quote 11, Table B, quote 10, Table C, quote 9.

5. Is assessed by the general practice team as being expected to need 'intensive clinical management' (at least two hours of clinical management) over the following six months.

The PHOs signalled that this criterion is a useful modifier when considered as an adjunct to the other criteria. It was anticipated that some chronic conditions or previous hospital or ED admissions would not be amenable to intensive clinical management.

For supporting quotation please refer to Table A, quotes 9 and 10

Use of the information

Information provided by the Ministry of Health and/or DHBs had been, or was being, used to create practice packs to guide the establishment of Care Plus. Commonly information contained within the practice pack listed the five eligibility criteria to be used by the GP team in selecting patients who would benefit from Care Plus. The focus on the eligibility criteria qualifiers, rather than simply moving existing HUHC to Care Plus, was viewed as a means of emphasising the discretion of the GP team in selecting patients. It was also deemed necessary to ensure that the focus remained on selecting the patients who met the designated criteria rather than just swapping CSC or HUHC for Care Plus.

For supporting quotation please refer to Table A, quotes 3,6,7.

Information management

In providing guides to practices, rather than a set of rules, the PHOs hope to encourage practices to use their own ingenuity, experience and knowledge of the enrolled patients to select people who would best benefit from the Care Plus approach.

For supporting quotation please refer to Table C, quotes 7 and 8.

For the purposes of the pilot, PHOs require an up-to-date list of HUHC and CSC patients within their enrolled population. They also require detail about funding plans for all types of patients. This information facilitates resource and risk planning to keep within the capped amount.

TRANSFERRING HUHC PATIENTS TO CARE PLUS

The pilot study was seen as an assessment of

- Practice populations against the Care Plus criteria
- Care planning for patients with high needs
- Implementation of a primary care initiative to improve population health

It was not positioned as a trial of a replacement for HUHC. PHOs advised that they have not focused, or will not be focusing, on practices transferring HUHC patients to Care Plus. It is anticipated that whilst HUHC reimbursement is funded at an equal or higher rate and given directly to practices, that general practice is unlikely to see Care Plus as a viable replacement for HUHC.

For supporting quotation please refer to Table C, quote 10.

Identified Issues

All of the PHOs said that there may be a disincentive for practitioners to move HUHC patients, on expiry of the HUHC, to Care Plus given the extra work that Care Plus is perceived to involve. Early feedback would suggest that practitioners are sceptical as to whether or not the allocated funding for care plan reviews will cover the time involved in completing them.

For supporting quotation please refer to Table A, quote 13.

It was felt that there may be an incentive for practices to renew the HUHC to secure direct funding to the practice, as opposed to enrolling a patient in Care Plus, when practice funding would be received indirectly via the PHO. The PHO signalled that the extra capitation amount may act as an incentive to keep patients as HUHC holders.

For supporting quotation please refer to Table B quotes 12 and 13, Table C, quote 11.

It was anticipated that because of the desirability of receiving direct funding, HUHC patients who continued to meet the HUHC criteria might be kept on HUHC and not transferred to Care Plus.

For supporting quotation please refer to Table B, quote 14, Table C, quote 12.

PHOs identified two groups of high need patients who would be more likely to benefit from Care Plus as opposed to HUHC, more specifically patients who:

- have previously been HUHC holders but no longer qualify based on the retrospective 12 visits per annum
- are high need but never meet the 12 visit criteria because they can not afford to attend see a doctor or nurse more than four times per annum.

For supporting quotation please refer to Table A, quote 14, Table B, quote 16, Table C, quote 13.

Many interviewees said that not all HUHC patients are high need and that the retrospective 12 visit qualifier for HUHC predisposes the system to include patients who are no longer, or never were, “high need”. A typical scenario of the latter is a patient who returns frequently for tests or checks that are not necessarily related to a condition/s that qualifies as “high need”.

For supporting quotation please refer to Table B, quote 15.

One of the PHOs advised that there would be client subsidy issues to consider for patients who take a number of medications that fall under the 20 item qualifier for Pharmacy Subsidy Cards, but currently receive the pharmacy subsidy under existing HUHC provisions. They have allocated some financial resources towards completing pharmaceutical reviews with these patients in order to try to offset the loss of the subsidy.

For supporting quotation please refer to Table A, quote 12.

Professional satisfaction was cited as an incentive for practitioners to identify and manage Care Plus patients.

For supporting quotation please refer to Table C, quote 15.

SETTING UP CARE PLUS IN PRACTICES

Practice requirements

It was thought that practices require training and support to: identify Care Plus patients, move to care plans, recall patients, query PMS systems, and make nurse appointments and Care Plus clinics fit with the practice. PHO staff further identified that most practices need help to start booking and protecting nurses' time to complete care plans and reviews. Care plans were seen as new to most practice nurses and positioned as an area for full training. However, for two of the PHOs who had recent experience of implementing similar approaches, care plans were cited as an area for revision and support in clinical decision making.

For supporting quotation please refer to Table B, quote 19, Table A, quote 24, Table C, quote 18

PHO approaches to introducing Care Plus

Care Plus has been and will be personally promoted to practices via a project co-ordinator and/or clinical nurse specialist. Two of the PHOs have conceptualised Care Plus as a predominantly “practice nurse-led initiative.” The identification of a lead nurse within a practice was said to be key to the set up and implementation of Care Plus in most practices.

For supporting quotation please refer to Table A, quote 22

All of the PHOs recognised that GPs must understand the concept in order to lend their support. Two PHO teams advised that they later communicated the idea to the GPs having secured the support of the practice nurses. The remaining PHO conceptualised Care Plus as a more “Practice team initiative” requiring the input of both nurses and GPs. This PHO team advised that they will communicate the idea to both GPs and nurses at the same time.

For supporting quotation please refer to Table B, quotes 18, 20, 21, Table C, quote 17

PHOs who had experienced implementing care planning portrayed an understanding of the infrastructure and support that practice staff require to move away from reacting to illness and towards planning care.

For supporting quotation please refer to Table C, quote 19

Guidance and support for practices

Commonly PHOs are providing guidance to practices via:

- Project co-ordinator or clinical nurse specialist
- Written documents, namely:
 - Care Plans (in some cases adapted from those previously used by the practices for another project)
 - Eligibility criteria
 - Patient invitation letter
 - Patient agreement/consent form
 - Minimum service requirements
 - Fee structure
 - Enrolment and claim forms

One PHO will additionally utilise a clinical board to govern and support the implementation of Care Plus and the review of patient selection (if there are any concerns).

Practice information will typically:

- Describe Care Plus as additional funding to primary care teams for selected patients with high needs
- Define the target group as HUHC or patients who meet one of the four criteria and criteria number five
- Convey the Care Plus funding and patient co-payments allocations
- Specify the core components of the programme, patient outcomes and reporting, privacy issues and consent, care plans and reimbursements
- Provide a patient invitation letter, care plan and consent form, assessment and review forms
- Give some guidance for the selection of patients with common chronic conditions

The patient-held care plan, developed for the practice's use, commonly consisted of information to assist patients in the management of their health, more specifically:

- Personal patient information
- Contact details of the practice
- Summary of health condition
- List of medications
- Lifestyle goals
- Tests and check up purposes and times
- Action plan
- Patient education points/booklets/pamphlets

Process for practices identifying and selecting patients

It is important to note that Care Plus seems to involve a process of identification and selection that includes an intangible element. That is, the clinical judgement of a health professional as to which patients will benefit from a care planning approach. It was noted that, of the practices who have started to implement Care Plus, some have taken a proactive approach towards the identification and enrolment of Care Plus patients. Other practices have adopted an opportunistic approach where the patient is invited to join Care Plus during a routine visit to the surgery.

For supporting quotation please refer to Table C, quotes 6 and 7

PHOs expected that practices, in order to identify Care Plus patients, would use:

- PMS systems to access utilisation and disease coding data
- Lists of patients who have had a hospital admission and/or ED attendance
- Hand held lists of patients who are high need, would meet the criteria and benefit from a care plan approach
- Clinical knowledge, judgement and experience to select patients who would best benefit from a Care Plus approach
- A project co-ordinator or clinical nurse specialist to aid the set up and management of Care Plus

MANAGEMENT OF CARE PLUS

Patient enrolments

PHOs are, and will be, collating Care Plus patient enrolment details on a weekly basis or as they happen. Two of the PHOs run a paper based system with one PHO opting to employ an electronic system. The latter explained that the electronic data collection would easily afford the PHO support for the follow up of enrolled patients who have not completed the necessary reviews. It was anticipated that practices will be paid on a monthly basis.

For supporting quotation please refer to Table C, quote 21

Feedback

All of the PHOs were planning to obtain feedback from practice staff throughout the duration of the pilot using existing professional “cell groups”. It was expected that most operational issues would be fed-back via the project co-ordinator and/or clinical nurse specialist.

For supporting quotation please refer to Table C, quote 16

Early feedback, from practices who have started to implement Care Plus, would suggest that the Care Plus concept has been welcomed. However, there appears to be divided opinion as to the funding allocation which falls into the two categories below:

“Too much work for too few dollars” – The allocation for assessment, enrolment and care plan development is sufficient but the income per quarterly review allocation will not be sufficient to cover the practitioner’s time.

For supporting quotation please refer to Table A, quotes 18, 19, 25, 26

“Great – we are doing this anyway” – Care Plus is positioned as legitimising the practice of typically discounting high need patients. It was reported that early experience of implementing Care Plus would signal that practices may prefer to focus the funding on fewer high need patients.

For supporting quotation please refer to Table A, quote 20 and 21

Validation of patient selections

At this early stage, there has been no validation of selected patients. The enrolment forms do include details of the criteria under which the patient was selected for Care Plus. One PHO anticipated using this information to complete an audit on a sample of patients. The others did not anticipate any validation process unless there were concerns about patient selection.

For supporting quotation please refer to Table B, quote 25, Table C, quote 20

COSTS

The following were cited as PHO costs for the set up and ongoing administration of Care Plus.

PHO	Practices
<p><i>Set up costs</i></p> <p>Care Plans Practice packs Launch Promotion Training</p> <p><i>Ongoing costs</i></p> <p>Project co-ordinator/clinical nurse specialist Vehicle expense Administration support (clerical, accounting, data entry miscellaneous) Management <ul style="list-style-type: none"> • Implementation of risk strategies • Support for practice management of Care Plus • Payment of practices • Monitoring of Care Plus selected patients </p>	<p><i>Set up costs</i></p> <p>Practice staff training and time to comprehend the concept and set up identification processes.</p> <p><i>Ongoing costs</i></p> <p>GP and nurse times to complete the care plans and reviews Nurse time to recall patients Vehicle expense if reviews are completed at home for terminally ill patients</p>

Hidden costs

Two of the PHOs had yet to receive monies for set up and so were not in a position to comment at length on any areas of hidden costs. It was noted that the PHOs have, to date, devoted many unfunded hours to developing the Care Plus approach and conceptualising its implementation. It was suspected that under the current arrangements, there is little or no provision for reimbursement of practice staff training time.

For supporting quotation please refer to Table B, quotes 22, 23, 24

QUOTATION TABLES

Table A: PHO A

Id	Verbatim quotation
1	“It [referring to Care Plus] had a bit of a rocky start and the documents have been slow in coming and that has pushed us into the winter.”
2	“ We have just given them [practices] a list of patients who had admissions.”
3	“Transitioning HUHC to Care plus is being left at the discretion of the GP team. We have been pretty hands off. This is the criteria: over to you.”
4	“There’s a risk of increasing patient dependency. It’s [referring to care planning] an opportunity to integrate self management focus, healthy lifestyles for people with chronic conditions where the goal is a competent well educated manager of own care.”
5	“ Care Plus allows us to gradually, over time, weave self-management in.”
6	“We want ingenuity and ideas to flow from GPs rather than us, in a bureaucratic sense saying here are the rules, rather there is a set of guidelines.”
7	“ We have wanted to keep it open, how do you interpret it for your patients.”
8	“Our expectation is that we won’t hit the ceiling.”
9	“There may be some that meet number four [chronic conditions criterion] but are not amenable to intensive clinical management.”
10	“Its [referring to the criterion of intensive clinical management] a strong modifier if you look at four and five together, rather than rules.”
11	“We gave them a list of disease codes but ultimately it’s their call.”
12	“One of the issues about converting HUHC patients to Care Plus is the pharmacy co-payment. We have agreed to fund.....pharmacy reviews for patients who qualify for Care Plus and are on x number of drugs.”
13	“If they do renew the HUHC, why bother with Care Plus because they are getting the same level of funding without all the work.”
14	“ There’s quite a lot of churn in HUHC, people qualify and then at the end of the 12 months they don’t because they haven’t made the 12 visits. They might be an attractive group to put onto Care Plus.”
15	“We have a practice that has over five percent HUHC anyway. In theory, we should have said you can’t enrol Care Plus patients because you are already at five percent but they have been told to go ahead on the basis that other practises won’t get three percent.”
16	“Some will be ultra conservative and want to keep a few percent up their sleeves and others take a more ‘gung-ho’ attitude.”
17	“Managing the risk, from a PHO point of view, is achievable if we manage it across the total population.”
18	“The feedback we have had from some practices is that Care Plus involves a whole lot more work for not too much money.”
19	“Too much work for too little gain.”
20	“ We are doing this anyway. We discount anyway and this legitimises current practice.”
21	“ The concept we like, but we would prefer to see increased funding for less patients.”

22	“These guys targeted the practice nurses and told them about Care Plus. We had a launch with practice nurse, they came in here and got the practice pack and care plans.”
23	“We are getting new enrolments as and when they [referring to the practices] get them.”
24	“Care plans are quite different from what most practice nurses have been taught and are used to; it’s a different way of looking at it.”
25	“ When you look at the quarterly review it’s really \$36 to \$45 plus the patient co-payment of \$5 to \$10, it’s not much more than the standard consultation.”
26	“It may take the same time to complete the reviews and that’s the fear.”

Table B: PHO B

Id	Verbatim quotation
1	“We have had no information from the Ministry as such; our information came from the DHB, the service specifications.”
2	When we submitted our patient register they found a glitch in the information system and the CSC and HUHC register that we got back was not correct. Until we have got the correct levels, we can’t implement Care Plus.”
3	“Practice nurses will have taken a good health assessment before the patient sees the GP. The GP will look at the medical issues and they will co-ordinate the plan together.”
4	“It’s all aimed at improving the health of the population.”
5	“We think it’s [referring to HUHC number] around two percent .”
6	“It’s a good first shot at identifying. The only problem in that criterion is the ED info. It is OK if they went to EastHealth and we need information from Middlemore, but they are investigating how to set this up if they go elsewhere.”
7	“Using the first criteria is really going to get people who would benefit the most.”
8	“It’s easy to go in there and run the query for them and then the practices, from the list, can identify people that are suitable. They will know who they are.”
9	“Free home visits for people requiring palliative care but, at this stage, we would be unsure of the fit with this [referring to Care Plus]”.
10	“We have several conditions that the GPs regard as ‘chronic’ as they have been educated to Read code, they were defined by the DHB, so we already have a fair idea of what they will see as a chronic condition.”
11	“ I see it as a pilot of a primary care initiative to improve the health of our population.”
12	“There is a very basic reason why GPs will carry on with HUHC, quite simply the funding goes direct to the GP.”
13	“You are looking at an extra \$400 in capitation for the patients whereas with Care Plus, funding goes to the PHO.”
14	“If they have had the 12 visits, they are most likely to keep them on the HUHC.”
15	“ I am not sure that having a HUHC always signals high need. They have just managed to meet that visit criterion. We all know how that can happen and how it continues to happen.”
16	“Some people can only afford to come four times a year, they save things up but they are high need. These people would benefit from Care Plus.”

17	“We have not got to the point of finally deciding but we think it [referring to management of the capped amount] will be at a PHO level. Practices have different populations, I don’t think we can say to them – you can have this amount.”
18	“One thing that we did learn from FAMA (Frequent Adult Medical Admissions) is that if you don’t educate the GPs and they don’t understand the process, that they won’t buy into it. They need to know to allow, so to speak, the practice nurses to do it.”
19	“We are not introducing a totally new concept....We are quite lucky because the practices which are in the PHO participated in FAMA and we had sessions on care plans so they are quite familiar with using patient care plans.”
20	“We will go in and talk to them about the fee structure, who is eligible and what is expected of them at a minimum service level.”
21	“They need to know who is eligible and part of my job will be to explain and help set up the identification.”
22	“If you want to work up a comprehensive care plan on someone, you are looking at at least one hour.”
23	“Assessment and care plans will be time consuming and practice nurses time is grossly undervalued.”
24	“Ongoing it will be practice staff time. That is the biggest resource and the one which they have the least of.”
25	“When they enrol someone and send us the forms they are going to have to say what the enrolment criteria was that they enrolled the patients in Care Plus.”

Table C: PHO C

Id	Verbatim quotation
1	“We have been working with the other PHOs who are taking part in Care Plus”
2	“Care Plus information has been provided gradually. The only version of the service schedule came from the DHB.”
3	“The information was late [referring to CSC and non-CSC funding plans] and it presents a risk if you have the same payment for CSC and non CSC. We have to somehow make up the difference as the baseline capitation for non-CSC is lower.”
4	“We have been able to gather more information on HUHC trends. They are still trending upwards but the rate of increase has slowed.”
5	“It’s about incentivising practices to increase the quality of care. This will give a timely relation to illness.”
6	“We will use a risk management model to stay within it [the capped quota]. In the service schedule it says that we should aim to have in the Care Plus programme and HUHC, somewhere between three and six percent of the population.”
7	“You would want to preferentially give a Care Plus place to a high need patient who has the best ability to benefit from the care plan.”
8	“There is a skill in knowing patients that the GPs and PNs have. They will know if they can relate to them to produce a significant change.”
9	“We don’t expect the suggested chronic conditions to be the only ones. We are hoping others will be included under this criterion.”
10	“While HUHC is funded higher than Care Plus there is very little chance that Care Plus will replace it.”
11	“They have a legitimate right to re-apply for HUHC if the patient meets the criteria.”

	It is difficult to see why they would not do that.”
12	“You make money as a practice if you keep people on HUHC as opposed to [Care Plus]. It is a blunt instrument but under capitation, practices need to capture all HUHC patients.”
13	“Some non-qualifiers for HUHC have substantial high health needs but they have never met the 12 visits criteria. These are people who need help but don’t go to the GP often enough so don’t qualify for HUHC. Care Plus brings a more timely response to illness”
14	“We are seeing it as a mixed approach – we are roughly allocating places to each practice so you end up with a fraction of patients on HUHC and Care Plus. But we expect variability on uptake and we will not let places go to waste.”
15	“A major incentive for Care Plus is the satisfaction that it will give you as a professional.”
16	“Most of the feedback will come through support co-ordination, the clinical nurse specialist.”
17	“We will visit each practice to support the set up. There is a role for the GPs in the initial assessment but on the whole the nurses will complete the care plans.”
18	“Care Plus requires training for practices to be able to plan care for high risk patients. We need to assist them to do this in a consistent high quality manner.”
19	“We have experience of the care planning approach and we recognised fully the infrastructure and support you require to make and sustain this kind of change in general practice.”
20	“ We have the right to that [referring to validation] whether we choose to do it will depend on any concerns.”
21	“If they miss one or two visits we will do something to find that person to understand why they have missed the visit.”

STORAGE OF MATERIALS

CBG Health Research will, unless otherwise specified, hold all documentation pertaining to the research for a period of not less than three years unless otherwise specified.

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CBG Health Research Ltd

- ◆ will keep the research project and its results confidential except for the purposes of undertaking it.
- ◆ acknowledges that the Ministry of Health will use the findings of the research as necessary and appropriate.

Care Plus Formative Report

Acceptance Form

This Report, submitted by CBG Health Research
Ltd, has been accepted by

Name

Organisation

on the day day of Month 2003