

Care Plus Process Report



Prepared for the Ministry of Health

March 2004

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BACKGROUND TO THE RESEARCH

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

As a part of the evaluation, the Ministry of Health requested a report that describes the process of setting up and implementing Care Plus in general practices. The following describes the findings of a process evaluation completed with 12 practices from three PHOs, located in Auckland, Christchurch and Northland, who had established the Care Plus programme.

RESEARCH OBJECTIVES

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

RESEARCH DESIGN

SAMPLE AND RECRUITMENT

Twelve practices were selected to complete the process evaluation. At the time of the interviews (March 2004), three PHOs were implementing the programme with their practices. Each practice was contacted by telephone and invited to take part in a one hour interview with an experienced health researcher at a time and date convenient to them. Participants were sent a semi-structured interview guide before the interview.

DATA COLLECTION AND ANALYSIS

The interviews were all completed at the practices in the month of March 2004. 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 40 minutes to one hour.

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). A summary of the discussions was sent to each practice for validation of the interpretation of the information given during the interview.

KEY POINTS

Practices had elected to be part of the Care Plus pilot because the initiative appeared to target patients with chronic conditions, had the potential to improve patients' access to general practice and encourage more regular consultation.

Most practices favoured the selection of patients under the chronic conditions criterion. The transfer of High Use Health Card (HUHC) patients to Care Plus was seen as problematic, by most of the pilot practices, both from a patient and practice finance perspective.

Patient responses to an invitation to take part in Care Plus had been favourable with a limited number of refusals. The level of involvement expected from patients by practitioners was varied; from an expectation that patients take an active part in their health care and make appointments for review visits, to lower expectations of involvement where the practice actively recalls the patient.

In the experience of most of the practices, the care plans are largely unread by patients. Many practitioners had tried to encourage patients to write in the booklets but advised that this had been relatively unsuccessful. It was advocated that the programme should focus on the use of brief interventions and simple, one page documentation.

Opportunistic recruitment of patients returning to the practice for a prescription appeared to be a successful recruitment process. Active recruitment had also yielded good results but practices had been unable to sustain it, because of the nursing time involved. A good recall system was considered to be imperative to the success of the programme.

In the experience of the pilot practices, the time involved for patients and practitioners, patient apathy towards a more active role in their own care, and staffing, were the main barriers to implementation of the programme. Patients who have limited interest, education, time and understanding about the management of their condition have difficulty engaging with Care Plus. Two patient groups were identified as more likely to have problems with the approach - older males and the very elderly.

Most practices thought that there should be a nurse co-ordinator, at a PHO and/or national level. It was thought that Care Plus fully utilises nursing skills and increases their profile with patients. Nurses appeared to be taking a lead in care planning in most practices, but the input of GPs and nurses in Care Plus visits, particularly reviews, was varied and constrained by funding, time, and practices' support of autonomous nursing practice.

Getting the right staff involved in the Care Plus programme at a practice level was most strongly predictive of successful implementation. Establishing the number of nursing and GP hours required in relation to patient numbers and implementing a plan to stagger the introduction of the programme was seen as a key to success.

The majority of pilot practices thought that Care Plus was not an easy scheme to run in the busy and time restricted environment of general practice. Practices advised that the length of time required for Care Plus does not always fit with the time available during everyday general practice.

GPs appeared to have been more successful in integrating Care Plus consultations into the normal working day. The provision of nursing consultations had required, in some practices, extra nursing cover and limiting appointments to specific times and/or days. Discussions highlighted that limiting Care Plus visits to specific times can present access issues for some patients, and difficulties integrating nursing and GP input into the programme.

Practices had not reached the capped rate because, for the most part, they had not had sufficient time to implement the programme for all of the eligible patients.

Some practices were experiencing problems with patient drop out rates (between five percent and 50 percent, typically 50 percent) at the review stages. The reasons included: no active recall for review appointments, negative perceptions of nursing consultations where nurses were completing the review and Care Plus was being offered at limited times because of the need for extra nursing cover.

Some practitioners warned of hidden costs, in terms of the extra nursing and GP time required to complete care plans for more complex cases. Providing training for nursing staff, so that they could be more involved in chronic care management, was also seen as a hidden cost for both practices and PHOs.

The funding of reviews was not viewed as sufficient to support both nurse and GP input.

The key issues perceived by practitioners as likely to face Care Plus if it is extended to all practices to replace HUHC, were thought to be the loss of prescription subsidies for A3 patients, ensuring practice revenue exceeds that already derived from HUHC funding, given more work is required, and improving funding of review visits to allow the incorporation of both nursing and GP inputs.

Some practitioners warned that the programme could experience a lack of support in practices that have not previously promoted either nurses' independent practice and/or a care planning approach.

Increased use of electronic systems to support the programme was recommended to remove disincentives associated with increased paperwork.

QUALITATIVE FINDINGS

DECISION TO TAKE PART

The majority of practices had elected to be part of the pilot because the initiative appeared to target patients with chronic conditions who require more time than is available during normal consultations. Practices anticipated that Care Plus would improve patients' access to general practice and encourage more regular consultation. Practitioners further explained that they had welcomed the opportunity to offer patients, especially those managing chronic conditions who did not qualify for any other benefits, some financial support.

'We saw a need for increasing the care for our patients with chronic illnesses, better access. This seemed to provide an opportunity that is not usually financially available to us or our patients.'

SET UP AND ESTABLISHMENT OF CARE PLUS

Setting up of the programme had involved planning, at a practice level, about how to identify and recruit patients and manage the workload. The time spent and methods used to identify patients were varied. In some practices, patients had been identified from "head held" lists of GPs and/or nursing staff. Other practices had run patient management software (PMS) queries to identify potential patient groups. The queries were also varied, some focusing exclusively on a particular chronic condition/s and others including identification of patients with a high number of GP visits and/or hospitalisations. These lists were usually reviewed by GPs and/or practice nurses to identify those patients who should be approached and invited to take part in the programme.

'It began with the doctors giving me a list of patients, off the top their heads. They know the patients very well. From that list, I went through and phoned people and then followed up with a general letter about Care Plus.'

Most practices had opted to opportunistically recruit patients when they presented for medications and this was associated with a good response rate. Some practices, as highlighted in the quotation below, had actively recruited patients; usually a nurse had personally contacted them by phone and/or letter. Patient response to a personal contact (75-100 percent response rate) was reported to be more effective than the response to mail recruitment (40-60 percent).

'I know that some places have actively targeted particular patients. We have decided not to do that. We decided to be opportunistic about it when they present.'

In order to manage the work involved in completing Care Plus for the entire "selected" eligible group, most practices had opted to spread out the enrolments. Some practices had identified and aimed to enrol more patients than had eventually proved possible given the work involved. All of the evaluation practices had eventually decided to stagger the implementation and reduce the numbers of people invited to take part in the programme.

'Initially we aimed to get as many patients as possible enrolled. By week three, we knew that this was not a good way to tackle Care Plus as it is so labour intensive. We staggered and reduced the numbers.'

INCENTIVES TO TAKE PART

For practices

Financial benefits to patients, quality of care afforded by the extra time, and the care planning approach were seen as the key incentives for practices to implement Care Plus. Professional development, especially for nursing staff involved in Care Plus, was also viewed as encouragement. It was thought that Care Plus fully utilises nursing skills and increases their profile with patients.

'I think that professionally it has extended me. It has developed my rapport with so many patients. We are really involved in educating and it is better quality of care.'

Improved outcomes, increased patient access to general practice, better continuity of care and financial reimbursement were thought to be the key factors that will keep practices taking part in Care Plus in the longer term. Streamlining the Care Plus process with better use of electronic communications, adequate financial reimbursement and limiting data collection to that which is essential and relevant were thought to be issues that will be important in the longer term. It was felt that practices will move away from the scheme if it fails to keep abreast of the financial reimbursements required.

'For us, cost is a huge factor, so if we can help patients to access [health care] by taking the cost out of the equation, that will keep us involved.'

For patients

The promise of health improvement and extra time with practitioners were positioned as the main probable reasons for patients to take part in the programme. Self interest in health and a desire to be more involved in health care were also thought to be motivation for some patients. The voluntary nature of the programme and financial help, especially for those that have not benefited from other access initiatives, were thought to be incentives for patients.

'They want to improve their health and this programme promises that.'

PATIENT SELECTION

Practices had largely favoured the selection of patients under the chronic conditions category. Many practices further explained that they serve a high needs population that contain a relatively high number of patients with two or more chronic conditions. Care Plus was seen to be ideally suited to this group in its planning approach, active engagement of the patient and encouragement of regular review. The decision about the patient requiring 'two or more clinical hours of care' was seen to involve a judgement call but mostly it was expected patients with two or more chronic conditions would require more than two hours of clinical care.

'We give the doctors the list and they decide who should be involved. It is a judgment call, most need more than two hours.'

Few practices that had received hospital admissions and emergency department (ED) data from the PHO and/or DHB had made use of lists. Most practices advised that this has not been a main criterion, to date, under which Care Plus patients are first selected.

'It is incredibly time consuming to go through lists [referring to ED and Hospital lists] when it is not the biggest criteria under which you can enrol patients.'

In the entire pilot practices, some selection process, applied to those identified as 'eligible' had been employed. Key considerations in selecting patients who should be approached for Care Plus included one or more of the following:

- Illness severity
- Compliance
- Patient motivation and/or interest and/or needs
- Use of other benefits
- Improved health outcomes that could be achieved through the Care Plus initiative

Some practices had enrolled terminally patients onto the programme. It was explained that there are relatively few terminally ill patients who are able to come into the practice. Practices advised of alternative schemes such as the West Auckland Terminally Ill programme, that they believe are better placed to meet the needs of the terminally ill patients because they provide for home visits. In addition, the three month Care Plus review time was not seen as appropriate for many terminal care patients who require shorter review timeframes relative to disease progress and life expectancy.

'There are other, better schemes for terminal care; those that help us to visit people at home, that are better to use than Care Plus. Only a select few can get into the surgery and most need shorter review times.'

HIGH USE HEALTH CARD TRANSFERS

The transfer of High Use Health Card (HUHC) patients to Care Plus was seen as problematic by most of the pilot practices, both from a patient and a practice finance position. For A3 patients taking medications, a move to Care Plus was seen to involve a rise in the amount charged per prescription item. For patients taking more than three medications, the reduced consultation charges were not seen as a fair exchange for the \$12 rise for each prescribed item. Interim funded practices explained that more financial reimbursement was associated to HUHC patient managements as opposed to Care Plus. Access funded practices found there were difficulties aligning Care Plus as a replacement for HUHC, for patients who exceed the capitation funding quota of visits. It was explained that Access practices are funded for between 1.95 visits (for a 15 to 24 year old male) to 9.82 visits for a four and under child. A HUHC increases the funding and affords between 11.2 and 13.95 visits. The amount received for Care Plus patients was reported to be no more than the HUHC payment and yet it requires more extensive time and reduced co-payments, none of which is required for patients under the HUHC system.

'We feel that patients benefit more financially from HUHC than Care Plus. If you are on the HUHC your pills are way cheaper.'

'If they were a high user, they stayed a high user because we did not want them to lose their HUHC status. That would not be beneficial for this practice's funding.' [Interim funded]

'Under capitation if you have a HUHC holder, it is an increased amount and if the patient exceeds the visits per annum allowed under the capitation then HUHC extra gives you a bit more cover. Care Plus pays no attention to frequency of visits. A significant number of our patients do exceed that annual quota.' [Access funded]

PATIENT INVOLVEMENT

All of the practices acknowledged that a patient's involvement with Care Plus largely reflects their historical attitude to health care. Thus, more motivated, interested and previously self caring patients become actively involved with the programme. Those who have a poorer self care attitude and/or utilisation of health care find it more difficult to become active participants in the approach.

'Patients with a heap going on, multiple health and social issues...do they have the time or the energy for this? The worried well, those who were caring for themselves anyway, yes they do well.'

The level of involvement expected from patients by practitioners was varied. Some practices perceived that Care Plus requires active patient engagement where the patient must take initiative for their own health care. This translated to patients being encouraged to set their own goals, positioning patients' use of the patient care plan booklet as a key part of the process, and patients being expected to make an appointment for reviews without any recall. Other practices appeared to expect a lower level of involvement, which translated to goal setting with the emphasis on practitioners taking the lead, the booklet being positioned as something that the patient could use if they wished, and active recall of patients to attend reviews.

'This is a proactive scheme where you want the patients to take initiative; to be constantly recalling is expensive and seems to contradict the aims of Care Plus.'

In the evaluation participants' opinions, Care Plus had been well received by patients. Few practices had experienced refusals and the limited few that had explained they were usually because the patient was too busy to devote any time to the programme. A few elderly patients had refused because they feared that the free and subsidised visits would adversely affect their disability allowance.

'It has been excellent. We have had a couple of people refuse because they did not have the time to come to the doctor's every three months.'

Some practices were facing problems with patient drop out rates (between five percent and 50 percent, commonly 50 percent) at review stages. This appeared to be associated with one or more of the following:

- The patient bearing the responsibility to make an appointment to complete the review i.e. no active recall or patient follow up for review visits.
- Patient perception of the importance of a nursing consultation where nurses were largely completing the reviews.
- Restriction of reviews to Care Plus clinic times and the practice not being able to offer visits at other times.
- The assessment and/or review not being aligned with the patient's need for a prescription and/or health check.

- Consequence of the patient's introduction to and subsequent commitment towards Care Plus. In some cases the patient had been sold on the programme as a funding mechanism rather than a voluntary care process that could improve their health status.
- Practices and GPs reducing their support for the programme as a consequence of examining the financial reimbursement in relation to the time spent completing the programme.

'We have had a phenomenal drop out rate. About 70 have enrolled but about half have dropped out at various stages... We tried to align the Care Plus visits with the patient's medication requirements but often patients will come in between to see the doctor and grab a prescription then. These patients are likely to drop out and not come back for the Care Plus review.'

BARRIERS TOWARDS THE PROGRAMME

Time for patients and practitioners, patient apathy and staffing were thought to be the main barriers to implementation of the programme. The latter comprised of two issues, firstly, the availability of staff to complete consultations. Secondly, and less common, a perception that the programme encourages increased nursing involvement and autonomy in patient care. Practices identified that there is a wide variation in the independence of nursing staff throughout general practice. It was noted that some practices actively encourage nursing autonomy and try to fully utilise skills. However, others were described as tending towards a more limited and traditional use of nursing staff where there is little or no self-directed practice. Additionally, practices had noticed that some patients have quite a negative attitude towards nursing consultations, preferring to see a GP.

'Some patients do not want to spend 30 minutes with the nurse. They want to see the doctor.'

'People who are working and busy, they often don't have time to take part in Care Plus.'

Practitioners reported that some patients who have historically exhibited poor health care behaviours and/or have limited time to devote to health issues, particularly older males, and/or limited education and/or language barriers, have difficulty engaging with the Care Plus process. It was noted that some very elderly with hearing and/or vision impairments also have difficulty with understanding and participating in the process. Some practices felt that Care Plus does not always engage Māori and/or Pacific people, especially older males. However, two practices taking part in the evaluation had successfully used a family approach to engage Māori and Pacific patients with Care Plus.

'You have to involve the family if they want that, they need to feel supported and that is often having the family with them.'

The provision of free visits and reduced fees had been seen, by some of the pilot practices, to attract some patients on the basis of the funding offer rather than commitment to, or interest in, the approach. Most of the practices, who took part in the pilot, thought that 'Care Plus patients' should be recruited as those people more likely to become actively involved with their health care and/or prepared to make lifestyle changes.

'I think that it is important that it is made clear to the patient that this is not just a monetary thing and that it does involve some work and changes on their part.'

TRAINING AND ROLES

Commonly, nursing staff had attended a training session at the PHO premises. Some practices had been afforded training using a 'show and tell' approach where the staff from another practice outlined how they had established the programme. This form of training was cited as most helpful and practically useful. In cases where the training had been more theoretically based, staff were less satisfied.

'We were given the forms and then I went to a meeting at the PHO. Another practice nurse went through what had happened at his practice. I found that very helpful.'

'The training did not give us a lot of practical help. I found it quite unrealistic, they talked about bringing in Grandparents and that would just not work in this practice.'

The role of the nurse was usually described as assessment, co-ordination, planning, monitoring and management of the Care Plus portfolio. GPs were seen to be covering the medical issues, reviewing the patients from a more clinical position, supporting the nursing staff and prescribing medications. It was noted by some GPs and practice nurses that Care Plus pushes the boundaries of information sharing between the two parties. Care planning and management of chronic disease were positioned as role enhancements and areas requiring more training input for nursing staff.

'The nurses need a good idea of chronic care management, training on interview techniques and finding the patient problem areas...The nurses have a role in patient education, identifying problems that the patient brings up, monitoring, co-ordination and getting other professionals involved.'

PHO SUPPORT

Most practices thought that there should be a nurse co-ordinator, at a PHO and/or national level, to oversee the set up and establishment of Care Plus, monitor progress and provide feedback to practices. Smaller PHOs advised that size of their organisations would not support having a designated Care Plus co-ordinator. The majority of pilot practices thought that Care Plus is not an easy scheme to run in the busy and time restricted environment of

general practice. In the experience of some practices, practitioners had quickly run out of motivation to the detriment of enrolment of patients and completion of reviews. In one practice, all but two of nine GPs had removed their support for Care Plus on financial and workload grounds. It was anticipated that more regular feedback and input from a co-ordinator could help to maintain staff enthusiasm, and address resistance, such as that indicated in the quotation below, towards the programme.

'We started with strong support from two or three doctors and the others were "we will give it a go", now we have support from only two and none from the rest... The GPs have recognised the work involved but they remain unconvinced as to the benefits for the patients. It all comes back to that \$45 consultation. They were seeing these patients four times per year anyway.'

MANAGING THE CAPPED RATE

Most of the practices had not reached the capped rate because they had not been able to afford the time required to implement the programme for all of the eligible patients. Most did not anticipate having any problems staying within the quota. However, practices serving more high need populations, with the inherent high proportion of patients with two or more chronic conditions, warned that to remain within the capped amount, they will not be able to offer the care to all those who are eligible.

'We can fulfil that quota five times over. We have a heap of patients that have two or more chronic conditions, high needs, presenting with very complex issues that would benefit from this approach. Under the current arrangements, we will not be able to offer the care to all of them.'

CARE PLANNING

Care planning was reported to be new to some nurses but aligned to a nursing approach and a good use of their skills. In most of the pilot practices, the nurses were completing care plans with or without inputs from GPs. The time taken to complete the plan and the person completing the assessment and review visits was varied. The initial Care Plus assessment was estimated to take between 30 and 80 minutes completed by only nursing staff or a GP or shared between the two. Subsequent review consultations were often completed by a GP and estimated to take 15 minutes. However, some practices had opted to have nurses completing the reviews, reported to take 20-30 mins, with or without GP input (usually a 15 minute consultation). Practitioners warned that for complex cases, care planning is more time consuming than the estimates given above.

'The first visit is usually 30-40 minutes. I talk to them about Care Plus, introduce the diary, ask them if they want to enrol, complete the assessments and whatever else is needed.'

Staff who had been trained in a care planning approach appeared to be able to stay within the designated time for the visits. Others, new to care planning, often advised that they have difficulty completing Care Plus consultations within the appointment time. Nurses, who were, or had become, experienced in the care planning approach, described reducing consultation time by reading the patient's past medical history and preparing possible goals prior to the patient consultation.

'What would have been better is practical advice such as looking at the patient notes and thinking about the goals that they might want to set. That reduces the time that you take to care plan.'

OUTCOMES

Most practices advised that it is too early to see any real outcomes from the Care Plus approach. In the future, it was anticipated that the programme will result in measurable improvements in patients' health status and use of general practice services. It was expected that some patients would increase their compliance, interest and involvement in health care. A few participants commented that the approach has positively challenged health professionals, particularly nursing staff, and increased direct contact with nurses for patients. Both general practitioners and nurses reported that they had been surprised at some of the issues that appear to be important to patients as opposed to those that the practitioners would expect given the patients condition. This had highlighted to staff that Care Plus encourages insight into issues from the patients, rather than from a medical or nursing position.

'We pick up a lot of things that they do not talk to the doctor about. They talk to the doctor about their condition...they tend to tell us what is worrying them, more general things that tend to come out during the Care Plus interview.'

FACTORS ASSOCIATED WITH SUCCESS

Getting the right staff involved in the Care Plus programme at a practice level was most strongly associated with successful implementation. Support from practice managers and nurses were positioned as imperative to the successful implementation of the programme. It was acknowledged that, in many cases without this support, the programme would not have been maintained in busy practice environments. The attitude and support of the general practitioners was also cited as vital to the success of the programme. If the GP positioned Care Plus as a funding mechanism, rather than an enhancement of a patient's care and/or did not see Care Plus an integral part of the patient's care, the patient would be more likely to drop out of the programme and/or not realise the commitment required on their part.

'Patients who have stayed with Care Plus are from the GPs who continue to support it. Coming in to see a nurse for 30 minutes, without seeing the doctor, it breaks down and the review is only funded for one or the other. It is not sufficient to support both.'

Planning the implementation of the programme at a practice level was associated to successful implementation. The more successful practices, as perceived by the evaluation participants, had established the number of nursing and GP hours required in relation to patient numbers and implemented a plan to stagger the introduction of the programme.

'We wanted to do this well [and] we decided we wanted good nursing input so we trained the nurses. Secondly, we wanted good selection and reviews from the GPs. Thirdly, we didn't want the practice to be stretched so we introduced a staggered approach focusing on asthma and COPD [chronic obstructive pulmonary disease] patients and actively enrolled them.'

Opportunistic recruitment of patients returning to the practice for a prescription, especially those with chronic conditions, appeared to be a successful recruitment process. Active recruitment, employed by some practices in the early stages of the process, had also yielded a good response rate. However, practices had not been able to sustain it, because of the time involved, and had eventually moved to more opportunistic methods.

'From actively recruiting, we are now at the point where we are "ad-hoc" recruiting as the patients attend the GP. It was too labour intensive as soon as the practice workload began to interfere.'

A good recall system was positioned as imperative to the success of the programme. Active recall, where the patient receives a phone reminder and/or letter to attend the review and integration of the Care Plus visits with the other health needs of the patients, had proved successful for many of the practices. It was expected that some more flexibility around the review timing would further enhance this effort.

INTERGRATION ISSUES

Few practices had been able to easily integrate Care Plus into their everyday working. They tended to be the practices who appeared more focused on the GP consultations, with limited nursing input, and/or those that had the flexibility to complete 20-30 minute consultations. Practices advised that the length of time required for Care Plus consultations does not always fit with the time available during everyday general practice. GPs appeared to have integrated Care Plus consultations into the normal working day. In order to facilitate Care Plus, from a nursing perspective, practices had often resorted to limiting Care Plus appointments to particular times or day/s and/or clinics.

'One problem is that not all of the doctors are here at the clinic time so we have to fit patients in at other times. The clinics are there to provide the extra nursing time, extra cover. We cannot have that available all of the time.'

'If they are interested, we make an appointment for their assessment with the nurse. We have extra nursing cover on Mondays, Wednesdays and Fridays so that we can do the interviews.'

Commonly, GPs questioned the amount of nursing time taken up by Care Plus in relation to patient benefits and other requirements of nurses. Discussions highlighted that providing nursing cover at specific time can be viewed as limiting patient access and has proven problematic for some patients.

‘That is the biggest problem. It limits access in some ways, It takes lots of nursing time and we can’t offer the extra cover all of the time, therefore it’s there for a limited time period that does not always suit the patient.’

The available funding for reviews was not viewed as sufficient to integrate both nurse and GP input. There appeared to be a variation in the way that the funding arrangements were being interpreted. Some practices were certain that there was no funding for nurses in the review process and had limited them to 15 minute GP consultations. Others had elected to solely fund nursing staff to complete the reviews, believing that this was the best use of the resource. Many practices had involved both nurses and GPs in reviews but reported that they were funding the extra time, for one or the other of the practitioners, not covered by the Care Plus funding.

‘Initially the review was understood as a GP visit but we are trying to work the nurses into it too, they need to stay with the patient to review goals. What the nurses offer is different from the medical care and lots of the goals are around the nursing input...The nurses’ time spent with the review is funded by the practice at this stage.’

Some practices had experienced difficulties assimilating the use of the patient booklets into the process. It was reported that patients commonly lose the booklet and/or forget to bring it to the consultation. In the experience of most of the practices, the care plans are largely unread by the patients. Many practitioners had tried to encourage patients to write in the booklets but advised that this had been relatively unsuccessful. It was advocated that the programme should focus on the use of brief interventions and simple one page documentation.

‘The whole writing down goals, what difference does that make to telling the patient what they should do? I am not convinced of the benefits. They don’t even bring the booklets back.’

COSTS

Overall, most practices were satisfied with the funding mechanism employed to reimburse them for Care Plus. At the time of interview, one of the PHOs had yet to receive funding. Set up costs for the practices were described as time to plan the programme, complete staff training, and identify patients. Ongoing administration costs were cited as the provision of extra nursing hours and clerical time. Hidden costs for practices were thought to include the time spent interpreting PHO guidelines for each practice situation, planning the implementation, time spent recalling patients and faxing claims information. Some practices warned that there are hidden costs, in terms of the extra nursing and GP time, required for

more complex cases. Training of nursing staff so that they can be more involved in chronic care management was also seen as an area that will contain hidden costs for both practices and PHOs.

THE FUTURE

In the future, practitioners could envisage being able to utilise other primary care nurses, such as those specialised in prescribing exercise, diets, chronic care and mental health interventions in Care Plus. Practices thought that there was a role for pharmacists in evaluating medications and providing education for patients with more complex drug regimens. Some practices advised that they had an existing relationship with a pharmacist and had already involved them in the review of medications of some of the Care Plus patients.

‘There is a role for pharmacists in reviewing the more complicated cases, giving advice, back up to the professionals and the patients.’

Some practitioners questioned Care Plus’ seeming neglect of patients with one severe chronic condition who require an equivalent amount of care to those with two or more conditions. It was advised that many of these patients could be prevented from developing further chronic problems.

‘Asthmatics often don’t fit the Care Plus criteria only on the basis that they [have] one condition. They need the same time, input and would benefit but you can’t fit them into Care Plus, [they have] high needs that just don’t qualify for any access type funding.’

The key issues perceived by practitioners as likely to face Care Plus if it is extended to all practices to replace HUHC, were thought to be: the loss of the prescription subsidy for A3 patients, alignment of the funding arrangements to be the equivalent or more than HUHC to compensate for the extra time that Care Plus is perceived to involve, and the funding review visits if they require nursing and GP time.

‘We had expected to approach those HUHC patients and those with chronic illness. However, we found that the practice does not get funded as much under Care Plus than the practice gets for continued management of HUHC.’

Finding the time for nurses to complete assessments and reviews was thought to be an issue that most practices will face. In the pilot practices’ experience, the time required managing and completing Care Plus, for all eligible patients, was not always available.

‘The main issues with the programme are the staffing and time to complete the plans for all the patients that need them.’

Organisation of staff training was thought to be an issue that will face the national ‘roll out’. It was anticipated that some of the smaller PHOs may lack the resources required to train and support practices implementing Care Plus. It was advocated that communications and training

should incorporate GPs and practice managers so all practice staff have a good understanding of the programme.

'This is a difficult scheme to run and people run out of motivation. Some nurses are made to complete assessments and care plans, others can't get the hang of it.'

The problem of patient drop out throughout the review stages was thought to be an issue that practices will continue to face. In the pilot practices' experience, the lowest rates were associated to alignment of the review visit with the patient's need to visit the practice to obtain a prescription and/or complete a health check. Practitioners advocated that there should be more flexibility surrounding the timing of review appointments so that they can more closely suit the patient's needs and utilisation of services.

Some practitioners warned that the programme could experience a lack of support in practices that have not previously promoted either nurses' independent practice and/or a care planning approach.

Increased use of electronic systems to support the programme was advised as a means of removing the disincentives associated with paperwork.

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.

LIMITATION OF LIABILITY

CBG Health Research Ltd will endeavour to ensure the accuracy of the research reports but no warranty is given as to the accuracy of any information contained in the report. CBG Health Research does not accept liability for expenditure or costs incurred in reliance on the report or loss or damage arising from its use.

The research has been completed in concordance with the accepted proposal and every endeavour has been made to ensure that the research process meets accepted standards for best practice.

USE OF INFORMATION

Research data and material, pertaining to this project, will be the property of the Ministry of Health and will not be released to any third party by CBG without the Ministry of Health's prior written consent.

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.

APPENDIX ONE

February 2004



Care Plus Evaluation

Practice Process Interview

The following guide provides an outline of the areas that will be covered. The questions are indicative of the subject matter and are not verbatim descriptors of the interviewer's questions. Appropriate sections will be selected for each interviewee.

Introduction	Comments
Explanations of the use of the evaluation data	
Appreciation of contribution	<p>Report to Ministry of Health</p>
Confidentiality and procedure of the interview (including the use of audio equipment)	
Confirmation of the duration of the session	<p>Establish parameters and develop rapport</p> <p>1 hour</p>

1. Set up and Establishment of Care Plus

A. Why did this practice decide to be part of the Care Plus project?

- Philosophy of practice
 - HUHC issues
 - Financial
- Existing Care planning process

B. What guidance and help were you given by the PHO to set up Care Plus

- Information and Materials
 - Support/Training
 - Satisfaction

C. What has the set up and establishment of Care Plus involved for this practice?

2. Incentives and patient involvement

A. What do you see as the incentives for practices to implement Care Plus?

- Check any barriers to implementation, more specifically, time, costs and staffing

B. What are the incentives for patients to become involved in Care Plus

- Check any barriers to involvement, more specifically, time, apathy issue

C. How would you describe the patient up-take?

D. Are there any groups of patients who have difficulty engaging with the Care Plus process

- Check elderly, M and PI

E. What do you think will keep practices taking part in Care Plus in the longer term?

3. Training and support

A. Please describe the training that staff has undertaken to be able to implement Care Plus

- Place of training

- Time
- Sufficient to support the process?

B. Tell me about the role of the nurse in the Care Plus process

- Repeat for GP and Pharmacists
- Explore any role enhancements for each professional

C. Is there a role for a nurse co-ordinator? – why /why not?

- At what level, PHO or practice

D. In the future, can you envisage being able to utilise other primary care nurses in providing Care Plus reviews?

- Any barriers towards this

Repeat for Pharmacists

- **Mental health nurses**
 - **Social workers**
- **Community workers**

E. What support is required by the person managing the Care Plus portfolio?

- Input into Care plans
 - Patient review

4. Patient Selection

A. Please describe the processes that you have used to identify Care Plus patients

- Transfer of HUHC
- Chronic condition selection
 - Terminal illness
- Use of hospital admission lists/ED and disease code guidance

- Use of head-held lists

B. This is the criteria for selection (Show Ministry of Health criteria), do you have any comments about this with regard to the selection of patients within this practice

- Check any discrepancies

C. How do you decide who will benefit from Care Plus?

D. Tell me how you decide that the patient requires two or more clinical hours of care?

E. How has the practice managed patient numbers within the capped rate?

- Check PHO guidance/involvement/monitoring of patient selections

5. Care Planning

A. In your experience, how has Care Plus been received by patients?

- Check uptake for various age groups and ethnicities

B. Who completes the Care Plans

- If not evident, what input does the GP (nurse) have?

Repeat for

- Management of the portfolio
 - Recall, reviews etc

C. Can you give me an estimate of the time involved in the care planning process?

Repeat for

Reviews

Patient identification/recall

- Management of the Care Plus patient portfolio

D. Are there any other issues associated with the use of Care Plans

Check

- For practitioners?
 - For patients?

6. Outcomes

A. What do you see as the outcomes from Care Plus for patients?

Repeat for

- Professionals
 - Practice

B. Has the practice been able to integrate Care Plus into its everyday working?

C. What factors, if any, do you associated with the **successful** implementation of Care Plus

Repeat for**Problematic****7. Costs**

A. What process been implemented regarding the reimbursement of the practice by the PHO?

- Satisfaction with the funding mechanism

B. What were the set up costs for the practice?

- Reimbursement

C. What are the ongoing administration costs?

- Reimbursement

D. Are there any hidden costs for practices?

- Identification of patients

- Patient recall
- Management of the Care Plus portfolio
- For all check time involved and try to decipher areas that are above and beyond those that should be covered under practice running costs

8. The Future

A. What do you see as the key issues likely to face Care Plus if it is extended to all practices to replace HUHC?

- Funding
- Organisation
- Practitioner support
- Seek in-depth explanation

Summary of key findings.

Invitation to raise any other issues/comments

Thank and Close

Care Plus Process Report

Acceptance Form

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

Name

Organisation

on the day day of Month 2003