Care Plus: an Overview

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Summary

Care Plus is a new initiative as part of the Primary Health Care Strategy. It provides additional funding for primary health organisations (PHOs) to give better care to people who use high levels of care or have high needs because of chronic conditions or terminal illness. With Care Plus, patients receive expanded, better-coordinated, lower-cost services from a range of health professionals.

Care Plus aims are:

- improved management of chronic conditions
- reduced inequalities
- improved teamwork within PHOs
- lower-cost services for high-need primary health users.

Eligible patients are high-health users or have chronic conditions that need 'intensive clinical management'. These patients will usually be managed in the practice by a team of health professionals.

All PHOs will offer Care Plus services once they have completed a preparatory phase and their detailed business plans have been approved by the DHB.

Who will provide Care Plus services?

In time all PHOs will offer Care Plus services. Before they do so each PHO must complete a minimum three-month preparatory period. This preparatory period gives PHOs and their practices time and funding to start to identify Care Plus patients, train staff, help make sure disease coding is up to date and plan and develop the financial and administrative systems.

What are the direct benefits for patients and providers?

Care Plus patients will receive:

- low or reduced cost access to nurse and/or doctor expertise and time
- continuity of care that includes a Care Plan jointly developed with the patient and ongoing support through pre-planned regular reviews
- advice on improving health outcomes through better self management, with support to identify and meet realistic personal health goals

Care Plus provides additional capitation funding (approx 10 percent) to target about five percent of the enrolled population – those patients with the highest needs in each PHO. The percentage of Care Plus patients will vary across PHOs depending upon the make-up of their enrolled populations. Age, socio-economic status and ethnicity will affect the expected number of Care Plus patients. PHOs decide how to use this funding to provide services through their practices.

How has Care Plus been developed?

The Care Plus project developed from a proposal from the Independent Practice Association Council (IPAC) to replace the Access and Interim PHO population-based funding formulae with a way of targeting individual 'priority patients'. The Ministry of Health has worked with IPAC on this issue since late 2002.

From the start, the Ministry has actively consulted and involved DHBs, PHOs and professional groups through all stages of Care Plus - the initial consultation and piloting, coupled with evaluation of the pilots, development of service specifications and the funding formula for both the preparatory and implementation phases of the programme.
Key events in developing Care Plus were:

- development, in consultation with IPAC, of preliminary proposals for service delivery and funding based on distribution of high needs patients from examining general practice records

- pilots in three PHOs during 2003/04 year

- external evaluation of the pilots (CBG Health Resources (CBG): three reports: September 2003, December 2003 and March 2004)

- setting up the Care Plus reference group in October 2003 with membership from PHOs (both Interim and Access), DHBNZ, RNZCGP, IPAs, First Health, Net Care and Health Care Aotearoa to advise on:

    - service specifications

    - a funding formula and

    - process for national roll-out

- running six Ministry-led regional workshops to help prepare PHOs and DHBs for Care Plus in South Auckland, West Auckland, Rotorua, Wellington, Christchurch and Dunedin during March 2004

- using feedback from individual pilots, workshops and evaluations to fine-tune the Care Plus funding formula and services specifications. In March 2004, the Care Plus reference group had its final meeting, and CBG submitted its final evaluation report on the Care Plus pilots

- joint PHO, DHB, and Ministry of Health agreement to contract changes for Care Plus (April and July 2004)

What was the role of the Care Plus Reference Group?

In October 2003, a Care Plus reference group – mostly providers actively involved in PHOs and DHBs – was set up to see what happened in practice as Care Plus was piloted in PHOs. The reference group looked at CBG's evaluations – the formal, independent agency's assessment on the Care Plus pilots. The reference group looked especially at practical issues such as providers' views on what they saw as being critical to Care Plus success; how to resolve problems; and, importantly, how to vary the programme to meet its key aims.

The reference group paid particular attention to the preparatory phases in pilot PHOs to see how on-site practice experience (as well as the formal evaluations) could help shape Care Plus development. It recommended a funding formula (including services specifications) and proposals for a national roll-out of the programme.

How were the Care Plus Pilots evaluated?

Three PHOs piloted Care Plus – Tihewa Mauriora PHO in Northland, HealthWest PHO in West Auckland, and Canterbury Community PHO in Christchurch. The evaluation of Care Plus looked at actual, day-to-day issues and practice experience as Care Plus started up.

Three evaluations were undertaken by CBG – an independent research agency[1]. The first evaluation describes the 'formative' stages of operation in three Auckland PHOs. The second studied 28 primary management systems. (This involved data on 180,000 registered patients.) The final evaluation took a close look at the specific processes 12 practices used as they set up Care Plus.

The objective of the first evaluation was to understand PHOs perspective in setting up and implementing Care Plus. It tested and assessed the early stages of Care Plus so that lessons learned could be used to fine-tune the programme.

The pilots all viewed Care Plus favourably. They saw Care Plus as fitting in with increased practice nurse specialisation and patient self-management. Care Plus was seen as complementing other services such as hospice care and district nursing. Early concerns raised in this first report were about time constraints and the loss of pharmacy payments.

The second evaluation (December 2003) estimated the number of patients that would be eligible for Care Plus. Data on 180,000 registered patients came from 28 primary care practice management systems, in four PHOs[2]. The research estimated the number of patients with chronic conditions that needed 'intensive clinical management'. A series of Practice Management System (PMS) queries were used

[1] Full evaluation reports will be published on http://www.moh.govt.nz/primaryhealthcare

[2] Health West (10 practices) East Health (5), Procare (10), Canterbury Community (2) and Tihewa Mauriora (1)

to measure any recorded diagnoses, prescription subsets for selected conditions (to gain better data on diagnosis prevalence), and, the number of encounters in the previous six months.

The research had two main findings:

- practices estimated that 56 percent of High Use Health Card (HUHC) patients would be eligible for Care Plus
- overall, up to 8.5 percent of a practice population might meet Care Plus eligibility criteria.

The final evaluation (March 2004) – like the first evaluation – concentrated on understanding the processes involved in setting up and implementing Care Plus from a practice point of view. Twelve practices from three PHOs who were implementing the programme were consulted for this evaluation. Overall, practices and patients continued the positive attitude to the scheme. Key concerns centered on lack of incentives to transfer HUHC patients to Care Plus, hidden 'system' costs, infrastructure and resource constraints – especially for nurses.

What did the pilots find?

Changing from a disease focus to a health focus

'Nurses played a critical role in the introduction of Care Plus,' says Ann Osborne, clinical project nurse for HealthWest PHO, a West Auckland Primary Health Organisation.

Nurses not only helped develop the programme, but practice nurses, as well as GPs, were also instrumental in identifying patients likely to benefit from the new service.

Ann, who co-ordinated the introduction of Care Plus, says practice staff found the programme meant a real change of approach towards their patients.

'It's a change from a disease focus to a health focus,' she says.

'This means moving from what's wrong with the patient to what the person wants to achieve. It also means recognising that the patient stressors are more than medical.'

Ann emphasised the importance of patients determining their own goals and being supported by the nurse to do so, because otherwise the patient was less likely to be able to achieve the goal. For example, if the nurse sets an unrealistic aim for the patient, such as losing 5 kg and the patient feels they can't do it, they may avoid going back to the nurse, lose their Care Plan, or see the doctor instead. She says if the goals are more determined by the nurse than the patient, then the patient does not engage as much.

'This is a new concept for the patient and nurse to learn.'

Before HealthWest rolled out the pilot in March 2003, practice nurses met at lunchtimes to talk about Care Plus concepts such as patient identification, and documentation.

‘We also had to make sure that people like nurse specialists (diabetes, chronic care), dieticians and pharmacists knew what was going on and where they fitted in to the care plan team,’ Ann says.

Nurses involved in Care Plus already had motivational interviewing skills and further education sessions built on these and extended their abilities to help patients set goals.

‘We did a lot of role-playing and trying out ways to approach different patients,’ says Ann.

‘We had to work out good ways of presenting Care Plus so the patients knew they had to actively participate in improving their own health; not just expecting the health professionals to do it all for them.’

Nurses discussed Care Plus with GPs at regular meetings, summarising what was involved – the level of commitment, staff time requirements, and the funding.

The Care Plus nurses were also able to extend their professional skills to include running their own clinics and managing their time for consultations.

Identification of patients involved various options. HealthWest, with a population of about 150,000, calculated it had about 4500 potential participants.

‘We didn’t want to be disease-specific,’ Ann says.

‘We wanted patients – who fitted the criteria – with high needs who would benefit from the increased attention.’

Although they tried searching existing databases, they found the best way was opportunistic – ensuring doctors and nurses were aware of the criteria and getting them to raise the possibility of joining Care Plus when a suitable patient arrived for a regular appointment.

In the end, identification of patients tended to come mostly from nurses or at a GP appointment. They knew who would benefit from the extra care and attention, and would ask the patient if they would like to be involved, Ann says.

This usually meant setting up a first session with the GP, nurse and patient. This needed to be arranged at appropriate times for the practice and the patient.

While most of those who enrolled in Care Plus tended to be older people with diabetes or chronic cardiovascular problems, there were also younger people in their 30s (mostly women), and children with extensive eczema and recurrent respiratory infections.

HealthWest also found that the existing relationship between patient and practice staff was important to the programme. Getting a locum nurse to do all the Care Plus interviews wouldn't work, because the regular practice nurse had to build up a good relationship and also needed to know what was going on.

Being involved in the Care Plus pilot has given Ann a good opportunity to think about what works and what could be improved.

She says she would put more emphasis on educating nurses in patient-centred advice and care. Setting up Care Plus support groups may be helpful for the patients, to encourage their efforts to improve their health.

Ann would also recommend other practices consider starting Care Plus in November when there is more opportunity to make contact with each patient and time to work with them over the holiday season.

Low-cost reviews an incentive for patients

Northland's Tihewa Mauriora PHO volunteered to pilot Care Plus because, as practice manager Catherine Turner put it, 'we loved the philosophy'.

As a small, single-practice PHO in Kaikohe with a roll of about 9000, it was also relatively easy to identify which patients would benefit from being part of the programme and who would respond best to being approached.

Catherine Turner says there were some patients who were sceptical about how much they'd benefit and who felt uncomfortable about talking with the doctor and nurse for up to an hour.

'They thought they might be lectured about their weight, or their diet, or their lifestyles. We had to work hard on building up the relationship. But when they saw the folder, and the care plan, they became very positive. The folder's working well – they bring them every time they visit and they also show them around to their family.'

For patients, the main incentive to join Care Plus was the prospect of a free annual health check-up, and regular low-cost reviews. Because people who fitted the criteria were already coming in regularly, they appreciated having one free doctor's consultation and three subsidised visits a year.

Most recruitment was opportunistic. Tihewa Mauriora did mail drops targeting specific conditions, but staff found it was more effective to chat with patients when they called into the surgery.

Six months after start-up, 163 patients were enrolled in Care-Plus – one child under 5, nine people aged 25-44, 70 in the 45-64 age range, 60 aged 65-74, and 23 aged 75-plus.

'We did find that if we enrolled one member, we might well get more from the same whānau, particularly spouses.'

Practice nurse Cathryn Henty was one of two nurses assigned to Care Plus working with the 6.5 GPs attached to the practice.

Despite the staff enthusiasm for the concept, she says it was sometimes a challenge to motivate patients. However, she said the positive patient response to the Care Plus trial was encouraging.

'In providing Care Plus, one of the barriers we have had to tackle up here has been a lack of realisation that individuals can make small changes in their way of life that can positively impact upon their health. Examples of this are stopping smoking, losing weight or starting to exercise.

'Many patients have a poor understanding of their health conditions.

'As a nurse, you want to get in there and change their world view – but you can't. Rather, you have to ask – if you could change something to improve your health, what would that be?'

This means that patients identify things they would like to improve, therefore owning the 'goals', and this means they're more likely to follow through with the suggested actions.

She says Care Plus has identified how patients are reluctant to take medications if they do not know why they have actually been prescribed them. Explaining what the different medications are for and how they basically work helps patients understand why they need to take them.

'When you've taken the time to sit down and talk through what the medication does and explain why the instructions are important, the patient will often say, 'oh now I know what it's for and what it's doing, I'll take it,' she says.

'Sometimes we also have to overcome patients' suspicions that we are somehow checking up on them. To counteract this we make the goals achievable so that the person does not feel a sense of embarrassment at not achieving the goals that they have set for themselves. As nurses we know that we're not going to achieve great things all the time, but little improvements in someone's risk factors are still beneficial.'

'Patients find it really important to know that they can be active in their own care, that they're doing something about their condition and that their efforts are supported and appreciated by the health care people in their lives.'

Finding out the real issues and setting priorities

Care Plus fits around patients like a glove, says Linda Ngata, manager of the Canterbury Community PHO.

'Most of our patients do have complex needs. Care Plus involves finding out the real issues for people with those needs, setting priorities and finding the right workers for the right task.

'So while we might be dealing with diabetes and concerned about a sore foot, we're also looking at lifestyle and the whole range of relationships for that person.'

There are three general practices in the small Christchurch-based Canterbury Community PHO, which also has 13 affiliated community health providers.

Care Plus patient identification is done through clinical team meetings attended by the practice manager, a nurse, doctor, community health worker and whanau worker.

Identifying suitable participants has not been difficult. At least 200 of the PHO's 6000 patients meet the criteria, and 130 are so far recruited. The youngest is 20 but most are in their 60s or older.

Diabetes figures largely in the medical conditions, as does asthma. They have also enrolled a number of mental health consumers.

'We seem to have a rapport with this group,' says Linda. 'Yes, they are extremely time-consuming but they respond well to the extra care they receive.'

Union and Community Health Centre, practice nurse Kathryn Phipps agrees that Care Plus works well for people with mental health needs.

'The care plans are very effective, especially for those with opioid drug dependency. They've got the time, they know they've got good support, and they are motivated to work with us.'

The care plans developed under Care Plus draw in workers from the community providers as well as the practices.

'The care plans starts with an individual patient and identify who is best to work with that person. It may be a nurse at the practice they attend, and it may be a whānau worker who visits them at home,' says Linda. 'Families also take part in the process.'

The original care plans have been modified and condensed to make them more patient-oriented. Kathryn says the patient decides on the key symptom they would like to address – say chest pain, or breathlessness – rates their present state on a scale of 1 to 10 and then sets where they would like to get to over the coming weeks.

Goal-setting focuses on the first three-month period to begin with, and the emphasis is on realism – for example, an achievable 3 kg weight loss over three months.

'We ask the patient to write down what they can do to reach their goals, and then what their care team can do.'

A weekly walking group set up to help put care plans into action has been very popular with some patients, who enjoy the company as well as the exercise. For instance, Kathryn says, it's made a huge difference to one mental health patient, who is now motivated to turn around his lifestyle.

Only a few of the written care plans go home with the patient – they tend to get lost, or ignored because they seem too complicated. Kathryn has found it's better to give out a pamphlet focusing on ways to reach a particular goal, such as a daily diabetes testing regime or low-fat cooking or medication management.

Each patient's care plan is entered on the PHO database, so any worker can view it, check goals and comment on progress.

What would be their advice to those starting Care Plus?

Don't try to recruit patients for a first session when they've come in for a different reason, Kathryn says.

'Their focus is on what's wrong with them, not on health promotion.'

‘And set aside a dedicated space allowing enough time for those first consultations. Patients need to feel they can ask questions, and you need to know you won’t be interrupted.’

What is the Care Plus template?

Six workshops brainstormed a business planning template. The original template – a series of questions and answers – was developed by the reference group as a non-prescriptive checklist to help PHOs and DHBs complete business plans for Care Plus.

The template has typical, practical questions and answers in five key areas to help PHOs and DHBs. The workshops raised many ideas and questions about aligning Care Plus services with current service initiatives, identifying eligible patients, funding and finance, the support practices needed, and, how to best prepare for Care Plus.

For PHOs, the template helps them prepare for the establishment phase – a three-month preparatory phase that’s part of the Care Plus service set-up.

For DHBs, the template makes sure PHO Care Plus plans match their business needs as well as the overall aims of Care Plus.

Workshop feedback on the proposed business template included:

Aligning Care Plus services with existing services and priorities

- While ‘Plus’ implies more – it’s really about using Care Plus funding to enhance existing services to patients who need it most. Services like Diabetes Get-Checked, community palliative care services, Outreach chronic care, Community mental health services and asthma programmes.

Identifying patients

- Many practices will know who is eligible already - this can be done through Practice Management Systems (PMS) – but the data systems need to be right. Data on after hours and Emergency Department admissions needs to be added to practice information systems.
- Disease coding - Make sure practices use the correct disease coding. Do disease coding during a consultation - not the end of a session. Have incentives to encourage quality and comprehensive coding that identifies pharmaceutical use and hospital data (on two or more admissions) as well as primary health care presentations. HealthWest used incentives such as competitions and chocolate cake prizes.
- Opportunistic enrolment works well – but build links with Māori and Pacific providers, other health care workers and databases in the community. Use

these contacts to find high users of secondary and home-care patients that GPs don't always know about.

- Promote Care Plus to patients – use posters in surgeries to encourage patients to initiate contacts for Care Plus. Use incentives for practices to identify and encourage patients like free initial visits.
- DHBs should supply hospital admission data in a standard format.
- Privacy issues – clinical identifiable information needs patient consent for wider distribution.
- Introduce Care Plus into keen and willing practices - not those who don't want or aren't ready. Don't impose Care Plus.

Funding and Finances

- Work out finances practice by practice – but draw on other practices' experience. Small and larger PHOs could work together to save costs. HealthWest set up a steering group with a GP, clinical project manager and nurse, liaison pharmacist, public health physician to develop the model of care and tools, IT, communications and resources as well as financial and administrative processes.
- Review finances at least six monthly. Establish a risk reserve.
- Look at the impacts and differences between Access and Interim PHOs, HUHC to Care Plus transition and fee for service (FFS) reimbursement of practices. Health West paid practices more to make up the gap between Care Plus Community Services Card (CSC) subsidy and non-CSC fees.
- Look at alternatives: FFS or PHO bulk fund, or mix of FFS and targets. Look at free initial visits and options of FFS for different consults, or a standard fee that is paid out by the PHO every month to PHOs.
- Keep administration simple – a 'tick box' approach to move people from HUHC to Care Plus – leave it to the practices to develop the best system.
- Have regular system reviews. A clear description of funding streams from the PHO to practices would be helpful.
- Give practices quotas (for the prospective eligible group) and have a PHO central committee determine priorities among different groups.
- All staff – clinical and administrative – should be trained. Perhaps set up a steering group with a financial advisor to separate out administration and training requirements, and see where PHOs can make savings.
- Employ a Care Plus nurse / case manager.
- Make sure there are enough resources to cover nurse involvement in both initial and follow up assessments.
- Rationalise staff deployment. Avoid overlap and duplication. Don't have nurses taking bloods when Med labs already do. Avoid having nurses doing reception work.
- Don't add another layer of bureaucracy and management.
- Some PHOs (eg, Māori based PHOs) don't have a GP – they can get Care Plus funding too.
- Different arrangements may be needed for terminally ill patients.

Support for practices

- DHBs should be flexible when PHOs are in the start-up phase and give non-prescriptive support.
- IT system upgrades require support to ensure data is correct.
- Consider wider PHO networks – use email.
- All PHO staff need training: from reception through to GPs.
- Fund practice time – develop national templates to share training material.
- Sell Care Plus carefully – don't impose it.
- Have a directory of training services at the area level and share information within and between PHOs – be careful to respect patient confidentiality.
- Use and learn from Care Plus pilots – look at their Care Plus templates.
- Use existing sources (MedTec and LinkTech) and build on existing in-house training programmes – especially in rural areas.
- Have realistic, achievable aims when setting goals for patients; provide choices and give positive feedback: don't disempower them.
- Goal setting should involve GPs and nurses, not just patients who would benefit.
- Set up a clinical sub-committee in the PHO to help identify those that are eligible for Care Plus funding.
- Multi-disciplinary and outreach teams work well but remember that complexity increases with co-morbidity.
- Recognise nursing workforce shortages – Care Plus is a team approach but many contacts will be nurse-initiated.
- Keep up ongoing support – not just at the set-up stage. Don't forget new staff.
- Emphasise the importance of teamwork to maximise multidisciplinary skills and expertise.
- Consider opportunities for part-time work across practices.
- Build a directory of training services at an area level (rather than PHO level) and share utilisation.
- Developing patient and staff information material will take time – even if training infrastructures exist.
- Support material for disease management – remember children need different information from older patients who have chronic conditions. English-only material may not suit recent migrants.
- PHOs should set up a template for a PMS Care Plan for all practices to use.

Preparing for implementation

- Pilot one practice first.
- If practice infrastructure is not in place, then don't start Care Plus.
- Foster ways to get buy-in from patients and the community - their understanding and support is vital. Community education forums may help generate interest. Start them early on.
- Remember whole-team planning is critical to Care Plus planning.
- Conduct a risk analysis to identify pitfalls.
- Identify where HUHC use is high.
- Winter may not be the best time for practices to implement Care Plus.

- Get payment systems and IT up and running in the three-month period prior to implementation.
- Different PHOs operate at different levels – allow time for all, don't impose.
- Acknowledge expertise from both within the practice and outside - be prepared to headhunt people that have the skills to help implement Care plus such as pharmacists, mental health workers and counsellors.
- Look at employing a Care Plus project manager.
- Make sure nurses have enough space for assessments – consider going offsite perhaps hire a nearby room.

What's happening with Care Plus now?

- Twenty-five PHOs entered the three-month preparatory phase for Care Plus on 1 April 2004.
- By 1 July 2004, 43 out of 73 PHOs were being funded at some stage of Care Plus development.
- DHBs will advise the Ministry towards the end of each quarter of which PHOs are ready to be funded for Care Plus preparatory or implementation phases.
- DHBs need to contact HealthPAC in Dunedin to request that they activate a contract variation for the DHB and PHO to sign regarding Care Plus services, for both the preparatory and implementation payments to PHOs.
- Separate Crown Funding Agreements (CFAs) between the Ministry and DHBs have been created for Care Plus preparation and implementation phases. The CFA for Care Plus implementation references the standard DHB/PHO service contract that now includes services specifications for Care Plus.

What is the funding formula?

Care Plus funding is based on the expected number of Care Plus patients in a PHO. Overall, funding allows for five percent of the population to be Care Plus or High Use Health Card (HUHC) patients (currently around 1.7 percent of the population have a HUHC).

The expected number of Care Plus patients in a PHO varies according to the age, gender, ethnicity and socio-economic status of the enrolled population. An allocation table[3] showing expected Care Plus percentages in each of these sub-groups has been developed based on the patterns of chronic disease, hospital admissions and primary health care use shown in general practice records. The Care Plus reference group agreed that the table was a fair allocation given the available evidence but the group recommended that the allocation should be reviewed after one year when better data were available. The contract gives a commitment to such a review.

[3] A detailed step-by-step guide to the funding formula is on the Ministry of Health website under **www.moh.govt.nz/primaryhealthcare**

PHOs are funded according to the expected number of Care Plus patients (calculated from the allocation table) less the actual number of HUHC patients. The monthly payment is one twelfth of $199.51 (plus GST) per expected patient in an Access practice, and $211.75 (plus GST) in an Interim practice.

Care Plus funding increases on a quarterly basis as more Care Plus patients are enrolled but with higher initial funding because of the higher costs of initial visits.

Initially, all PHOs receive 50 percent of their full funding even though no Care Plus patients are enrolled. When a PHO has enrolled 50 percent of the expected total Care Plus patients, then they receive 65 percent of full funding – and similarly when Care Plus reaches 65 percent of expected of patients, funding increases to 80 percent. Once 80 percent are enrolled (provided that at least 70 percent of expected numbers in deprivation quintile five and in Māori and Pacific groups in high need sub-groups are enrolled) then, the PHO will receive full Care Plus funding.

Care Plus will eventually replace HUHC. Practices are encouraged to transfer HUHC patients to Care Plus on the expiry of their HUHC card – if this benefits the patient. The practice decides based on clinical assessment of the individual patient. However, if a HUHC patient is designated as Care Plus the PHO needs to take care that it does not pay the practice twice for providing services – once through HUHC funding in the capitation payment and once through Care Plus payments.

What are the target group and eligibility criteria?

The following is an extract from the Care Plus service schedule, a part of the DHB/PHO Services Contract:

Assessing Eligibility for Care Plus Services

You will only offer Care Plus Services to an Enrolled Person who:

1. Is assessed by a Practitioner who usually delivers their First Level Services as being expected to benefit from 'intensive clinical management in primary health care' (at least two hours of care from one or more members of the primary health care team) over the following six months; and either

2. Has two or more chronic health conditions so long as each condition is one that:
    - is a significant disability or has a significant burden of morbidity; and
    - creates a significant cost to the health system; and
    - has agreed and objective diagnostic criteria; and
    - continuity of care and a primary health care team approach has an important role in the management of that condition; or

3. Has a terminal illness (defined as someone who has advanced, progressive disease whose death is likely within twelve months); or

4. Has had two acute medical or mental health related admissions in the past twelve months (excluding surgical admissions); or

5. Has had a total of six First Level Service and/or casual general practice consultations and/or emergency department visits within the last twelve months; or

6. Is on active review for elective health services.

Service Specifications

Agreements between DHBs and PHOs in Service Specifications cover the fine print of Care Plus services: patient definition, payment arrangements, service objectives and components, rights and obligations for care for PHOs and patients, support and administrative services from DHBs, adding new services, quality standards and reporting requirements.

Where can I get more information?

All Care Plus information is available on the Ministry website. Click on www.moh.govt.nz/primaryhealthcare or contact Bridget Caird at bridget_caird@moh.govt.nz or phone (04) 496 2199.