Very Low Cost Access Practice Case Studies: Summary Report for the PHO Services Agreement Amendment Protocol Group

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Executive Summary

The case study team visited five Very Low Cost Access (VLCA) practices selected to represent a broad range of ownership, practice size, rural and urban, and clinical and social complexity.

The case study team were impressed with the commitment and the staff work ethic of the practices and their willingness to be part of the study.

All five practices had a good understanding of their sources of income and the associated claiming processes. However, all practices had some level of income not correctly claimed and outstanding as unpaid revenue. Except for patient debt, this would be relatively easy to resolve by reviewing if the lost income is actual, or is as a result of a lack of reconciliation with the practice management software.

ACC claiming was generally reasonable, but practices should ensure there is follow up of all rejected and unpaid amounts to avoid any lost income.

All sites had separate practice management and accounting software and the two systems need to be reconciled.

All practices managed their costs tightly and we did not see evidence of any areas where further savings could be made.

The General Medical Subsidy (GMS) was a small source of income, which reflected that the practices lacked the capacity to see casual patients. The level of claw backs was also not significant.

None of the practices charged the maximum VLCA maximum co-payment allowable across all age groups, although all practices charged adults either the maximum or close to the maximum allowable co-payment. All practices noted that there was further discretionary discounting of their advertised fee.

For all five practices there is a difficult trade-off between patient charging and ensuring access to services. All the practices prioritised access over patient charging. Practices noted a trade-off between increased practice fees on the one hand, and reduced access and increased unpaid patient accounts on the other.

Each of the five practices depended on PHO and DHB contracts for both the additional revenue and most importantly the additional support they provided for patients with complex needs. Many contracts also assisted practices with hard to reach patients.

It was noticeable that additional contracts added the most value when a certain amount of synergy and integration was achieved. For example, when the additional contracts enabled a comprehensive suite of wrap around social and health services to be offered, this had the added benefit of reducing the demand on practice clinical staff. However, the revenue from additional contracts needed to be weighed up against the administration and reporting requirements of these contracts.

The case study team noted that there were some issues around the ease of reporting on some contracts and their clinical compliance costs. We recommend that PHOs and DHBs engage in dialogue with practices about improving reporting methods. This dialogue should aim to improve

the understanding of the support that practices need to assist with managing high and complex needs patients.

All five practices relied heavily on experienced senior doctors and nurses to manage the high patient demand and clinical complexity. None of the practices had any spare staffing capacity.

Two of the practices had developed health care assistants positions to undertake some routine work, and thereby, relieve the pressure on nurses and doctors.

There was a stable work force across the practices with a high percentage of staff employed greater than five years.

All practices reviewed are vulnerable to loss of senior clinical staff. The practices indicated that it was difficult to train nurses to a senior level and meet patient demand. Some practices had received assistance from their PHO to train nurses.

Staff demonstrated commitment to the practices by working over and above their paid hours and were committed to providing the best services possible for the patients.

Four of the five practices reviewed had sustainability issues and were showing a deficit for the most recent or current financial year.

The fifth practice had turned a deficit into a small profit although the margins were tight.

The clinical complexity of their patients coupled with a lack of ability of many patients to pay for services impacted on practice viability.

The practices are caught up in a cycle of high demand for services and on clinician's time and expertise, and lack of time available for strategic planning and reviewing different care models.

The case study team considers that DHBs and PHOs could potentially have a role to assist in both business planning, clinical model of care reviews, and staff training going forward.

Recommendations

The case study team recommends that practices:

- work with their accountant on an annual review of all practice income to identify outstanding income (debt) and debt that is not likely to be retrievable.
- Review their methods of administration of debt for income claims to ensure all money owed is collected.
- engage with the local ACC practice liaison person to ensure all staff fully understand ACC claiming so all services provided are charged back to ACC.
- Review patient debt, work with their accountant to write off non-retrievable debt and to seek to make some flexible payment options for those with debt over 60 days.
- explore working with their the local WINZ office in order to assess what support WINZ could offer patients.
- continue to improve their process of reconciliation for all the accounts in the practice management system to enable an accurate picture of the size and management of debt be established.
- actively engage with their PHO and DHB to identify all opportunities for additional contracts for services that could be benefit the practice in terms of generating income and/or targeting services to better meet patients wider health and social needs.

The case study team recommends that DHBs and PHOs:

- meet with their VLCA practices with very high proportions of high need patients with little ability to pay to discuss:
    - ways that the DHB and/or PHO can assist the practice to improve their claiming and reconciliation processes, for example by providing some administration support and/or expertise.
    - the additional contracts that may be available and identify those contracts that would add the most value for patients and the practice.
    - the administration and reporting requirements of any additional contracts in order to achieve the right balance between accountability and compliance costs.
    - whether the practice may require some additional support in order to be able to take up a contract
    - whether assistance with training of nurses and/or health assistant type roles could be provided.
- review how contract reporting requirements could be adjusted to reduce compliance costs, but maintain accountability for the service.
- ensure timely review of contracts that are approaching their expiry date.
- Improve methods of reporting on contracts in order to provide data that enables an assessment of the value both financially and clinically of the contract to the practice.

1 Introduction

This report summarises the findings of in depth case studies of five VLCA practices.

2 Background

VLCA Policy

VLCA was introduced in 2006 as a means of reducing cost barriers, particularly for high needs populations. It is a voluntary scheme that practices can opt out of at any time if they find it is unsustainable for them. At the time it was introduced the entry criteria was solely that the practice had to agree to maintain their fees at or below the set thresholds, although it was considered that Access practices with 50 percent or more high needs enrolees would be the most likely to enter the scheme.

In 2009 there was a need to review the scheme due to uptake being greater than expected resulting in funding pressures. In October 2009, the entry criteria was tightened to restrict entry to the scheme to practices with 50 percent or more high needs enrolees. Practices that entered the scheme prior to October 2009 and who did not meet the 50 percent or more high needs criteria were allowed to continue in the scheme.

VLCA Practice Statistics

As at July 2013 there were a total of 296 general practices receiving VLCA funding, with a combined enrolled population of 1,295,553 of whom 727,684 or 56 percent are high needs (Maori, Pacific or Quintile 5). Of the 296 VLCA practices the proportion of the enrolled populations that are high needs varies as follows:

- 0% to 30%: 46 general practices and 214,406 enrolled patients (of which 46,721 are high needs),
- 30% to 50%: 70 general practices and 367,857 enrolled patients (of which 145,376 are high needs),
- 50% to 70%: 70 general practices and 292,311 enrolled patients (of which 178,301 are high needs), and
- 70% or above: 110 general practices and 420,979 enrolled patients (of which 357,286 are high needs).

The 110 VLCA general practices with greater than 70 percent high needs populations currently receive a total of $10.9 million (GST exclusive) or 25 percent of the total VLCA funding.

VLCA Expenditure Overtime

PHO Capitation Expenditure	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14
Very Low Cost Access	$26.8m	$33.8m	$39.1m	$41.2m	$42.1m	$42.8m	$44.8m
Annual rate adjustment		9.24 to 9.74%	14.53 to 15.32%	8.27 to 8.65%	0%	0%	4.10 to 4.29%

PHO Service Agreement Amendment Protocol Group Process

At the 2 August 2012 meeting of the PHO Service Agreement Amendment Protocol Group (PSAAP) some PHO representatives raised concerns in a Very Low Cost Access (VLCA) paper about the sustainability of some VLCA practices. In response to this, a PSAAP working group was established to gain a clearer, evidence-based and more in-depth, understanding of the nature of the sustainability issues facing some VLCA practices. The VLCA working group members are:

- Sue Dashfield, Ministry of Health PSAAP representative
- Justine Thorpe, Health Care Aotearoa, representative
- Rea Wikaira, National Hauora Coalition representative
- Philip Grant, PSAAP PHO Alliance/GPNZ representative
- Andrew Coe, DHB representative

To assist in gaining a more in-depth and evidence-based understanding of some VLCA practice sustainability issues, it was decided to undertake case studies of five VLCA practices. Five practices were selected based on these assumptions:

1. VLCA practices with high need populations of 70% or more will be most affected. Focus on this group in the main.
2. The smaller the size of the enrolled population the less ability there is to manage risk. Select a large (e.g.>10,000), medium (e.g.<10,000) and a small (e.g <3,000) VLCA practice.
3. Practices with high numbers of special needs populations (e.g. refugees, mental health and addiction) that are not recognised as high need according to the standard definition but have complex needs nevertheless. Select a VLCA practice in the 50% to 70% high need range that has high numbers of special needs populations.
4. Practices with high numbers of patients with multiple long-term conditions will be more affected than practices an average number of patients with multiple long-term conditions. Select a practice(s) with high percent of Care Plus patients.
5. There may be different sustainability issues relating to geographic factors such as urban, rural VLCA practices, high deprivation, North/South Island. Select a rural (very rural, medium rural) and an urban (medium, high) VLCA and aim for a reasonable geographic spread.
6. There may be different sustainability issues for Maori VLCA providers and non-Maori VLCA providers. Include a Maori VLCA provider.
7. VLCA practices that are not-for-profit (NFP) will face the most pressing sustainability issues compared a for profit (FP) VLCA practice. Include a for profit VLCA practice.
8. As far as possible the practices should represent a wide geographic spread.

A former Practice Manager with over 20 years' experience and a General Practitioner (GP) with over 20 years' experience as sole GP serving a very high needs population were commissioned to undertake the case studies. The case studies gathered practice information covering the following domains: ownership and business model; staffing, training and recruitment; financial; operational processes; and clinical processes.

The case study process involved practices filling out a pre-practice visit template and a practice visit template was completed on the day long practice visit. The templates are attached as appendices 1 and 2. The practice team members were interviewed during the practice visit. The case study team also interviewed key members of the relevant PHOs and DHBs.

Each practice that agreed to participate was advised that their names would be kept confidential and that they would receive a practice report that would be confidential to them.

Participating practices were advised that a summary report would be prepared for PSAAP. It was agreed that the summary report would not contain any information from which a particular practice could be identified, and that practices, the relevant PHOs and DHBs would have an opportunity to review the draft summary report. The practices, PHOs and DHBs that were involved in the case studies have had an opportunity to review this summary report.

3. Practice income summary

The table below summarises the case study team's key observations relating to the sources of practice income.

Table 1: Sources of practice income

Income Source	Comments
Capitation and VLCA funding	This was the largest source of practice generated revenue for all the practices.
ACC	ACC claiming appeared to be reasonably well understood by all the practices. Four of the five practices appeared to be claiming the appropriate portion of ACC revenue. One site's claiming appeared to be lower than it should be. We have recommended they review this to ensure the practice is capturing all potential ACC income. However, all practices showed some level of outstanding ACC income due to errors in claiming not being corrected and re-sent, and errors in the sending of claims so the claim was not received by ACC. It is important all staff understand the full set of ACC claiming codes to minimise this. We have recommended that practices investigate the source of ACC claiming errors, and work to ensure that ACC receives all claims. Three of the five practices have already started this review process. The two remaining practices need to address this as this is lost income.

	We note that this requires administration time to address.
GMS	GMS was only a small amount of total income as all five practices were unable to see many casuals due to high demand from enrolled patients.
Maternity	Maternity claiming income was a small amount of total income in all five practices as none had Lead Maternity Carers in the team.
Immunisation	All the practices were within the expected range for this income source. However, there was some loss of income that needs to be followed up to ensure all claims are made, processed correctly and received.
Patient co-payments	Practices faced difficult trade-offs if they tried to maximise revenue from this source.
Income from work done for medicals or other services such as rest home visits.	This was not a major source of revenue. There was evidence of outstanding amounts in all five practices. This is potentially retrievable income that should be followed up.
Additional contract income	Compared to capitation this was a not a major source of practice generated income for any of the practices. It was the major source of income for a Trust that owned one of the practices, and the Trust's contracts were designed to provide a comprehensive suite of wrap around services for the practice's high needs patients.

The review team noted that all the practices had some level of income not correctly claimed and outstanding as unpaid revenue. Except for patient debt, this would be relatively easy to resolve by reviewing if the lost income is actual, or as a result of a lack of reconciliation with the practice management software.

It is also important that practices review the time restrictions that agencies put on claiming and ensure that claims are not rejected due to claiming outside of the allowable time period. Claiming of income needs to be reviewed to ensure all claims have been received and any rejections due to absent data are corrected.

All sites had separate accounting systems in which income and expenditure is recorded. This is a standalone system from the practice management software. Practice administration staff have to manually reconcile these systems. This requires careful attention to detail around the reconciliation in both systems, especially income that is paid directly into bank accounts. The case study team consider that best practice would ensure a careful matching of the two systems to ensure the practice management software matches the amounts recorded in the financial software. Not all sites had been able to do this. For some sites this was due to a lack of administration resource and expertise available to review and follow up rejected claims, re-submit corrected claims and reconcile with the practice management system when the revenue is received.

The case study team recommends that all practices work with their accountant on an annual review of all practice income to identify outstanding income (debt) and debt that is not likely to be retrievable.

The case study team recommend that PHOs discuss with their VLCA practices with very high proportions of high need patients and little ability to pay on ways that the PHO can assist the practice to improve their claiming and reconciliation processes, for example by providing some administration support and/or expertise.

4 Patient co-payments

As shown in the table 2 none of the five practices charged the maximum allowable VLCA patient co-payment across all age groups. However, most charged adult patients the maximum, or close to the maximum allowable fee. In addition, all the practices indicated that they did not always actually charge the advertised fee to all their patients. It was not possible to quantify this discounting as it was not recorded in the practice management system. It is possible to put a code in the PMS for discounting which would enable practices to measure how often discounting occurred.

Table 2: Patient co-payments

Site	Under 6	6-17	18-24	25-44	45-64	Over 65
Practice 1	$0	6-12 yrs$7 13-17 yr$11	$17	$17	$17	$10
Practice2	$0	$0	$17	$17	$17	$17
Practice3	$0	$10	$15	$15	$15	$15
Practice4	$0	$0	$15	$15	$15	$5
Practice5	$0	$6	$16	$16	$16	$16
Maximum allowable	$0	$11.50	$17	$17	$17	$17

Four of the practices noted that there was a direct correlation between patient access to services and patient co-payments as higher co-payments led to fewer patients accessing services. These practices also noted that past increases in co-payments had resulted in a corresponding increase in patient debt.

All five practices referred to the trade-off between patient co-payments and access to services. The practices viewed providing access to services for their patients as central to their practice philosophy. The patient group of each practice represented both high clinical need and low income with little ability to pay higher co-payments. As a result, the practices are under pressure to balance the two factors in order to maximise co-payment revenue while retaining ready access to medical services.

The case study team recommends that practices review patient debt, and work with their accountant to write off non-retrievable debt and to seek to make some flexible payment options available for patients with debts that are over 60 days old.

All five practices prioritised maintaining patient access to services over charging higher fees. However, the case study team notes that charging lower patient co-payments than is allowable affects practice revenue from this source. We have sought to estimate this revenue loss using patient utilisation data. These estimates are shown in table 3 below.

Table 3: Estimate of patient co-payment revenue loss	
Practice	Estimated revenue loss using PHO utilisation and assuming all charged the maximum and all patients paid
Practice 1	$24,533
Practice 2	$18,478
Practice 3	$9,337
Practice 4	$59,772
Practice 5	$30,196

The case study team noted that one of the practices had responded to this challenge by implementing a communications campaign to inform all their patients about the costs associated with providing their services and the benefits of the services for patients. They combined this campaign with a drive to request that patients pay on the day or make a flexible payment arrangement if unable to do so. All reception staff were trained in these processes so patients received consistent messages. This strategy enabled the practice to reduce its patient debt levels by around two thirds. There was an added benefit of less administration time spent on following up patient debts.

5 Practice profit and loss summary

The case study team noted from the audited accounts concerns about the deficits and small profit margins of the sites reviewed.

Site	Profit and Loss March 2012	Comment
Practice1	**$35,880**	Had a loss in the previous year (March 2011). Into profit due to outside contracts and excellent business management and planning.
Practice2	**$20,508**	This profit for March 2012 is due the practice receiving a one off special payment from the PHO. At the time of the visit the practice was tracking towards a deficit for this financial year.
Practice3	**$0 no profit**	All profit was paid to cover the doctor's salary. Note the salary range for the doctor was relatively low for such an experienced doctor. This practice would be unlikely to attract a buyer if the doctor retired and tried to sell the practice.
Practice4	**-$123,847 deficit**	Deficit last year was covered by savings. This will not be sustainable on-going. Deficit showing against budget this year.
Practice5	**-$3,689 deficit**	Expenses higher last year with some building and other additional one off expenses. On target to show a slight profit this financial year.

6 Practice expenditure summary

All five practices had closely reviewed practice expenses including staffing. The case study team did not identify any areas where further improvements could be made without impacting on patient services.

All sites mentioned the potential issue of managing the cost increases associated with the wage rounds that are coming up given they were either in deficit or had very tight margins.

From a small to medium business perspective all sites were managing their expenses tightly and their expenses were not outside the normal range expected for the business model and size of each site.

We observed at two sites that there was a potential down side to this close control of expenses. Paid administration hours had been reduced, but this resulted in some income loss due to lack of administration time to follow rejected claims and/or unclaimed services. This practice has subsequently reviewed this and reinstated some of the administration hours.

Replacement of outdated equipment could be a problem. One practice was unable to update their computer and phone system both of which had an impact on patient management.

Claw-back at each of the five sites on the enrolled patients was within the normal range expected. In general patients from these practices did not access the charged after hours services readily.

7 Additional Contracts Summary

The income from additional PHO contracts was seen as valuable by the practices.

Some of this income was fee-for-service from sexual health and palliative care contracts. In such contracts the practices need to follow a process and record these services in the management software in order to claim the fee-for-service amounts. Some of these contracts only provide a small dollar return for the record keeping and follow up required. In one site the IT infrastructure for claiming posed some issues and we saw evidence of the work being undertaken, but the record keeping was time consuming and not always completed by clinicians.

Some contracts included the provision of paid staff to fulfil the contract. There are potential synergies if this staff resource is located in the practice and becomes an integral member of the practice team. An example of this was a practice that had an additional 0.6 Full Time Equivalent Community Nurse funded by the PHO. The Community Nurse and Practice Nurse shared the Community Nurse role. This enabled them to provide much better follow up (e.g. a home visit) of their hard to reach patients resulting in better results for both patients and the practice.

Some contracts provided staff such as specialist nursing counselling and mental health services across the PHO or in groups of practices.

The provision of paid staff either within the practice or in the community was seen as valuable as the practices indicated that there was a direct impact on the ability of the practice's clinical staff to offer patients access to these services without consuming additional practice clinical time to assist these patients with their social and mental health needs.

Some contracts were bulk funded to the practices and a report was required in order to ascertain the accountability of the service delivery.

Some practices commented that there had been lowered contract amounts or contracts that had been discontinued. An example would be a reduction in mental health staff hours. The difficulty for the practices is that there is not a corresponding reduction in the clinical needs of patients.

It was of concern to the practices and the case study team that many contracts are provided in silos and have high reporting requirements for a small dollar return.

The term of a contract and the timeliness of its re-negotiation could also be problematic. For example, in the case of one 12 month contract the funder did not start the process of reviewing whether to roll the contract over or not until near to the expiry date. While this was happening the practice continued to provide the service, although the contract had expired. It was fortunate that the contract was rolled over, otherwise the practice would have been out of pocket for the period it was providing the service without a contract.

It was noticeable that additional contracts added the most value when a certain amount of synergy and integration was achieved. For example, when the additional contracts enabled a comprehensive suite of wrap around social and health services to be offered, this had the added benefit of reducing the demand on practice clinical staff. However, the revenue from additional contracts needed to be weighed up against the administration and reporting requirements of these contracts.

7.1 Contract reporting requirements.

The case study team recognises that practices should be accountable for meeting the terms of a contract. However, there needs to be a discussion with practices about the DHBs and/or PHOs reporting requirements, in particular the ease with which this information can be recorded in the practice management system and extracted from it. More than one practice indicated this was a problem.

The case study team considers that DHBs and/or PHOs need to better understand how reporting and claiming requirements can place additional pressure on already very busy clinicians.

The case study team noted that it is imperative that practice reporting for each service is up to date. We saw evidence at one site that reporting on one contract was behind. We suggested to that site that this needs attention.

The practice with the largest number of contracts noted that contract reporting requirements had previously been an issue. This was resolved by working closely with the PHO and DHB to review how contract reporting requirements could be adjusted to reduce compliance costs, but maintain accountability for the service. We complimented this group on their ability to resolve the reporting issues and maintain accountability of their service.

7.2 Up take of contracts

In general the case study team considered the current uptake on most contracts across the five sites was reasonable given their complexity and the individual nature of each contract.

We have indicated to two practices that there could be improvement in the uptake of contracts, but the dollar value of these available contracts was not large. The case study team suggests that there should be dialogue between the two parties at the time the contract was offered to ascertain it the practice requires any assistance in order to be able to take a contract that is on offer. For example, is additional nursing resource needed in order to be able to support delivery on the contract.

The case study team considers that practices need to understand the nature of all the contracts that are potentially available to them. The practice can also articulate the value of the service in terms of their high need patients and the impact of managing without these services.

It will also provide an opportunity for PHOs and DHBs to gain a better understanding of the compliance issues associated with additional contracts for practice staff.

An important part of this discussion is not only the revenue from additional contracts, but the value they could add to the clinical management required of high needs patients.

8 Patient demand summary

In each of the five practices there was higher demand for doctor and nurse appointments than could readily be accommodated. Many doctors worked through lunch times and until late to accommodate the number of appointments required. In most of the five practices this was also true of the nursing staff.

Practices managed this high demand by involvement of nurses in triage to ensure that patients with the most urgent needs were seen by the appropriate clinician, and by reserving some appointments for bookings on the day. Routine appointments were booked well in advance.

The clinical impact of this high demand for appointments often meant that clinicians were only able to deal with the presenting clinical issue that day, but not the longer-term care planning and review of patients with chronic care needs.

Many of the practices had high numbers of patients who presented sick on the day adding to the demand for appointments.

The practices saw the need to accommodate acute presentations and also provide other opportunistic non-acute services while the patients were in the practice. For example, they would review all other screening requirements for a patient while the patient was in attendance. This resulted in, for example, cardiac risk assessments, diabetes annual reviews, smears, immunisations and all other routine screening being done while the patients were in attendance. The extra time involved in this work meant the staff undertaking it had to be experienced enough to efficiently manage the variety and complexity of health issues and the high demand.

The practices that provided non-acute opportunistic screening advised that these high need patients do not readily attend requests for screening when they feel well or, in many cases, will not attend specially organised clinics that provide these services.

In all practices there was a lot of evidence of doubling of appointments to accommodate the high demand. It was observed that this was only possible to sustain due to the clinical experience of the doctors and nurses.

If appointments are doubled this potentially reduces the usual 15 minute consultation by half (i.e. 7.5 minutes). This does not allow much time to review a patient with complex needs. It was noted that many high needs patients put off coming to the doctor until they had more than one presenting issue to be addressed.

It was not uncommon for doctors at three sites to be seeing between 32 – 40 patients per day and have no time reserved for responding to additional requests, checking laboratory results and/or completing other paper work. Most practices would set aside time for doctors to go through laboratory results and respond to other requests.

At two sites Nurse consultations ranged between 30-34 a day and at the remaining sites this was slightly lower at 25-29 per day[1].

None of the five practices had any capacity to see casual non enrolled patients. The doubling of appointment also reduces the practice's capacity to offer longer 30 minute appointments, resulting in less clinical capacity for review of the health care plan and more focus on the acute demand of the presentation.

For less experienced doctors or nurses this appointment doubling would be problematic. Skilled doctors are more quickly able to assess the clinical issues and are more skilled at asking the most appropriate questions for the purposes of diagnosis. Many doctors were able to accommodate this pressure as they did not work full time, but some doctors who worked full time expressed concerns that they were close to burn out. These doctors considered that there was a risk of a missed diagnosis given the complexity of what they were dealing with.

9 Clinical and social complexity summary

All the practices are very aware of the impact of both high demand and clinical complexity of caring for large numbers of high need patients. It was noticeable that most practices found it difficult to prioritise time for strategic planning, reviewing business models and models of care, and developing strategies for improvement. Even with this planning in some of the practices it would be difficult to see how this could be improved as the appointment demand was such that simply meeting presenting needs took great experience and energy.

[1] This is information was obtained from the practice management system patient appointment book on the week of the practice visit.

One practice with high numbers of patients with mental health, counselling and social issues commented that these issues had a direct impact on the health of patients and on the clinical demands on the practice.

Practices that had contracts that enabled the employment of specialist health care workers or access to additional services to assist with the clinical and social complexity of their patients were much better able to manage. Examples of this include:

- staff who assisted patients referred to secondary care with navigation through the hospital process.
- Staff who assisted refugees to navigate and access the services they needed. The doctors in the two practices with these refugee staff commented that it would be difficult accommodate this group without this support.
- All five practices had access to specialist nurses[2] to assist with management of high and complex needs patients. All the practices noted that without this support the management of these patients would be much more difficult.

All the practices expressed a strong preference for these specialist nurses to be integrated into their own practice teams as this enabled these nurses to be more aware of other health and social issues of these patients.

In the practices where there was access to these services within the practice the uptake was in excess of the hours available. These workers were booked some weeks in advance**.**

In one practice the self-employed doctor due to the number of high needs patients employed a person to do this work within his practice. In this case, this was in addition to the area wide service which he also used.

Social service support from external contracts would appear essential in order to manage the clinical and social complexity. The practices indicated that having services available to assist their patients with access to income support and housing entitlements and other services available to them was invaluable.

In all five practices the adequacy of clinical care relied heavily on having very experienced nurses and doctors. Senior doctors do not require the same time allowance for supervision and would usually be able to cope with more routine and doubled appointments per hour than more junior doctors.

In two practices there was concern that it would be difficult to replace a senior experienced doctor that was leaving with a doctor with the same level of experience.

The commitment of the practices doctor and nursing staff to meeting the needs of their high need patients was noticeable.

We have recommended that four practices talk with their PHO to see if it can assist with facilitation of a review of the clinical models of care assist the clinical staff who otherwise do not have time to

[2] These specialist nurses were employed by the PHO or the DHB.

undertake such a review and identify changes that can assist management of their complex and high need patients. However, at one of the smaller sites we do not see how this could make a difference given the patient demand. We did not see a ready solution for this site.

We did see evidence at two practices where there existed a clinical review group that accessed the patients with high admission rates to review all aspects of their clinical care. Although intensive of clinical time, those participating felt that the outcomes for the patient group had been significant. In both cases only small numbers of patients were able to be reviewed so they were selected carefully based on clinical criteria. The practice doctors particularly appreciated opportunity for medication reviews and specialists input into on-going care plans. This showed excellent results for the small group of patients covered by the review. The review was an initiated jointly by the DHB and practice.

Many of these patients are not easy to manage but the doctors we saw were committed to improving the health and education and patient self care of their patients. They went out of their way to find creative ways of doing this to engage with patients in their own care. Many worked in their own time to do so.

All staff, both administration and clinical, were aware of the vulnerability of their special needs patients and were empathetic to their needs, culturally sensitive to the differing cultures within their patient group. All the practices had clear mission statements that the staff adopted as part of their work.

10 Workforce and retention summary

The table 4 below shows the patient ratio for doctors and nurses in the sites. It does not include specialist nurses employed by PHO or DHB.

Table 4: Doctor and Nurse Patient Ratio		
Site	**Ratio of Doctor to patient**	**Ratio of Nurse to patient**
Practice 1	1568	1300
Practice 2	1425	1134
Practice 3	1971	1232
Practice 4	1503	1326
Practice 5	1807	1807

In all five practices the experience level of the doctors and nurses was high. All practices were heavily dependent having very experienced clinical staff. Some of the larger sites were able to accommodate one or two nurses with less than 10 years practice nurse experience.

All five practices are very vulnerable to staff turnover of their senior staff.

The downside to having very experienced doctors and nurses is that as they reach retirement age it will be difficult to find such experienced replacements at the salaries offered. In one practice both nurses were past retirement age.

One practice was currently recruiting for a practice nurse and having difficulty obtaining one with sufficient experience.

Two practices had received notice of a senior doctor with over 10 years in general practice leaving. The pool of available doctors with that level of experience is likely to be small. Often such experienced doctors are settled into the practice of their choice.

The level of staff turnover was very low. Most staff had worked at the practices for at least two years and most sites also had very long standing staff that been with them for over 6 years. Four of the five sites had had no staff resignations over the past twelve months.

More than one practice mentioned the time and clinical input required to train nurses to the level of experience required as difficult to accommodate in such a busy clinical setting. Two PHOs had showed initiative in providing assistance with this. These PHO had run training modules suitable for practice nurses. Considering the reliance on skilled staff it is recommended that other PHOs adopt this approach.

One very busy practice was assisted by a Health Care Assistant position. This person had been with the practice for a long time as a lead receptionist and had been encouraged to attend training as a Health Care Assistant. There was strong evidence that this position really was invaluable to this small site by enabling the nurse and doctor to deal with patients with higher clinical needs. The Health Care Assistant did all routine measurements such as blood pressure, weight and checked for recalls, screening, laboratory tests, or medications prior to the patient seeing the doctor or nurse.

In a second practice the same principal was adopted using an enrolled nurse who undertook much of the screening programme and the simple observations on the acute presentations prior to the patient seeing the doctor or nurse.

The case study team considers provision of practical support for practice nurse training by PHOs and/or DHBs might assist practices to train nurses to the level required by practices with high need groups. This would hopefully buffer the current vulnerability of senior staff retirement and the lack of well trained nurses seeking these positions.

11 Practice protocols and operation observations

All the practices visited had a high standard of documentation associated with practice protocols.

There was evidence of good PHO enrolment processes.

Appendix 1: VLCA Information Request Template

Ministry of Health

VLCA Practice Request prior to Visit

XXXX Medical Centre

December 2012

Practice Overview

Practice Background Information

Practice Name and location
Associated Network **PHO** **DHB** **Network**
Patient Register Numbers **By Age** **Ethnicity** **High Needs** **Special Need groups?** **Number of casuals seen last two years**
Location **Description area and surrounding practices are they also VLCA and proximity?**

Opening hours of site **After hour arrangements**
Quality improvement programmes or other accreditation Last done Renewal due Is copy of last report available?
You may also wish to send the review team other information relating to your practice

Financial information report request

1 Practice Accounts last two financial years Do these accounts contain any items not relating to the practice?
2 Can you provide a copy of the current year budget
3 Print Practice Service Code description and cost of service report. If Medtech (Setup/ Services /Print list of active services)
4 Provide Service Analysis Reports

Request the two reports to match accountancy period of the practice accounts supplied and for last 6 months or since start of last financial year until the current month (If Medtech this is printed in Reports/ Analysis / Services)
5 Debtors Print current company and Government debt report Print current patient debt report export and remove patient names (if Medtech Reports/ Auditing/ Aged Balance summary Select account group of Government and company and run report) Patient debt run report export to excel and remove patient names but leave all other fields)

Other information

1. Please send a copy of your current practice enrolment form
2 Please send a copy of your current patient complaint process
3 Please send a copy of your Significant Event process

If you wish to comment on any practice background issues briefly please write a short note. Discussion on these will be part of the process.

Appendix 2: VLCA Practice Visit Template

Ministry of Health

VLCA Practice Visit Template

XXXX Medical Centre

December 2012

Practice Overview

Section 1: Practice Background

(Requested prior to visit check it is complete and no more questions required.)

Practice Name and location
Associated Network **PHO** **DHB** **Network**
Patient Register Numbers **By Age** **Ethnicity** **High Needs** **Special Need groups?** **Number of casuals seen last two years**

Location

Description area and surrounding practices are they also VLCA and proximity?

Ownership model

Describe

Charitable trust

PHO owned

Private ownership

Or describe other ownership model

How does ownership model relate to practice

Owner operated?

Other ownership if so describe how the entity management and governance structure is maintained

Practice Building ownership or rental

How does the entity model assist the practice describe the following but there may be others

Financial management and support by additional funds

Is the PHO Management fee retained by the practice

Clinical quality and governance

Employs additional staff to work as part of practice team

Provides the building at lower than normal market rates or other help?
Who are the main contacts for this review **Manager** **Doctor** **Nurse** **Reception and admin** **Directors or partners of the ownership model** **PHO** **Other wider network contacts** **DHB interface**
Opening hours of site **After hour arrangements**

Quantify the roster frequency for GPs the AHS arrangements create
Quality improvement programmes or other accreditation Last done Renewal due Is copy of last report available?
Are there other Practice Contracts held directly with another entity such as Charitable Trust DHB PHO? **Does the ownership entity fund any specific projects or additional staff?**

Section 2 Staffing Information (this will be recorded at the visit)

Doctor FTE (Record in hours) permanent locum (Given work out later FTE to register ratio) Number Vocationally registered?

Supervision requirements? and the way this is organised?

Are Doctors employed and therefore salaried or contractors

Clinical patient consultation time versus admin time how is this organised and paid?

(record hours exactly)

(Record billable patient contact time and admin or clinical supervision time)

Special Doctor responsibilities or qualifications that the practice uses actively

Doctor number of resignations or changes over the past two years

Methods for Doctor recruitment and length of time this has taken

Any concerns re potential future retirement in the team?

Doctor Peer support arrangements and frequency

Do these arrangements apply to all doctors

Is this a training practice for doctors? If so how many Doctor or nurse trainees each year and who in the practice undertakes this work describe how clinical time is organised while trainees are in the practice.

Nurses FTE (Record in total Hours)

How is nurse team organised? Please describe

(Given FTE Nurse to register ratio work out later)

Is there a nurse team leader

Do nurses have special responsibilities list and describe

What is the nurse involvement in long term condition work

Give the nurse led clinics number and nature per week or month if some infrequent

Length of employment and turnover of the team

What is the experience level of team members does this vary?

How is peer support and review organised

Record patient contact billable time and admin time

Reception (Record in total Hours)

State reception cover hours given the practice opening (they may be longer**)**

Number of reception FTE

Is there any Admin only hours and FTE

Management hours and FTE (Record in total Hours)

(Ratio of these hours collectively to register work out later)

What level does management cover?

- What level of financial management
- Responsibility for HR and IT
- Building management
- Serving Charitable Board
- PHO or network responsibilities?

Length of employment and turnover of the team

Other staff employment

Does the practice or ownership model support additional staffing roles to support patient care?

If so describe the skill set and role and the way this is funded

Staff training and Professional Development

Budget and process in the practice for this for all staff

What is offered and paid for

What time allowance is given for study

What training proposals

Level of skill set in nursing team to cover patient register requirements

CPR training are all up to date?

How does the PHO support training

How does the DHB support training

Staffing Salaries

If there are issues relating to attracting staff that affect salaries indicate

(include length of time worked if applicable to paying for more experience)

Doctor salary ranges

Nurse salary range

Reception salary range

Admin

Manager

Other positions Such as Finance counsellor etc

Any General comments or concerns re staffing

Such as recruitment, obtaining and keeping the skill resource or other items

Section 3 Financial Review

Most of this section requested prior to visit check all items have been given in this section and if any items require clarification.

Obtain Practice Accounts last two financial years Check accounts relate to practice and no additions to them that need to be removed before being analysed
Request budget figures
Print practice service code description and cost of service report.
Analyse Service Costing and Invoicing (Service Analysis Report) Run two reports to match accountancy period and for last 6 months or since start of last financial year. 1. Service costing 2. Do the numbers in the Service Analysis Report reflect the work (are all invoiced) 3. Check reports by provider to analyse work done by each 4. Check material cost recouping process internally to cost materials used.
Income – If not available run report **Income receipt Report** Analyse income sources and amounts ACC Capitation

GMS

Maternity

Immunisations

Patient surcharge

Performance management income

Casual numbers of consults

Provide claw back amounts and numbers what percentage of total.

Patient Debt Arrangements run reports

1. Process for payment on the day

2. Is the documentation of expectations to patients evident

3. Sending out patient accounts process

4. Process for non payers – what is offered as payment options

5. Is debt collection used- process for this success? Or philosophy not to take this action?

6. Level of debt – Age/Balance Summary Report

    - Report by Company

    - Report by Government Department

    - Report by patient

Levels of debt in 30 60 90 day

6 Are there any special account groups how are groups managed is there a difference to use of messaging and noting

Government Claims Check not covered in request for info

1. Who is responsible for claiming

2. Is process set out for the following:
   GMS

   IMMs

   Maternity

   ACC

3. Frequency sent

4. Reconciliation process and follow up process of unpaid

5. Level of failure

6. Any issues of non finalised claims awaiting correction.

7. Are provides set up correctly in the software set up so few problems

8. Level of outstanding in 30,60 and 90 day analyse this group for year incurred

9. Does the PHO and DHB support the collection of these?

Company Accounts for Medicals etc.

1. How are these managed and by whom

2. How many in 60 or over days outstanding

3. Any issues in relation to late payment

Banking

1. Describe banking process

2. Balancing evidence

3. Frequency of close off

End Of Day Report

1. Patients seen but not invoiced

2. Process that all patients who present placed on appointment screen and clinical notes written

End of Month Reports

1. Analysis of these and which ones used

2. From Information are there questions relating to these such as income on some services.

Practice Accounts payable process

Who checks accounts to ensure all items received in the practice?

Supply ordering Who is responsible

How is it run minimum and maximum numbers?

What involvement or feedback to staff if costs high

Analyse account items check any with the site where they seem high or coding of which expense is not clear.

IRD Compliance

1. GST reconciliation and completion of payments any penalties paid over last two years?

2. GST receipts to patients and companies is this set up correctly in software

3. Process and understanding
Staff leave liability Is a report run regularly and who oversees this area Analyse costs of short term locum cover to staffing costs. Describe how often sudden short term arrangements have been required over last two years. Have these costs been higher than using normal locum cover?
Cash flow current arrangements Are there any issues relating to cash flow such as overdraft costs do you have funds on term deposits?
Future Viability issues What costs could be cut without affecting patient services
Premises Costs and square metrs

Section 4: Appointments

To be discussed and documented at the visit so different arrangements are understood

Appointment Use Analysis

Methods for appointments

Are appointments pre-booked?

Are there other uses of appointment screens such a messaging RX etc

What is the average waiting time for an appointment

Are all the practice appointments used each day

How many days in advance are completely booked

1 Time allowed Doctor appointments all types

2 Time allowed Nurse appointments all types

Types appointment	**Dr**	**Nurse**
Routine		
Acute		
trauma		
Chronic stable		
Chronic unstable		

Preventative screening

Immunisations

Special needs

Procedures (surgery or other)

Other types?

Comment on special issues with

1. Doctor appointments routine and urgent

2. Nurse appointments routine and urgent

3. Triage of urgent resource that undertakes this describe phone or presentation

4. Do many patient arrive without appointments expecting to be seen

5. Nurse clinics

6 Numbers of appointments not filled

7 Consistent availability of patient appointment numbers by each provider per week and how much time is routinely available (not time blocked out for breaks and admin)

8 What time is blocked for catch up or admin work. Exclude breaks unless longer than usual

9 Special need patients requiring longer appointments how dealt with

10 How often is it required that appointments are doubled are there any risks that concern

you in this?

11 Are there additional groups of patients where there is an appointment time differences or the practice has quite a different process for organisation for any particular group?

12 What number of patients are declined appointments due to lack of appointment availability does this vary by month?

13 DNA appointment numbers per week on average.

14 Is there any process to follow up non attendees.

15 Rx time

16 Phone consults are they recorded by consult type/

Section 6: Clinical review

(Questions will be asked at visit to give background to clinical time requirements) and clinical issues that staff cope with)

Complex patients

Type and issues

Please take some time to describe to us the groups of your patients with additional high needs.

Give examples and numbers where possible

Do you have staff specially trained to work with some groups within your site

special needs groups such as refugees where additional time and cost involved

mental health patient numbers

With any specific groups can you indicate how this group (s) are identified and managed within the practice by staff

Other groups with clinical conditions which are considered complex and take additional time to manage

Where possible give percentage to total available appointments for that provider for any special groups that are kept specifically.

What clinical pathways or patient planning is adopted by the practice to manage special patient groups.

What methods does the practice use to manage non compliance and non attendance by high need patients and does this impact on clinical time?

Do the nurses offer special assistance and expertise for any complex groups

Are there other staff who actively participate in any programmes

Are there other special services or clinics are offered to any patient group

Has there been any additional funding for complex patients by DHB , PHO MOH or from savings or from the owners network

Is this funding likely to continue

Significant event process

Describe the process

How are these reviewed and who is responsible for what

Is there any external review

Patient complaint process

What is the process

How is it documented

Patient result handling

Review process describe who and how

Numbers results awaiting attention

Tracking and monitoring urgent referrals

How do they manage those patient you cannot contact

Recall and Screening

Process and who takes responsibility for

Recall

Screening

What is offered and how is it offered to patients what do you find works best

How do you manage non-compliant patients and are they reviewed again?

Immunisations process

do you manage outreach numbers as well as your own practice numbers

Practice performance management reports Please provide a copy of last two years
Health Promotion and preventive care programmes What is offered Who provides How is this funded
Clinical expertise of current clinical staff in any particular complex patient need? Would there be any risks from current staff resignations If so what would it take to remedy and what is the likely impact on other team members
Repeat Scripts Process charging Concerns
Standing orders Use how many give examples Process for development Review process Any issues

Do all doctors agree thst all nurses can use standing orders?
Disease coding How is this managed Who is responsible How is training given to new doctors and locums
Clinical Note entry will be discussed at time of review visit. **Method for ensuring all patient contacts are documented – Day report principal of all contacts on appointment screens**
What provision is there for review of clinical effectiveness by the clinical team

Section 5: Operational

(Questions designed to give background only and any special issues or pressures) within the practice)

Enrolment Process 2. Enrolment forms do they meet the national current standards 3. Evidence of eligibility criteria being applied and documentation evident. 4. How are the enrolment forms checked? Missing data followed up. 5. Filing process

6. Process for those not completing forms – 3 years and not seen
7. Import report monitoring
8. Accurate recording of transfer and casual patients
9. Gathering of NHIs as part of enrolment

Patient Feedback – process

Describe how the practice facilitates this.

Phones and patient enquires process

Answer timing and identification of the practice and person taking the call

Evidence of handling patient requests process such as

- Scripts
- Urgent appointments
- Speaking to doctor direct
- Results handling

Are all nurse phone conversations recorded on clinical notes

How are patient advised about return phone calls

Premises

Any observations to improve efficiency

Any barriers you have to work with and how does this impact your practice

IT

1 Are there sufficient computers for staff to use?

2 Evidence of monitoring backup

3 Safety of backup device and of site storage

4 Independent logins with passwords

5 Evidence of latest application of software

Clinical and Financial Software use

How well is the package used and understood by staff

Doctors

Nurses

Reception

Manager

How are new staff trained to use the software

Practice Protocols

1. Who develops the practice protocols
2. Where are latest copies kept
3. How do new staff know of their responsibilities

Patient Transfers

1. Is there a protocol around patient transfers
2. Are the timing requirements met
3. How does the practice document this process and track progress
4. How is new patient information managed who is responsible for what in this process

Scanning Patient Information

1. Protocol around scanning patient information and safe guards
2. How long are scanned items kept
3. Process for assigning

Appendix 3: Background to the Financial Summary Comments

The five practice sites provided their audited accounts for the financial twelve month period ending March 2011 and March 2012.

The case study team was also provided with financial information from each practice for the current period ending March 2013 of the actual income against budget.

As some of the audited accounts did not provide a breakdown of all income sources, the case study team also reviewed the income for all services provided from the data in the practice management software. This data enabled us to review the range of services and the income from each service.

All sites had separate accounting systems in which income and expenditure is recorded. This is a standalone system from the practice management software. Practice administration staff have to manually reconcile these systems in order to get a complete overview of total practice income, outstanding income and debt. This requires careful attention to detail around the reconciliation in both systems, especially income that is paid directly into bank accounts.

The review team considers that best practice would ensure a careful matching of the two systems to ensure the practice management software matches the amounts recorded in the financial software. Not all sites had been able to do this.

Complete breakdown of income sources was not available in audited accounts and had to be sourced from the practice management systems