Evaluation of the

Flexible Funding Pool

Final Evaluation Report

March 2018

National Hauora Coalition

National
Hauora Coalition

Published March 2018
ISBN 978-0-473-43581-3

Acknowledgements

This evaluation and report was completed by Julian King & Associates Limited (JK&A), the NHC wishes to acknowledge the work put in by both Julian King and Michelle Moss. Acknowledgement is also due to the Mōhio informatics team who generated the relevant data to support the evaluation and to Dr David Jansen, Lorraine Hetaraka-Stevens, Jonathan Murray and Tereki Stewart who contributed to the evaluation. Special thanks to all of the National Hauora Coalition general practice provider network who took part in evaluation survey and interviews.

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1. Executive Summary

The National Hauora Coalition (NHC) established the Flexible Funding Pool (FFP) programme in 2013 in response to a policy requirement under the Government's Better, Sooner More Convenient Healthcare approach. The FFP programme consolidates funding associated with Services to Improve Access (SIA), Health Promotion, Care Plus (Care+) and the PHO Management Fee, and aims to reduce barriers to access for NHC's 'high needs' population and support quality care. This dual intention is framed as the "clinical contribution to Whānau Ora outcomes".

NHC engaged Julian King & Associates Limited (JK&A) to undertake an evaluation of the FFP Programme. The overall purposes of the evaluation were to: assess effectiveness of the programme; understand provider satisfaction with the programme; and identify opportunities for improvement. The evaluation used a mixed methods approach, underpinned by an evaluation-specific methodology. Fieldwork and data collection took place in October and November 2017.

Findings

Evidence from general practice stakeholder feedback and administrative data indicate that the FFP programme has improved over time and is now an effective and valued programme. A number of opportunities for improvement have also been identified. Key findings are as follows:

Effectiveness

Overall, the evaluation found that the FFP programme is moderately effective (according to the definitions set out in the evaluative rubric, Appendix A) across the key focus areas: quality clinical care; reduced barriers to access; and contribution to clinical outcomes.

Evaluation data consistently indicate that the FFP programme supports **quality clinical care**. The programme has led to some improvements in adherence to clinical guidelines (including better and more consistent adherence), engagement with patients (including longer and more frequent engagement), and enhanced nurse roles. The majority of practices achieve expectations in regards to quality accreditation. Others are on the pathway to doing so. Most practices meet most performance indicators for national health targets.

The FFP programme contributes to reduced **barriers to access and uptake of care** by enabling practices to offer services at a reduced cost, or free of charge. Eligible patients (Māori, Pacific, and/or New Zealand Deprivation Index [NZDep] quintile 4-5 patients) are accessing these services and utilisation by Māori (a key target group) is increasing. However, there are concerns amongst nearly all stakeholders about the current NZDep eligibility criteria which are based on small area deprivation rather than individual deprivation measures. These measures do not perfectly reflect the individual needs of patients or whānau residing in these areas, and so the perception is that there are high needs patients missing out.

Due to issues of attribution and the types of evaluation data available, it was not possible to measure **clinical outcomes** directly as part of the evaluation. Therefore, the potential clinical contribution to outcomes must be inferred from FFP effects on quality and access. Bearing in mind the findings above, that the programme has contributed positively to quality and helped reduce barriers to access it is considered likely that the FFP programme does contribute to better disease management. Stakeholder feedback also suggests that the programme may contribute to fewer acute presentations and reduced hospitalisation.

Satisfaction

Overall, **satisfaction with the FFP programme was somewhere between moderately high and high**. Those who had experience with the FFP programme since it was first implemented agreed that it has become more flexible in terms of how the funding is managed, and more equitable (by extending the high needs definition to include quintile 4 patients in addition to quintile 5). In particular, stakeholders were satisfied with NHC staff and Mōhio support; the FFP suite of services; and the FFP programme's systems and processes.

Some of the most commonly raised **concerns centred on funding and how funding is allocated** (e.g., funding running out too soon, lack of flexibility around how to spend funding, losing un-spent portion of budgets). Some of these concerns reflect that there are limited funds available for the range and intensity of needs the FFP programme is intended to meet – as well as some possible misconceptions about the policy intent and purpose of the FFP, how FFP funding is allocated, where practice funding comes from more generally, and how it is claimed.

Opportunities for improvement

Key opportunities for improvement include:

- Consider ways to address issues around eligibility for high needs people who do not reside in quintile 4 or 5 areas, and who are not Māori or Pacific.
- Be more transparent to practices about how unspent budgets are used and be clear about how and why it works this way.
- Consider providing clarity around some areas of the FFP programme that are less understood, such as the original policy purpose, funding allocation, how to best use systems and processes.
- Consider some proactive outreach from NHC to a few individuals who are struggling with the programme's IT system.

Additional suggestions for improvement are presented in the body of the report.

2. Introduction

The National Hauora Coalition (NHC) began operating as a Primary Healthcare Organisation (PHO) in 2011. It was formed when a group of Māori PHOs decided to pursue a collective vision focussed on the health and wellbeing of their communities. Since then, the NHC has attracted over 60 general practices and health service providers, and provides services to an estimated 202,000 people nationwide.

NHC's Primary Care Network has 35 general practices enrolled in PHO first level services. They are distributed throughout the North Island.[1]

The Flexible Funding Pool Programme

The Flexible Funding Pool programme was established in 2013 in response to a policy requirement under the Government's Better, Sooner More Convenient Healthcare approach. All Primary Health Organisations (PHOs) and their General Practice Networks were required to develop new ways to construct, allocate and implement funding associated with Services to Improve Access (SIA), Health Promotion, Care Plus (C+) and the PHO Management Fee. These funding streams could be used flexibly as long as the original policy intent of each stream was met.[2] The intent was as follows:

- Care Plus: to improve chronic care management, reduce inequalities, improve primary health care teamwork and reduce the cost of services for high-need patients.[3]
- SIA: to reduce inequalities among those populations that are known to have the worst health status: Māori, Pacific people, and those living in NZDep index decile 9–10 areas (referred to in this report as quintile 5). A multi-disciplinary approach is encouraged for improving access to health care through the establishment of district alliances to coordinate the provision of health services between secondary, primary and community-based health services.4

The NHC Alliance Leadership Team (ALT), constituted by senior clinicians and senior managers from primary and secondary health providers, sought to reduce barriers to access for their 'high needs' population[5] and support quality clinical care through the FFP. This dual intention was framed as the "clinical contribution to Whānau Ora outcomes".

The FFP programme went live on the 1st of July 2013 after several months of intensive engagement with all NHC's practice teams and examination of their full range of programmes and services. A menu of programmes were identified as key to meeting the programme's dual intention. These services, referred to as FFP Suite of Access Services (Suite AS), are outlined in Table 1.

1 See: https://www.health.govt.nz/our-work/populations/maori-health/maori-health-providers/te-ao-auahatanga-hauora-maori-maori-health-innovation-fund-2013-2017/te-pataka/te-pataka-national-hauora-coalition

2 CAB min (10) 6/3

3 See: http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/care-plus

4 See: http://www.health.govt.nz/our-work/primary-health-care/primary-health-care-subsidies-and-services/services-improve-access

5 The Ministry of Health defines high needs populations to include Māori, Pacific and people living in NZDep quintile 5. NHC has broadened this to include those living in quintile 4.

Table 1: FFP's Suite AS

Suite AS	
After hours – reduced cost of access	Reduces cost barriers to access good quality After Hours services. Reducing cost improves the access, affordability and continuity of care for National Hauora Coalition Enrolled Service Users to After Hours Care. After hours subsidy paid direct to after hour clinic for NHC enrolled and funded population in specified localities.
Urgent support funds	A flexible urgent support fund managed by clinics, to fill a gap in funding with the aim of improving access to Primary Health care services and reduces barriers because of Enrolled service user financial difficulties
Multidisciplinary Intervention	A short-term service provided by Practice staff, to ensure continuity of care in the transition of care to provider clinics, or other services. Funding is available for an index event per patient with referral to ongoing support required.
GP or Nurse in home – Palliative/End of life Care	GP or Nurse provides in-home service, health education, nursing tasks, or an assessment in the home for palliative patients at the end of life stage. This service is specifically for palliative care patients at the end of life stage, not for general palliative care; hence the rationale for 6 visits over a 6 month period. Patient co-payment at Practice discretion, as services are likely to be home based care, and funding may not fully cover Medical Practitioner costs of visit. The intention is a subsidy not complete funding.
Sexual Health – cervical smear	NHC covers the costs of providing a cervical smear for the practice's eligible patients.
Sexual Health – Long Term contraception	Long-term contraception for high-priority population: Intra-uterine devices including Mirena; Progesterone Implants e.g. Jadellel; Depo Provera; Oral Contraceptives; Vasectomy.
Cardiovascular disease Triple Therapy	CVD Risk management as per national best practice guidelines, 60% of patients with CVD Risk score >15% prescribed triple therapy. Smoking cessation should be strongly and repeatedly recommended at any level of CVD risk. All people who smoke should be advised to quit and offered treatment to help them stop completely.
Reduced cost of access to podiatry	Reduced cost of access to podiatry, for patients with Type 1 or Type 2 diabetes; who meet the foot referral criteria for the at-risk and high risk foot.
Integrated support for long term conditions (LTCs)	Comprehensive assessment, Care Plan, up to 4 visits offered (extended 1st consult) per specified diagnosis. May be offered Nurse led services and included in Multi Disciplinary Services.
Smoking brief advice and cessation support	Smoking brief advice and cessation support referral to free quit smoking support services.
Youth sexual health and contraception	Free treatment and advice on sexual and reproductive health may include education and advice, provision of contraceptives, screening for and assessment, diagnosis and treatment of STIs. Based on best practice guidelines, limit of one annual screen per year with a follow up consultation if required. Further STI consults available if patient is symptomatic or there is a change in circumstances.

NHC's proprietary cloud-based, real time information system Mōhio is used for claiming and reporting. The system provides prompts for clinicians, based on clinical evidence, as they enter client data. This allows for a consistent, evidence based approach across practices in regards to claiming, reporting and patient care. Mōhio also provides real time feedback on performance against National Health Targets at practice and whole-PHO level.

From the overall funding pool, NHC retains top slices to cover the cost of managing the FFP programme; contingencies and after-hours care. The remainder is allocated to practices in the following ways:

- 25% for performance bonus payments – contingent on meeting National Health Targets (with part payment available for partially meeting targets in certain cases) including: Cardivascular Disease Risk Assessment, Diabetes Annual Review, 8 month and 2 year childhood immunisation, Smoking Status Recorded, Smokers Given Brief Advice or Cessation Support and Cervical Screening.
- 25% quality payment, for quality initiatives and accreditation; practices are expected to meet Cornerstone Aiming for Excellence standard, or be on an approved pathway to doing so.[6]
- 50% flexible fund, where practices allocate the funds as needed against the Suite AS programmes to meet the needs of the target populations (i.e., Māori, Pacific, and people living in quintile 4-5).

The funding and programme model is intended to ensure National Health Targets and Service Level Measures (previously IPIF, the Integrated Performance and Incentive Framework) are prioritised while providing flexibility for practices to use the funds as they see fit (albeit, within the criteria and provisions of the programme). The performance targets for the programme are set out in Appendix B and include targets for: CVD Risk Assessment, Diabetes Annual Review, 8 Month and 2 Year Childhood Immunisation, Smoking Status Recorded, Smokers Given Brief Advice or Cessation Support and Cervical Screening.

If practices do not claim all the funding available to them, or they have not met targets, this putea sits with the NHC as 'unclaimed FFP funding'. This can be reinvested, or used for projects to support population health and quality.

Expected outcomes

To help focus the evaluation, an outcomes logic (Figure 1) was developed in collaboration with the NHC. The logic posits that the FFP programme ensures that those who are eligible within the enrolled population of the NHC (i.e., Māori, Pacific, and people living in NZDep quintiles 4-5) can access (e.g., through reduced cost to accessing care) quality primary care (i.e., care that has been enhanced by quality accreditation and initiatives, and programmes underpinned by clinical evidence) and that in turn, this supports broader impacts such as better disease management, reduced disparities and Whānau Ora outcomes. The outcomes and impacts identified in blue text were the focus of this evaluation.

6 The NHC encourages their network to towards Cornerstone (top tier) accreditation, but depending on the circumstances, some may be be accredited against Foundation Standards (the entry level standard). Others, such as enrolling rest home providers require different accreditation pathways.

Figure 1: The FFP's outcomes logic

FFP content	FFP outcomes	Broader impacts
▪ Top slices for NHC management (10%), contingency fund (2%), after-hours care – and, of the remainder: ▪ 25% for performance payment to meet national health targets ▪ 25% quality initiatives and accreditation ▪ 50% flexible fund: menu of services for high-needs populations (Māori, Pacific, Quintile 4-5)	Quality clinical care ▪ Practices meet minimum standards, get accreditation ▪ Practices meet performance targets ▪ Better engagement with patients ▪ Adherence to clinical guidelines including greater consistency between practices ▪ Enhanced nurse role Reduced barriers to care ▪ Services are available at no/low cost to high needs populations ▪ Services are used by those who are eligible	Contribution to clinical outcomes ▪ Better disease management ▪ Reduced morbidity and mortality ▪ Reduced disparities for Māori, Pacific and vulnerable populations Contribution to other outcomes ▪ Whānau Ora outcomes ▪ More efficient and effective use of health care services (e.g., earlier intervention, savings to system)

Evaluation purpose

The overarching purposes of the evaluation included both learning for improvement and assessing effectiveness. The NHC also wanted to understand provider satisfaction with the FFP and the extent to which the FFP supports clinical contributions to outcomes.

Three Key Evaluation Questions (KEQs) were developed that denote the nature and scope of the evaluation:

KEQ1: To what extent is the FFP effective (and therefore potentially contributing to clinical outcomes) by supporting quality clinical care and reduced barriers to care?

KEQ2: How satisfied are providers with the FFP?

KEQ3: What are the opportunities for improvement?

Evaluation methods

The evaluation included:

- A workshop with the NHC to agree the aspects of performance the evaluation would focus on, and the basis on which judgments would be made
- Telephone interviews (N=21)[7] including:
  - GP/Owners (n=5)
  - Salaried general practitioners (GPs) (n=1)
  - Practice managers (n=6)
  - Practice managers/nurses (n=5)
  - Nurses (n=3)
  - Administrators (n=1)
- Written feedback from one GP who preferred this method to a phone interview. In addition, another staff member emailed through a summary of group feedback from others in the practice (N=2).
- A 'rapid feedback' online survey (N=44). Survey respondents consisted of:
  - Practice nurses and nurse practitioners (n=19)
  - Practice leaders (n=8)
  - Practice owners (n=11)
  - Salaried and non-salaried general practitioners (GPs) (n=14)
  - Community health workers (n=1).[8]
- Analysis of programme data from the NHC
- Review of programme documentation
- Preliminary analysis and synthesis of the evidence
- A workshop with the NHC to present preliminary analysis and synthesis, validate and contextualise findings, and discuss implications
- Preparation of draft and final reports.

Further details on the evaluation methods are provided in Appendix A.

7 Two people took part in one interview.

8 The NHC only hold records of Full Time Equivalents in their practices. Therefore, no accurate response rate could be calculated for the survey.

3. Findings

This section presents our findings in line with the three KEQs: effectiveness; satisfaction; and opportunities for improvement.

Effectiveness

KEQ1: To what extent is the FFP effective (and therefore potentially contributing to clinical outcomes) by supporting quality clinical care and reduced barriers to care?

Overall, the evaluation found that the FFP programme is moderately effective across the key focus areas; quality clinical care; reduced barriers to access; and contribution to clinical outcomes (Table 2). Evidence that supports these findings is presented in the paragraphs below.
The agreed criteria that provided the basis for making these judgments are detailed in Appendix A.

Table 2: Summary of findings – KEQ1

	Quality clinical care	Reduced barriers to access	Contribution to clinical outcomes
Strong			
Moderate			
Acceptable			
Poor			

Quality clinical care

Overall, the majority[9] of survey respondents (n=32/44;73%) were satisfied[10] that *'the FFP enhances the quality of care we provide for our patients'.* Of the remaining respondents, eight people felt neutral about the statement, three people, who were all GPs, dissatisfied,[11] and one did not know/felt unsure. Amongst interviewees, nearly all thought that the programme impacts positively on quality of care.

To further assess the impact on quality clinical care, the evaluation sought to understand the extent to which the FFP programme has supported improvements in adherence to clinical guidelines, improved engagement with patients, and enhanced nurse roles. It also looked at the extent to which practices meet programme performance indicators and expected accreditation standards. The following sections outline findings in relation to these aspects of quality.

9 Majority refers to more than 50%; vast majority refers to three quarters or more

10 Throughout the report, 'satisfied' includes survey responses of satisfied and very satisfied.

11 Throughout the report, 'dissatisfied' includes survey responses of dissatisfied and very dissatisfied.

Adherence to clinical guidelines

The FFP programme and Mōhio, NHC's real time information system, is underpinned by clinical evidence. This is expected to contribute to better and more consistent adherence to clinical guidelines across practices in regards to patient care as well as more consistent claiming and reporting. Evaluation data suggest that the programme has led to some improvements in adherence to clinical guidelines.

The majority of survey respondents (n=32/44;73%) were satisfied that '*the FFP supports better adherence to best practice guidelines.*' Most others felt neutral about the statement (10/44), while only two people felt dissatisfied.

Similarly, amongst interviewees, the majority believed that the FFP programme, through its systems and processes (e.g., Mōhio Forms, Mōhio Express prompts, live reporting and data collection, etc.), contributes to better adherence to clinical guidelines and supports consistency in care – in terms of screening, risk assessment, referrals and disease and patient management. The Mōhio Forms were considered useful for new staff and the prompts, good reminders for "what should be done".

> *The tick boxes [in Mōhio Forms] help to make sure you don't forget anything.* (GP)

> *Provides consistency in care for us – requires us to think in a certain way when we do a consultation, because we know with this particular health condition we have to go through this process to complete the reporting requirement - so that model of care is followed.* (Practice Manager)

Nearly all of those unsure, or who did not believe the FFP programme had supported adherence to guidelines, were GPs. They considered their quality of care had always been high and did not perceive the FFP programme to have impacted on how they do things. However, some acknowledged that the programme has helped streamline processes.

Engagement with patients

It is anticipated that the FFP programme should contribute positively to engagement by practice staff with their high needs patients. Findings indicate that the programme has led to some improvements in this area.

The vast majority of survey respondents (n=34/44;77%) were satisfied that '*the FFP supports good engagement with our patients*'. Eight respondents felt neutral about the statement, while two people felt dissatisfied.

The vast majority of interviewees also believed that the FFP programme contributes positively to their engagement with patients. In particular, they noted that:

- The funding helps practices meet patient needs. It:
  - Allows for more (e.g., longer and more frequent) and more targeted time with patients for chronic conditions (e.g., through the initial GP appointment and associated follow up visits for integrated support for LTCs)
  - Enables practices to provide vital services that would normally incur a cost to the patient, such as prescription, ambulance charges, palliative care home visits, at a lower rate or free of charge
  - Allows for more nurse involvement in patient care (see section below, 'enhanced nurse roles').

- Patients are more likely to show up because services are free; this allows for more preventative work as well as follow up care (the programme's impact on access and uptake is discussed further below).
- Mōhio FFP (and other) reporting identifies and Mōhio Express notifies practice staff of who is eligible, what patients are eligible for and what is due for patients. This helps ensure patients are regularly reviewed/re-called.
- Real time data from Mōhio supports practices to step up in areas they are underperforming.

These sentiments are demonstrated in the following quotes.

> *Because the LTC* [long-term conditions] *and diabetes budget is there, we can spend more time and more energy with chronic conditions.* (Practice Manager/Nurse)

> *I like the best practice recommendations for patients - it allows discussion (planting the seed) with patients in regards to preventions of major health problems prior to them seeing the GP.* (Nurse; survey respondent)

Enhanced nurse roles

Another marker that FFP contributes to improved quality care is enhanced nurse roles. Overall, there were more varied views amongst stakeholders as to whether this had occurred in their practice compared to the other aspects of quality care; it seems that the FFP has led to improvements in regards to enhanced nurse roles in some practices but not others.

Just over half of survey respondents (23/44;52%) were satisfied that '***the FFP supports enhanced nurse roles***'. Fourteen felt neutral about the statement, four people dissatisfied and three people unsure/did not know.

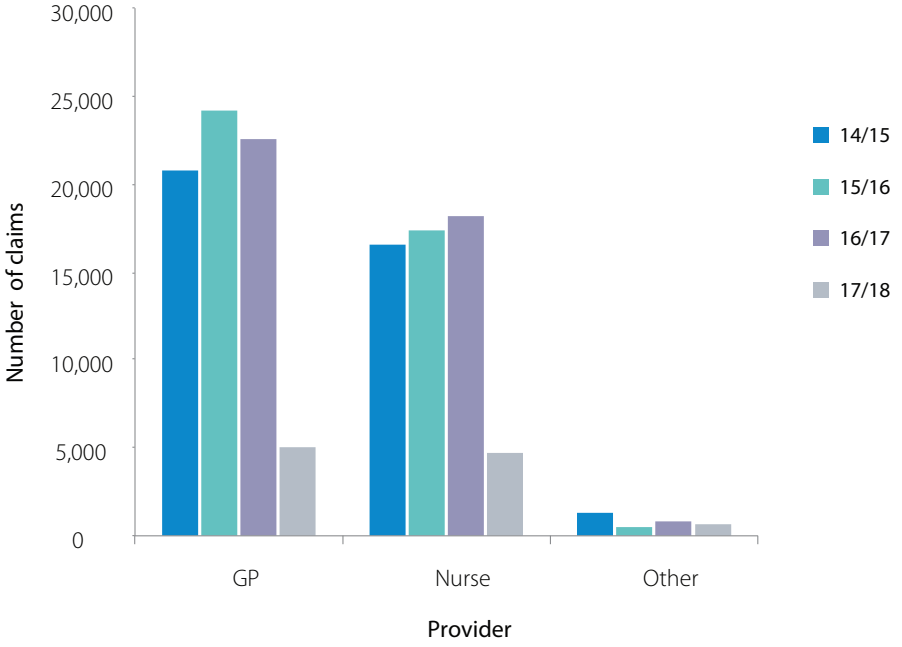
There were different views amongst interviewees too. Although some had not noticed a difference, others perceived the programme to have had a substantial impact on nurse involvement in patient care. In one practice, the practice manager attributed increased involvement in follow-up care by nurses, nurses doing management plans, up-skilling of nurses, and the ability to start up an asthma clinic to the additional time and resource the FFP programme has provided.

> [FFP] *has enabled nurses to be in more of a counselling and support mode than what we were doing, people were just coming in and treated on the spot for what they needed […] Nurses have been able to spend more time with patients with asthma and do management plans and follow up. Before we were too stretched. Before we didn't have the resource. I feel we have the resources now.* (Practice manager/nurse)

In another practice, a GP noted that access to multi disciplinary intervention funding through the FFP programme has allowed for gerontology nursing, where nurses visit elderly patients in their homes every three months to make sure they are managing – "it's been hugely successful". One practice manager highlighted that nurses are a valuable part of their workforce, and allowing nurses to claim through the FFP programme has meant they can lead most work around smear taking, immunisation, CVD risk assessment and diabetes annual reviews.

Administrative data shows that the number of claims by nurses has increased gradually over the last three years (Figure 2) – this would be consistent with stakeholder feedback that FFP supports enhanced nurse roles. Over the July 2014 to October 2017 time period 54.7% of claims were made by GPs, 42.9% by nurses and 2.4% by others. The proportion of claims made by others has also increased, from 3% in the 2014/5 financial year to 6% in the first quarter of the 2017/18 financial year.

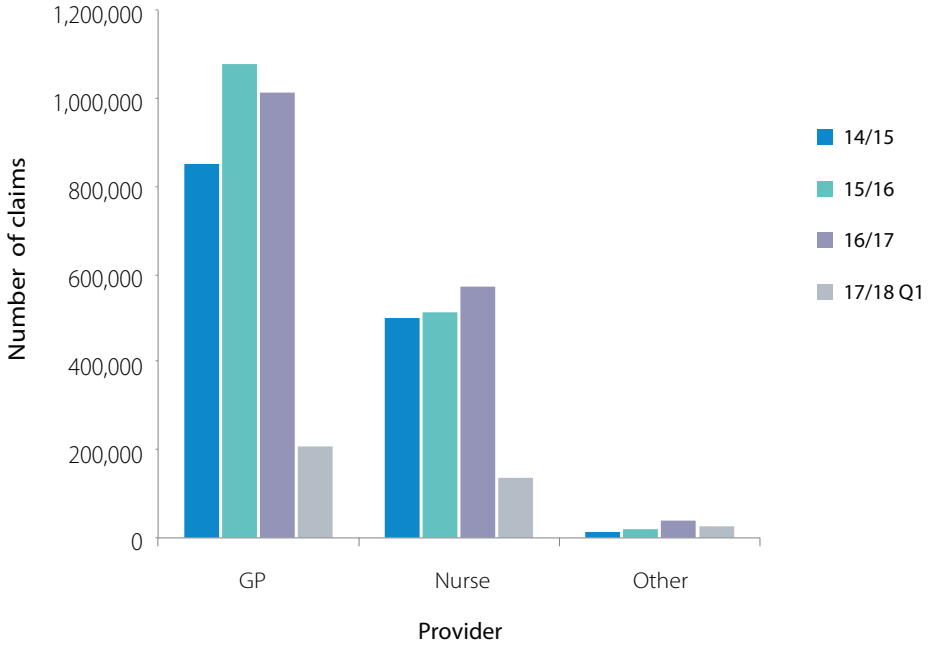
Figure 2: Number of claims by nurses increased over time



Note: 17/18 covers first quarter only

Over the July 2014 to October 2017 time period 63.8% of the value of claims were made by GPs, 34.3% by nurses and 1.9% by others (Figure 3). The claims value made by others has increased from 1% in the 2014/15 financial year to 7.1% in quarter 1 of the 2017/18 financial year.

Figure 3: Higher value claims made by GPs

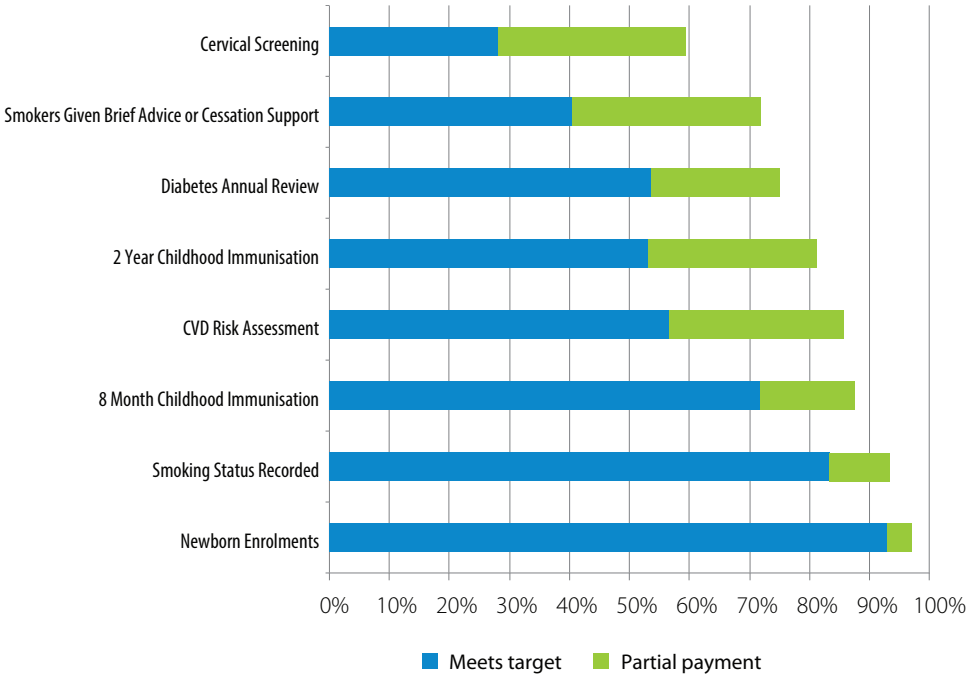


Note: 17/18 covers first quarter only

National health targets

Participating practices are expected to meet performance indicators for national health targets, as set by the Ministry of Health. Targets for full and partial payment are summarised in Appendix B. The percentage of practices meeting performance targets or qualifying for partial payment for the latest quarter (1/4/17) are shown in Figure 4. Quarterly time series were investigated and generally showed fluctuations rather than clear trends, so have not been included here.[12] Adding to the difficulty in discerning trends, some practices have entered or exited NHC over time and some targets have changed over time. However, based on the most recent quarter as shown, most practices met targets for full or partial performance payments.

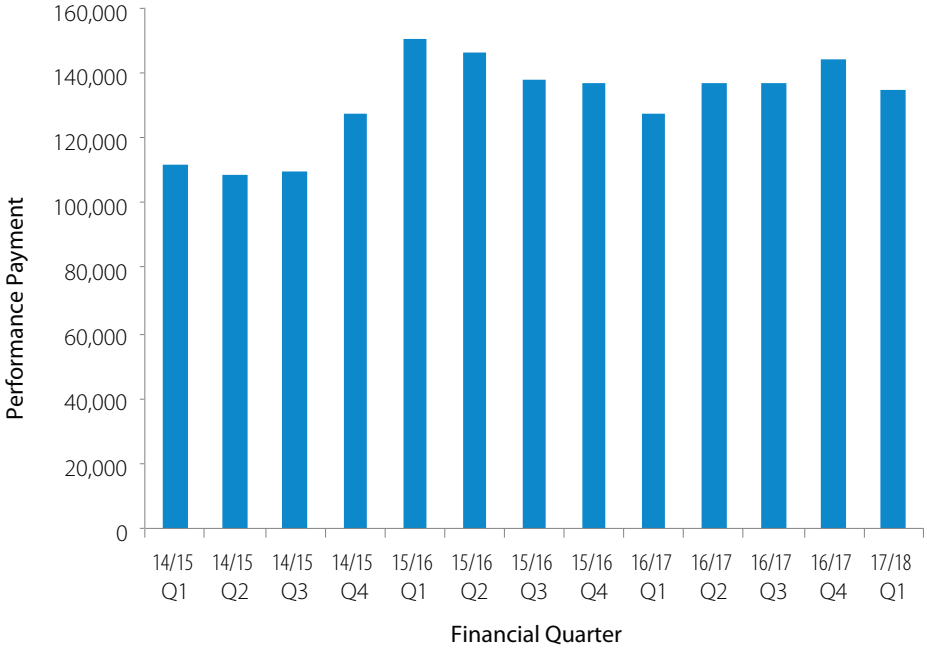
Figure 4: % of NHC practices meeting performance targets at 1/4/17



12 Newborn enrolments were an exception, showing a clear upward trend.

The performance payments increased after the first three quarters of the period shown, and peaked in quarter one of the 2015/6 financial year (i.e., July-September 2015) as shown in Figure 5.

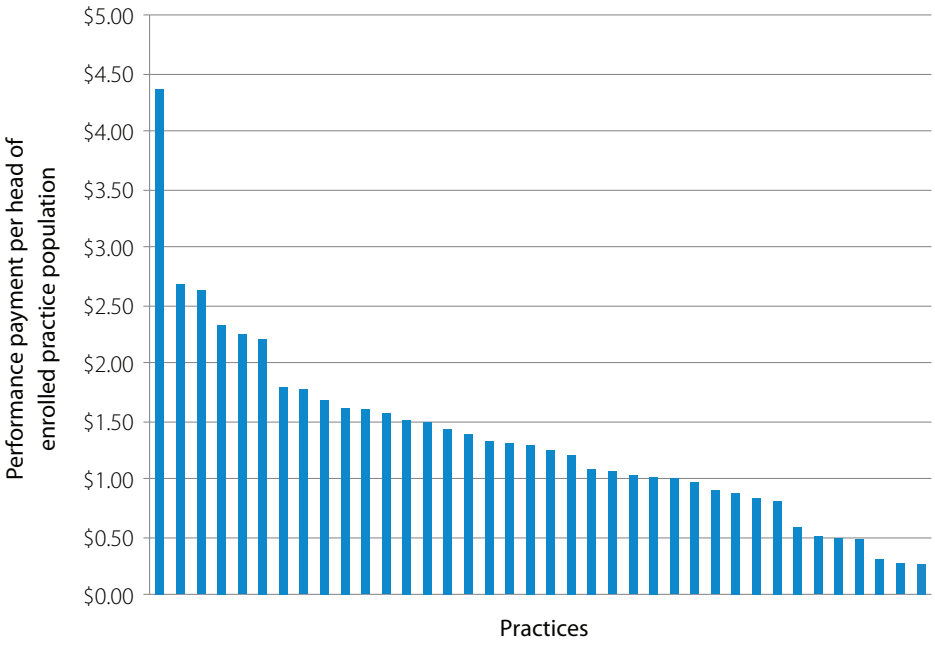
Figure 5: Performance payments increased



The performance payments from July 2014 to October 2017 were dominated by the three largest practices, which made up 28% of the payments during this time. Performance payments are strongly related to practice size; regression analysis showed that 84% of the variation in performance payments is explained by variation in practice size.

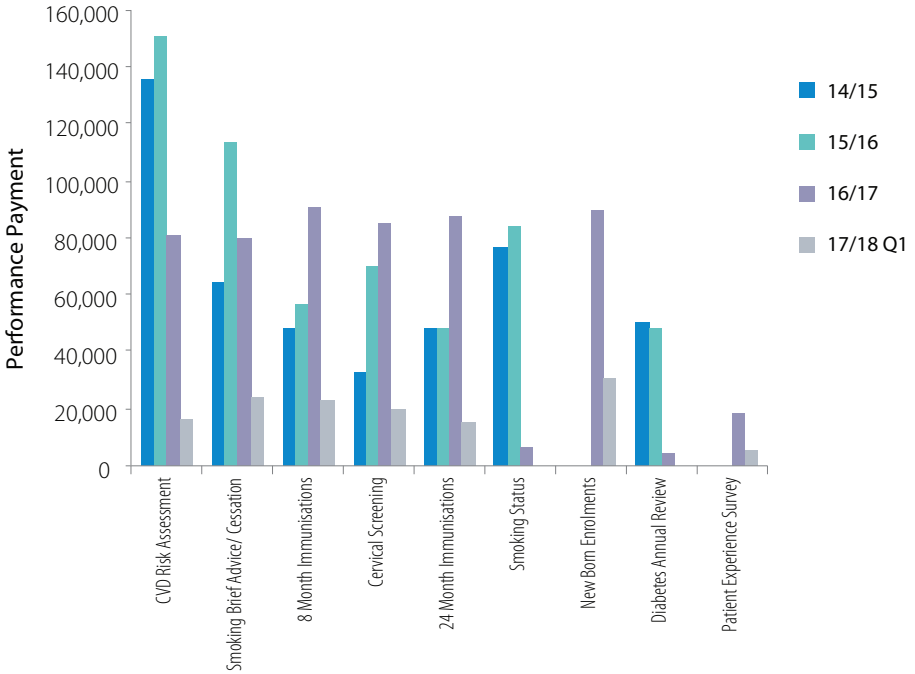
After adjusting performance payments for practice size (by dividing total performance payment by enrolled practice population), per capita performance payments averaged $1.34, with an interquartile range of $0.88-$1.60 (Figure 6). The variation may reflect differences in the composition of the practice population (e.g., by age, gender and ethnicity) in addition to actual differences in performance against targets.

Figure 6: Performance payments adjusted for practice size



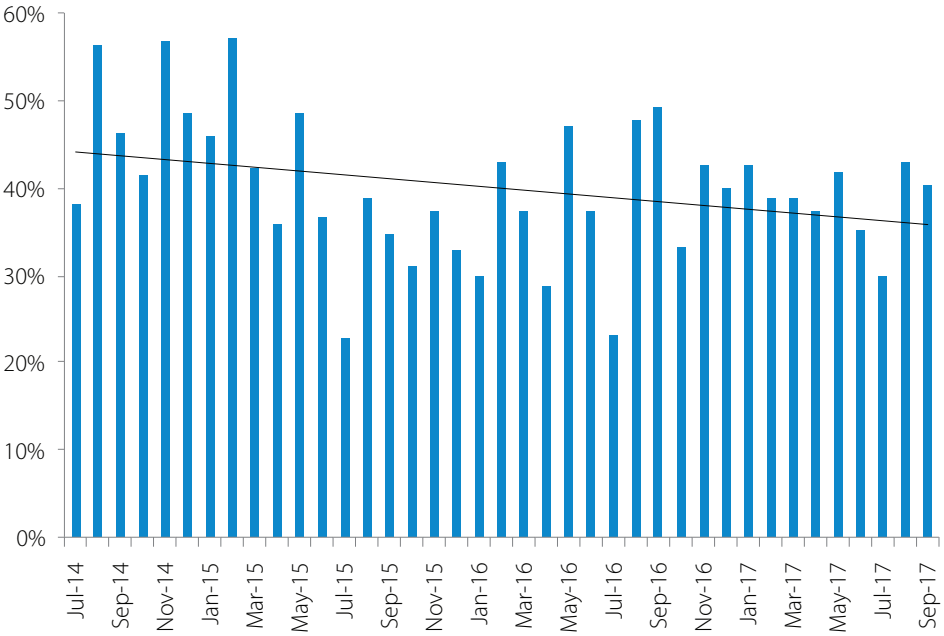
Looking at the performance payment types from July 2014 to October 2017 the cardiovascular disease risk assessment payment initially increased but fell sharply in the 2016/17 financial year. A similar pattern is seen for smoking brief advice and cessation programme based payments. Consistent increases across financial years can be seen for the 8 month immunisation and cervical screening programme payments (Figure 7).

Figure 7: Decreasing CVD and increasing immunisation payments



Overall, unclaimed performance payments are trending down, indicating improvements in performance over time (Figure 8).

Figure 8: Unclaimed Performance payments trending down



Accreditation

It is expected that participating practices achieve Cornerstone Aiming for Excellence Accreditation ('Cornerstone Accreditation'), or that they are on the pathway to do doing so.

At the time of the evaluation, the majority of practices had achieved Cornerstone Accreditation (25/35). Seven practices were progressing towards accreditation (e.g., had date booked), while three practices are up for renewal.

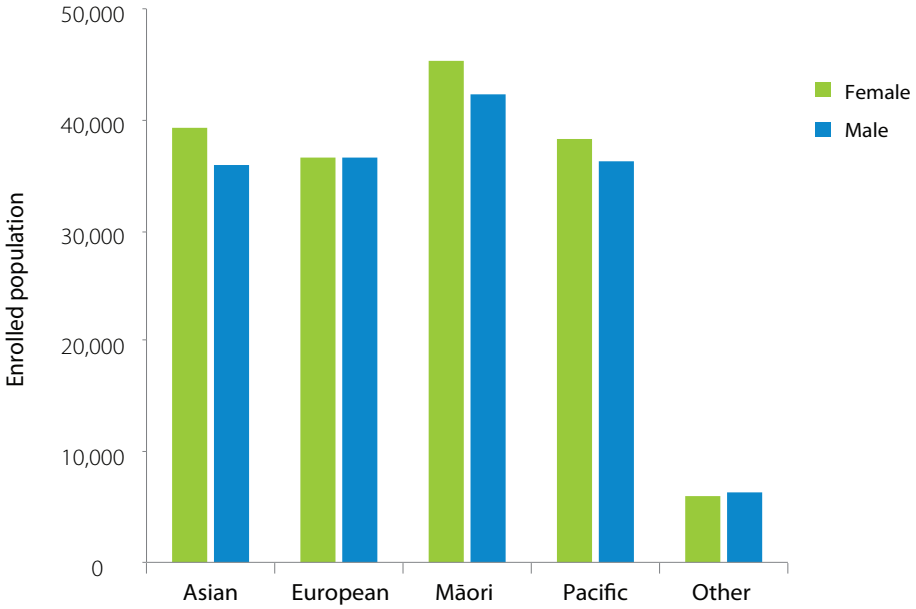
Reduced barriers to access

A key intent of the FFP programme is to reduce barriers to access and uptake of primary health care for Māori, Pacific people and those living in quintile 4-5. Overall, programme data show that the FFP programme is being used by the target population, and that uptake of relevant services have increased. These effects were also reflected in qualitative feedback. Although no patients were interviewed as part of this evaluation, these findings indicate that the programme has led to some improvements in access and uptake of relevant services for the target group.

What does NHC's eligible enrolled population look like?

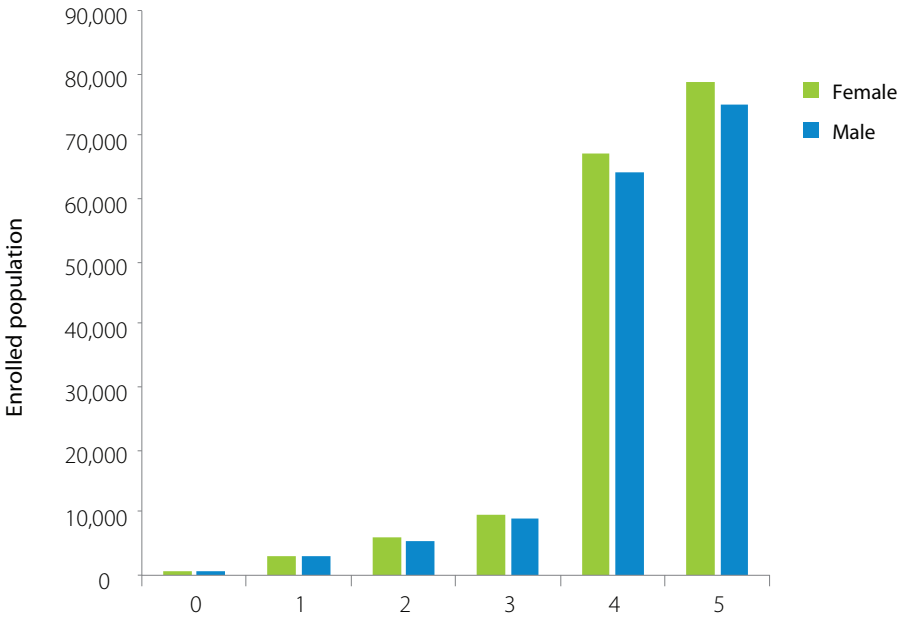
The number of FFP-eligible enrolled patients (i.e., patients enrolled in NHC practices who are Māori, Pacific, and/or living in NZDep quintile 4-5 areas) has remained fairly constant at around 80,000 from quarter four 2016 (i.e., Oct-Dec 2016) to quarter three 2017. During this period, Māori were the largest ethnic group in both genders making up a total of 27.3% of the eligible enrolled population. Pacific ethnic groups made up 23.3%. European and Asian groups also comprised a large proportion of the eligible enrolled population despite being limited to those in NZDep quintiles 4-5 (Figure 9).

Figure 9: NHC eligible enrolled population – Māori the largest ethnic group



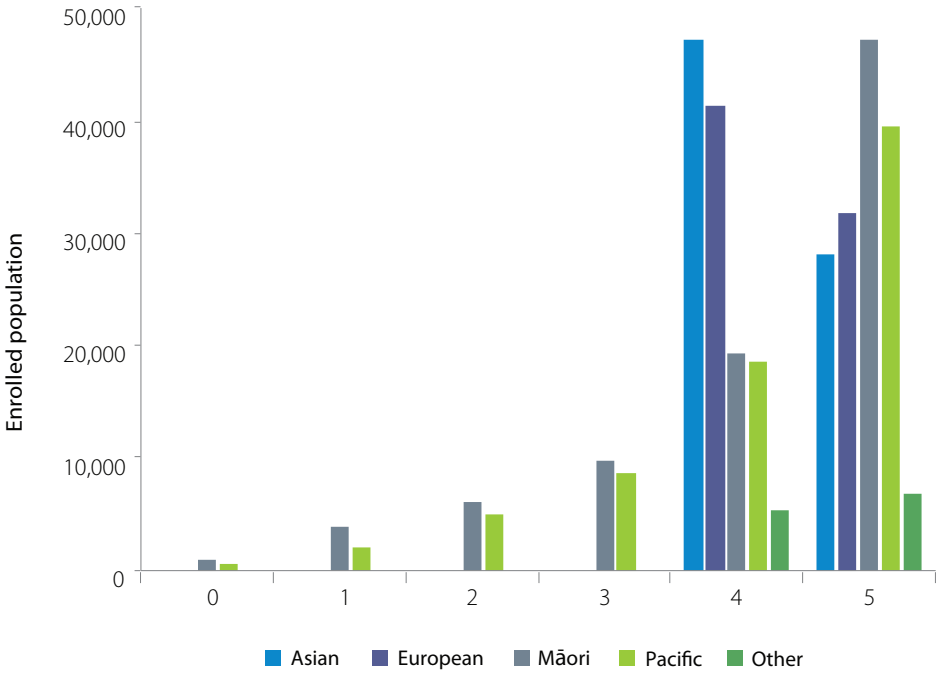
In the 12 months ending 30 September 2017, 88.4% of the NHC's FFP eligible enrolled population were in NZDep quintiles 4-5 (47.5% in quintile 5 and 40.9% in quintile 4). A very small proportion (0.5%) had no quintile recorded and were shown as quintile 0.[13] All of those in quintiles 1, 2, 3 and 0 were Māori or Pacific, consistent with the eligibility criteria (Figure 10).

Figure 10: NHC's FFP eligible enrolled population – quintile 5 the largest group



The largest ethnic groups in quintile 5 were Māori and Pacific; whereas in quintile 4 Asian and European ethnic groups dominated (Figure 11).

Figure 11: NHC enrolled population – Māori in Q5 and Asian in Q4 largest

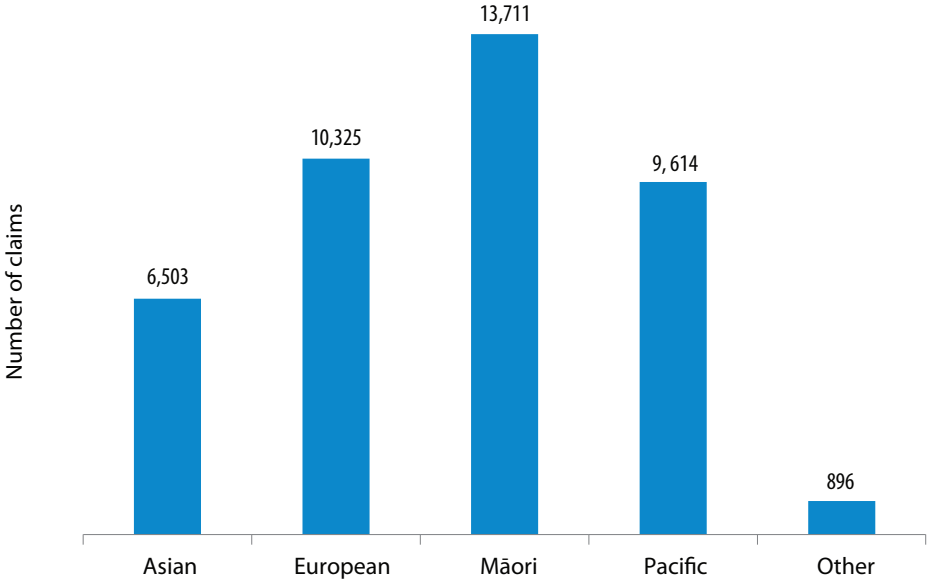


13 Quintile 0 represents those without a dedicated/appropriate address (e.g., homeless; where a new street is not yet registered; or where the wrong address has been provided).

What do FFP claimants look like?

The number of FFP claims averaged around 10,260 per quarter and followed a similar pattern to the total enrolments by ethnicity. Māori had the greatest number of FFP claims followed by European, Pacific and Asian ethnicities from October 2016 to September 2017 (Figure 12).

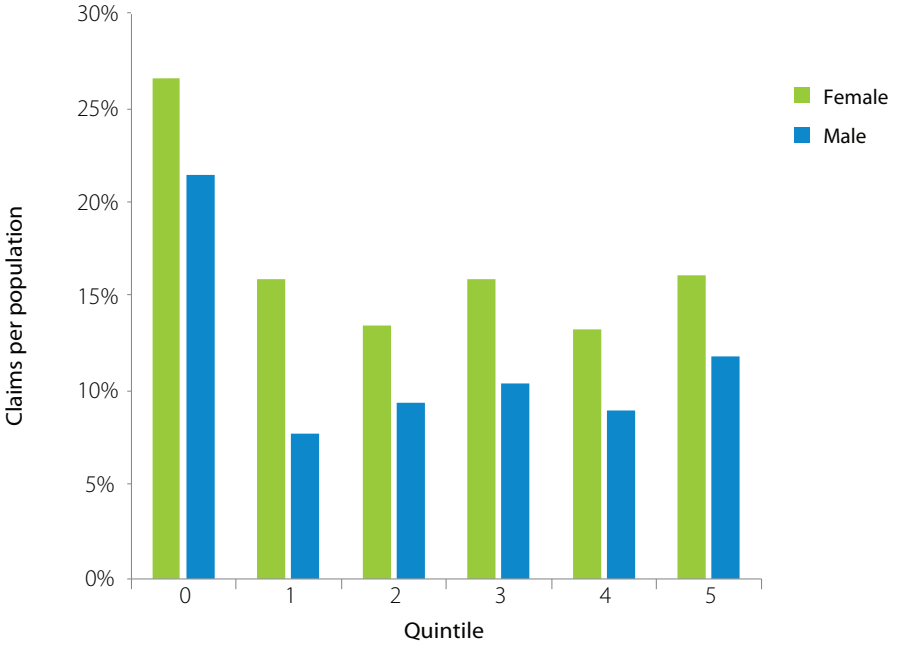
Figure 12: FFP – Māori the largest claims group by volume



Overall, females had a higher claim rate, at 14.9% of eligible claimants, than males at 10.4%.[14] Females had the greatest utilisation across all quintiles. This differential was most extreme in quintile one where the claim rate for females was approximately twice that of males (Figure 13).

Note that quintile 0 had the highest utilisation rates but that this represents a very small percentage (0.5%) of the enrolled population.

Figure 13: FFP – Female claims % of population greater across quintiles

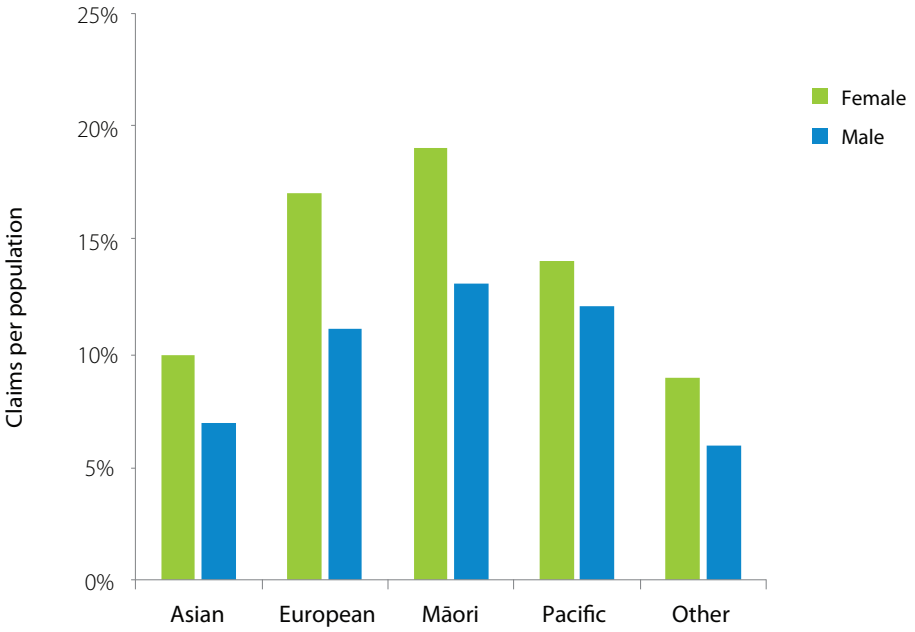


14 Females in Auckland are significantly more likely to visit a GP than males according New Zealand Health Survey data: see http://www.adhb.govt.nz/healthneeds/PHOPHC.htm

Trends in quarterly time series

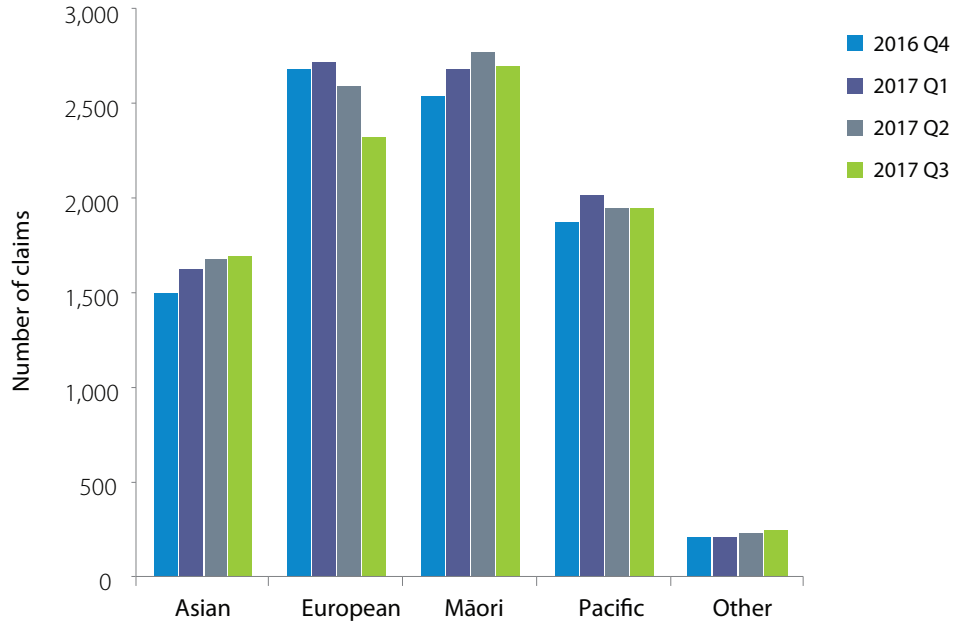
When looking specifically at claim rates by gender in quintiles 4 and 5 from October 2016 to September 2017 (Figure 14), the greatest users of the FFP were Māori females (19.1%) with males of 'Other' ethnicities the lowest users (5.9%).

Figure 14: FFP – Female claims % of population greater in quintiles 4-5



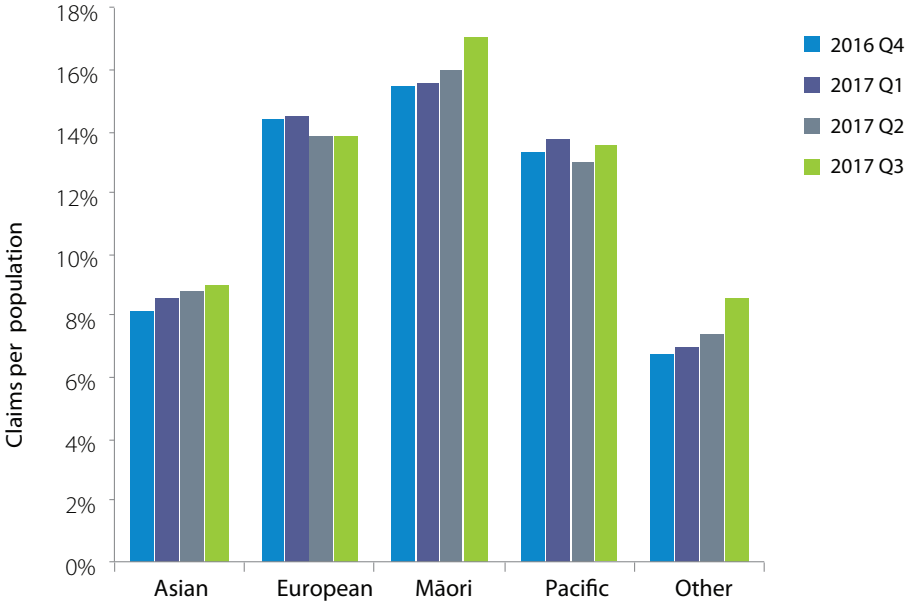
Looking specifically at quintiles 4 and 5 over the relatively short time frame from October 2016 to September 2017, the absolute numbers of claims have decreased for Europeans while increasing for the other ethnicities (Figure 15). A longer time series would be needed to establish whether this is really a trend.

Figure 15: FFP Q4 and 5 – European claims decreased over time



Over this time, for quintiles 4 and 5 the claim rates for Māori, Asian and 'Other' ethnicities, as a percentage of the enrolled population, have increased. The drop in the European utilisation is less pronounced than in the previous chart, reflecting the drop in the enrolled population during this time (Figure 16).

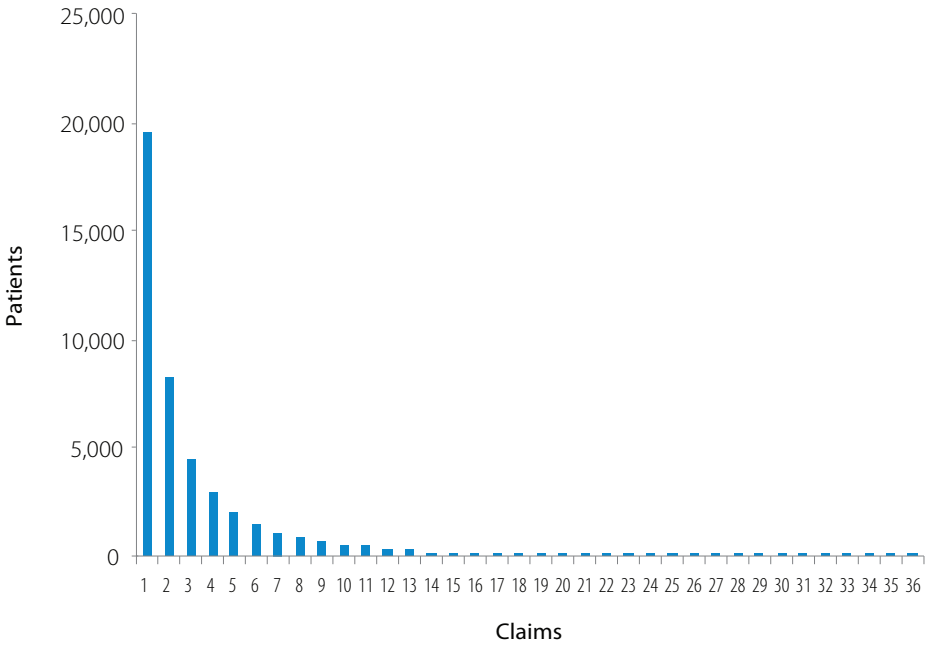
Figure 16: FFP Q4 and 5 – Claims % of population increased for Māori, Asian and Other



What is the frequency of access per patient?

During the July 2014 to October 2017 time period an average of three FFP claims were made per person. Most people (74%) made three or fewer claims; 26% of people made four or more claims and 5% of people made more than 10 claims during this time (Figure 17). One person made 53 claims.

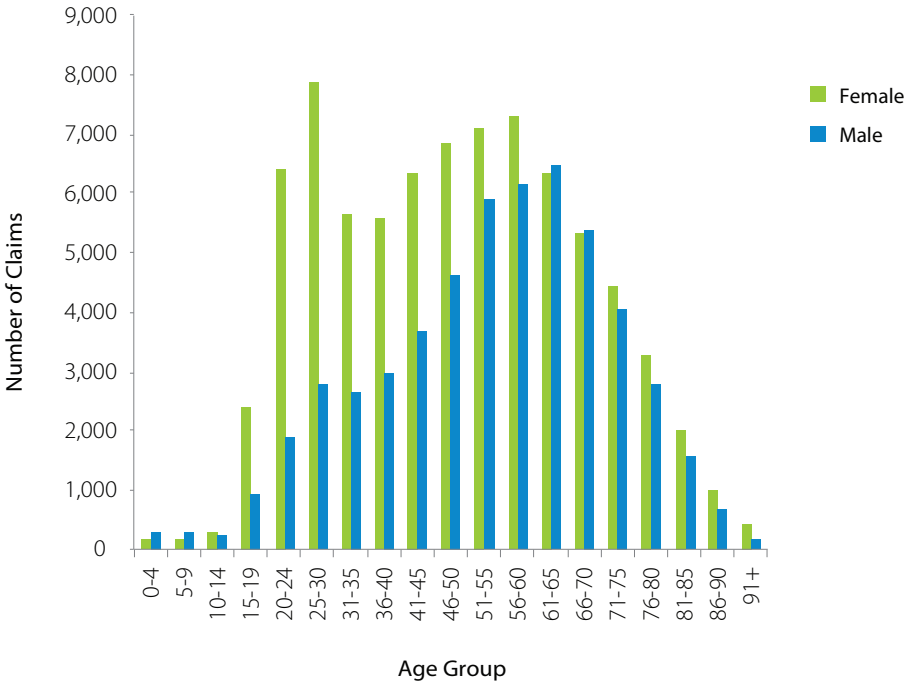
Figure 17: Three quarters of people made three or fewer claims



What volume and value of services are being funded?

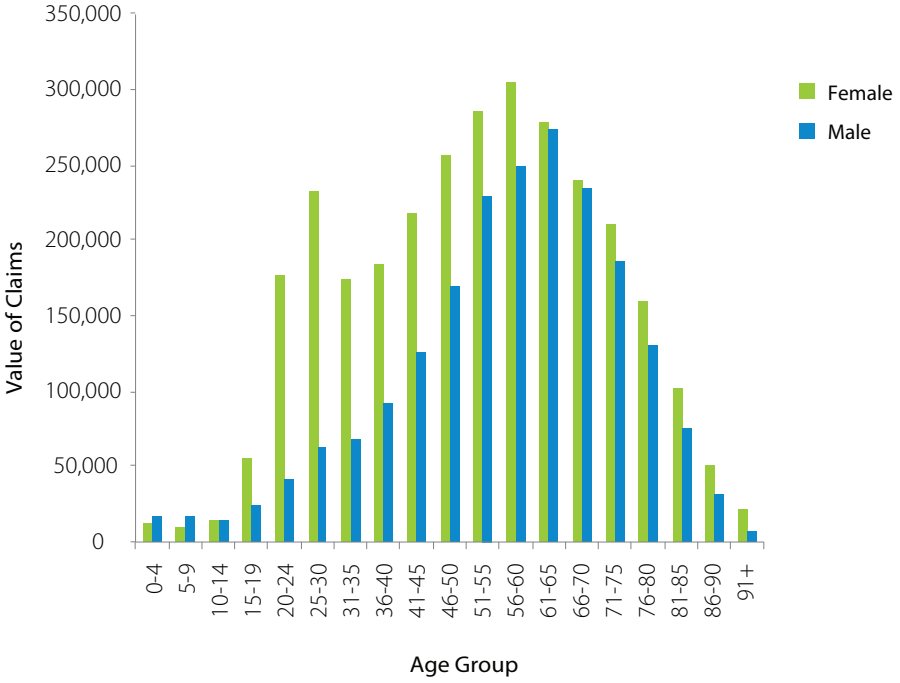
Looking at the profile of FFP claims made from July 2014 to September 2017, there is a skew towards younger/working age females and older males. The number of FFP claims are greatest in the female 25-30 group and remains higher than the claim rates for males through to age 60 (Figure 18).

Figure 18: FFP - Females 25-40 the highest claiming group by volume



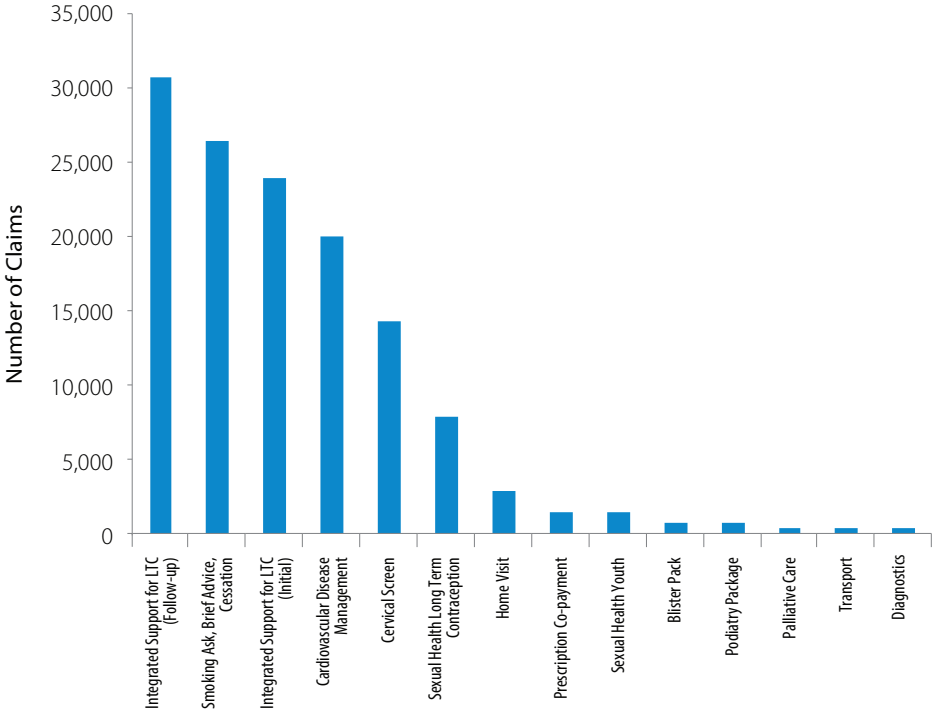
The value of claims from July 2014 to September 2017 (Figure 19) is higher for females than males and increases with age up to a peak at around 60 for both genders, reflecting the higher cost of the types of treatment provided to these age groups compared to younger people.

Figure 19: FFP - Females 51-60 the highest claiming group by value



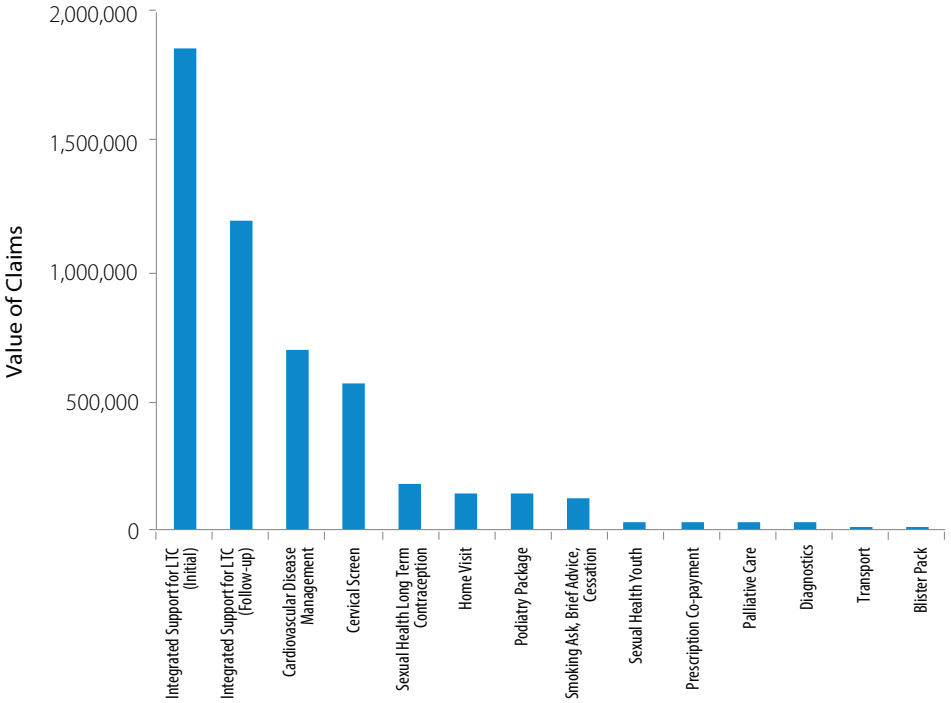
The greatest numbers of FFP claims during the period of July 2014 to September 2017 were related to Integrated Support for LTCs with Smoking Ask, Brief Advice, Cessation and CVD Management the next most frequent (Figure 20).

Figure 20: Greatest number of claims for LTC follow up



The service with the greatest total value was Integrated Support for the initial treatment of LTCs ($1.87 million). The follow up associated with this ($1.20 million) was the next greatest in value (Figure 21). These two items combined made up 60.9% of the total claims during July 2014 to September 2017.

Figure 21: Greatest value of claims for LTC initial



Programme data show that cardiovascular and endocrine conditions dominate claims value. Of all FFP claims made during the period July 2014 to September 2017 these two categories made up almost half of the value of claims (49.2%). The top four conditions collectively accounted for 71% of claims by value (Table 3).

Table 3: Cardiovascular and endocrine conditions dominate claims value

Conditions	Claim value	
Cardiovascular	$789,015	25.6%
Endocrine including Diabetes	$727,917	23.6%
Moderate – severe mental health	$352,626	11.4%
Respiratory	$319,139	10.4%
Neurological	$183,401	6.0%
Gastrointestinal	$155,507	5.0%
Musculoskeletal	$151,382	4.9%
Rheumatological	$113,844	3.7%
Dermatological	$82,221	2.7%
Non end stage malignancy	$70,003	2.3%
Genitourinary	$41,429	1.3%
Renal	$40,243	1.3%
Gynaecological	$31,179	1.0%
Other Rheumatological	$22,249	0.7%
Total	**$3,080,154**	**100.0%**

The total value of claims increased from financial Q1 2014/15 (i.e., Jul-Sep 2014) until Q1 2015/16 before levelling off, with a trough in September 2017 (Figure 22). The value of female claims was greater than for males in every quarter (Figure 23). We investigated seasonality in these data series but no strong seasonal patterns were evident.

Figure 22: Value of claims by quarter fairly level since 2015/16

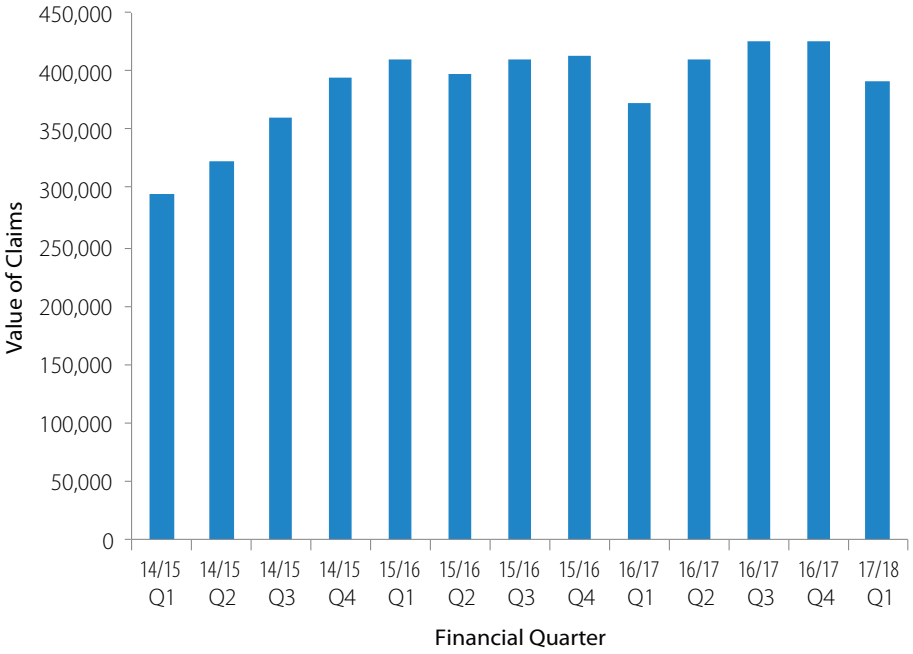
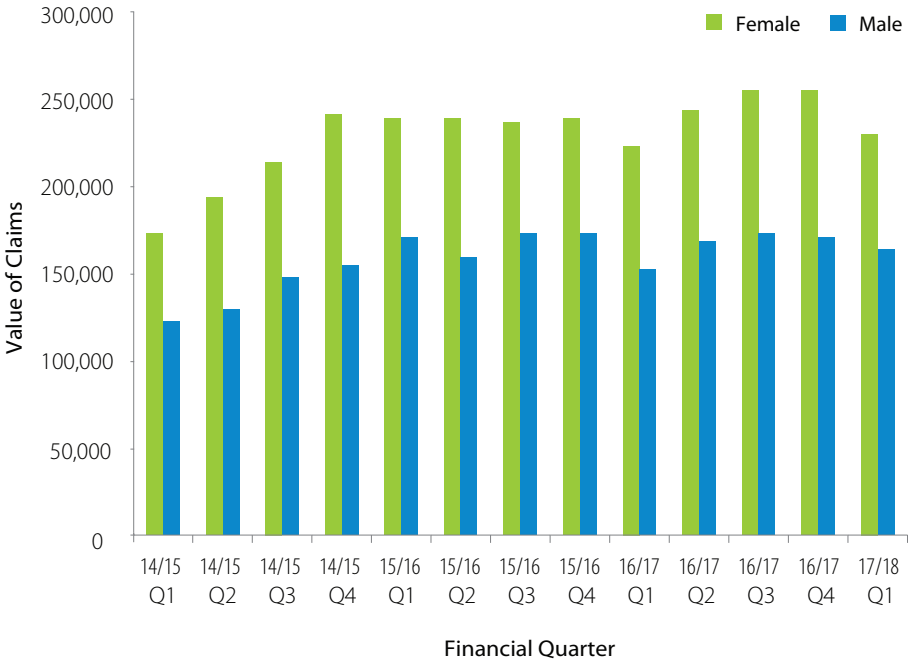


Figure 23: The value of female claims has remained greater than males



What do stakeholders think?

Nearly all survey respondents (n=40/44;91%) were satisfied that *'the FFP helps break down barriers to accessing care'.* Three people felt neutral about the statement, and one person was dissatisfied.

Similarly, nearly all interviewees considered the FFP supports reduced barriers to care. Many acknowledged that cost is a substantial barrier for their high needs patients, and that through the FFP programme practices are able to reduce or remove the cost associated with accessing FFP funded services. As a result they have noticed a reduction in declines, and higher uptake of follow up visits and other consultations.

> *When I first came down here, it was hard to get people. You'd recall them but not get them in. Now, they come because money is a big issue for a lot of these people.* (Practice Manager)

> *It's easier to convince someone to come in for a service, if we can say there is no charge for that.* (Practice Manager)

> *Yes it does improve access/uptake for our high-needs patients.* (GP owner)

Another GP had noticed benefits beyond her own patients.

> *The benefits are far-reaching, they bring their family and friends who have access issues. So I think that impacts on the community at large so I think it's a system that helps provide better outcomes for us. I've been here [at the practice] for 10 years and its slowly happening.* (GP)

The majority of survey respondents (n=32/44;73%) were satisfied that *'the FFP is targeted to the people who need increased access to services the most'.* Nine people felt neutral about the statement, and three people dissatisfied.

Again, survey data reflect interview feedback with nearly all interviewees perceiving the programme to be targeted to people who need increased access. However, nearly all interviewees, and some survey respondents too, expressed concern that many high needs patients who are not Māori or Pacific, but yet unable to afford services reside in quintiles 1-3 and therefore cannot access the FFP programme. The extent to which this was an issue varied across practices (e.g., some practices, particularly the larger ones, encountered this issue daily while for others it varied from 1-5 patients per month to 1-3 patients per year).

Examples were provided of: patients living in garages or sleep outs on a relative's or friend's property; patients who are "resource rich but cash poor"; poor elderly patients living in care homes in low quintile areas; and streets where one side is well off and the other is low income. Conversely, there are people who reside in quintiles 4-5 who are sufficiently well off to be able to pay for services.

Therefore, while it was acknowledged that the inclusion of quintile 4 in the eligibility criteria had helped increase accessibility, stakeholders questioned whether the measure of small area deprivation (i.e., NZDep quintile) rather than individual deprivation as the basis for eligibility is appropriate and most conducive to increasing access to those most in need.

> *Quintility is complicated […] and not best way to measure socio- economic status.* (GP)

> *FFP funding does nothing for the long-term disabled who are neither Māori nor PI nor quintile 4/5. It does benefit those who are well-off living in Q4/5 areas and those Māori/PI who are well-off.* (Practice owner/survey respondent)

> *We have quite a strange set up where you have one million dollar beach houses next to very low-income areas… and so the quintile 4-5 doesn't really reflect the needs of the patient.* (Nurse/ Practice Manager)

NHC recognises the issues noted by stakeholders in regards to eligibility. However, they note that there are challenges associated with individual deprivation measures too (e.g., self employed people who pay themselves a low salary); "there is no perfect way – targeting is imperfect".

Contribution to clinical outcomes

Due to issues of attribution and the types of evaluation data available, it was not possible to measure clinical outcomes directly as part of the evaluation. Instead, the ***potential*** clinical contribution to outcomes was inferred from FFP effects on quality and access – i.e., ***if*** FFP supports quality care and reduced barriers to access, then it could potentially contribute to better clinical outcomes (see Figure 1).

Findings outlined in the previous sections indicate that the FFP programme contributes positively to quality and that barriers to access are reduced. For example, systems and processes (e.g., Mōhio forms) help reinforce adherence to clinical guidelines, resourcing enables more involvement by nurses in patient care, and expectations around Cornerstone accreditation ensures high standards across the practice network. Findings also show that FFP funding enables practices to offer services at a reduced cost, or free of charge, and eligible patients are accessing these services. It may therefore be inferred that the FFP programme could contribute to better disease management.

Stakeholder feedback reinforces the suggestion that the FFP programme may contribute to clinical outcomes. The majority of survey respondents (32/44;73%) were satisfied that *'the FFP contributes to better disease management'.* Eleven people felt neutral about the statement, while one person felt dissatisfied.

Further, the vast majority of interviewees believed that the FFP programme contributes to clinical outcomes, including better disease management, less acute presentations and likely, reduced hospitalisation.

> *It definitively improves access – and definitively allows you to get people in more often, to follow up the next day, which should reduce hospitalisation. It allows us to manage more chronic conditions, I think, more easily.* (GP)

> *Over the years, we've seen the patients' health conditions improve because they have that access.* (Practice manager)

> *I have done audits around diabetes, and we have clinically improved our diabetes population. I have been allowed to spend time with patients, whereas we didn't have that before. We're seeing less acute presentations now too I think… this might be because people's health is better managed.* (Nurse/ Practice Manager)

> *Enables nurses and GPs to spend more time with high needs patients with chronic conditions – over the years it would seem this group are better managed.* (Nurse; survey respondent)

Furthermore, some stakeholders highlighted that although those who access FFP services may have better outcomes, there is still a large proportion of the high needs population who do not benefit. This observation offers a qualitative counterfactual, adding further weight to the suggestion that FFP supports clinical outcomes:

> *So, in the context of a high-needs population, if you suffered from a condition not 'supported' by the FFP or if you live on the 'wrong' street and are 'classified' as not high needs (while you may actually be high-needs) there is no help!* (GP owner)

Satisfaction

KEQ2: How satisfied are providers with the FFP?

Satisfaction with the FFP programme was somewhere between moderately high and high. For those who did not express satisfaction with the programme or particular aspects of the programme, the vast majority felt neutral rather than dissatisfied. For example, when asked *'How satisfied or dissatisfied are you with the FFP programme overall?'*, the majority of survey respondents (26/44;59%) were satisfied, 17 neutral and only one dissatisfied.

Amongst the majority of interviewees, the experience with the FFP programme currently was positive. Views ranged from being 'very happy' with the programme to considering it 'ok' or having 'pros and cons'.[15]

Those who had experience with the FFP programme since it was first implemented agreed that the programme has improved over time. In particular, it has become more flexible in terms of how the funding is managed, and more equitable in that it expanded eligibility to patients living in quintile 4 areas. Also, technical teething issues have been addressed (e.g., slow loading of Mōhio forms etc.).

> *I like how the funding is available across the whole suite of services, instead of separate areas. Now you can use the funding for whatever your population needs.* (Practice Manager)

Many stakeholders were complimentary of NHC staff, and had found their Mōhio support in particular very good.

> *I think the Mōhio personnel are the most wonderful people, highly responsive and provide a very high level of IT support and expertise.* (Nurse)

> *NHC – if we approach them for some reason, they are always happy to listen and be flexible around some things.* (Nurse/ Practice Manager)

The following sections provide more detail around stakeholders' satisfaction with the FFP programme structure and operational aspects.

Programme structure

The vast majority of survey respondents (34/44;77%) were satisfied that *'the services available under FFP (e.g., Sexual Health – Long Term contraception, Cardiovascular Disease Triple Therapy, Reduced cost of access to podiatry, etc.) match the needs of our high needs population'.* Eleven people felt neutral, and four dissatisfied.

Similarly, the majority of interviewees believed that the FFP programme matches the needs of their high needs patients in terms of the types of services available, and reducing the cost barrier.

> *It does serve the population group of high needs patients that it's intended to service.* (Nurse/ Practice Manager)

There were some suggestions for additional services, including dental and electrocardiogram[16] and feedback from two practices indicate that there are no funded podiatry services in their areas.

15 Three interviewees expressed dissatisfaction. Amongst these, there were individual issues that do not necessarily reflect the effectiveness of the programme, including Mōhio not being compatible with the patient management system in one practice (thus adding to staffs' administrative workload) and for one stakeholder, what appears to be a lack of understanding of how to use the Mōhio system (e.g., questioning why it is not automated when in fact, this is a key feature). Another issue was the lack of flexibility around the eligibility criteria, as discussed previously.

16 Skin cancer removals were also suggested; NHC acknowledged this but noted it is not part of the population health focus that underpins the FFP programme.

In terms of how funding is allocated, the majority of survey respondents (27/44;61%) were satisfied that *'the way that FFP funding is allocated works well for our practice (i.e., 25% for quality improvements; 25% for meeting National Health Targets; and 50% flexible funding)'.* Eleven survey respondents felt neutral about the statement, five dissatisfied and one did not know/felt unsure.

Similarly, the majority of interviewees found the funding structure to work for their practice. However, some commonly raised concerns centred on funding; in particular on the amount of funding available and how funding is allocated.

> *It [FFP funding] certainly helps to improve quality of care, but it is nowhere close to bridging the gap between the funding needs and actual funding provided to service a high-needs population in particular.* (GP owner)

> *The way the funding is allocated could do with a little more clarity.* (Practice Manager)

> *For mental health, funding seems to run out really quickly.* (Nurse)

> *It needs to be easier. Sometimes they give money for things I cant use, and other times, money for things I need I can't get.* (GP owner)

Some of the concerns raised reflect that there are limited funds available for the range and intensity of needs the FFP programme is intended to meet – as well some possible misconceptions and confusion around the policy intent and purpose of the FFP, how FFP funding is allocated, where practice funding comes from more generally, and how it is claimed. The issues raised and the NHC's responses to these issues are outlined in Appendix C.

Further, in regards to funding, a few stakeholders did not perceive the relative values of claimable items to accurately replicate time put in by clinical staff (e.g., in regards to youth sexual health) and suggested these be reviewed.

The majority of interviewees were satisfied with the quality component of the funding – acknowledging that quality standards are important to them. However, a few stakeholders expressed some frustration with the cost and complexity associated with Cornerstone accreditation. It was suggested that Foundation Standards[17] are less complex and more reasonable for practices to achieve.

Interviewees were generally content with the health target component of the funding. However, there were some who had reservations about this approach.

> *Quality or incentivised payments have their benefits and risks too. It is not uncommon to have practices focus on the numbers as the revenue is attached to the attainment of these targets where they run the risk of ignoring the multitude of other health conditions which are equally important to address and get right!* (GP owner)

> *Performance indicators have shown around the world to worsen care, rather than improve it.* (GP owner)

Two interviewees had recent experiences with other PHOs – and both were complementary of NHC and the FFP programme, finding it more transparent and user-friendly.

17 Foundation Standard is the entry-level criterion for general practices in the Ministry of Health Performance Incentive Framework and in the PHO Services Agreement.

> *It's a very transparent system as well. We know everything upfront, we know exactly what our contracts are, we know exactly what percentage of our patients are funded, we know exactly how much funding is available, we can use that and we can see how we're using it, we can track how much we have left, we know what administration fees are deducted. We never were given this information with our previous PHO. We worked in the dark completely. (*Practice manager/owner)

On the other hand, some stakeholders were concerned about practices not retaining their un-spent budgets (see Appendix C) and felt NHC could be more transparent about what this money is used for.

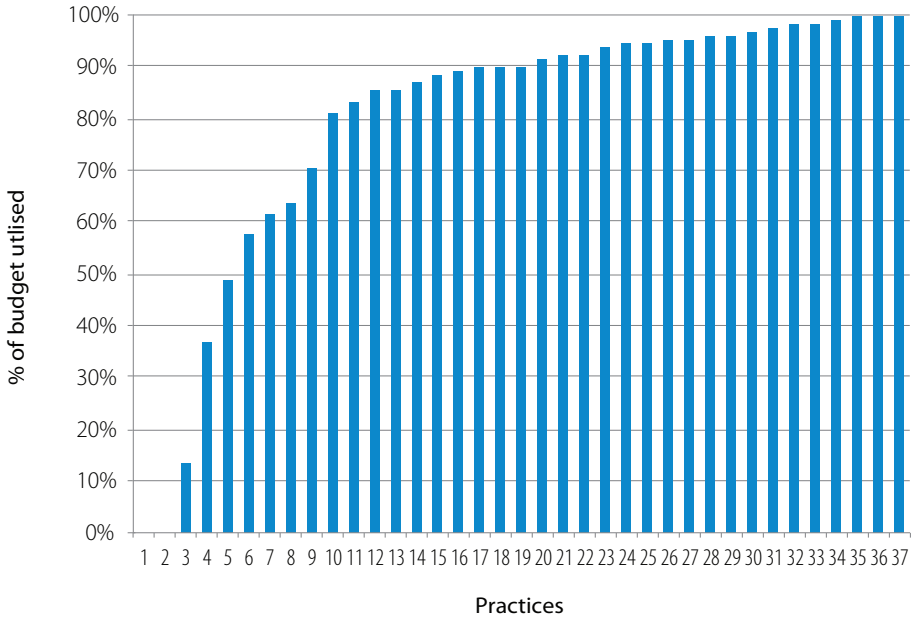
To what extent have practices utilised their available budgets?

To complement the qualitative feedback around funding, this section illustrates the extent to which allocated FFP patient and population budgets are claimed.

Looking at individual practices over the July 2014 to October 2017 time period half (19/37) of practices utilised over 90% of their budgets, and three-quarters utilised over 80% of their budgets. Five practices utilised less than half of their budgets, including two that were recorded as utilising none of their budget.[18] Overall 88.2% of the budget was spent. In total $675,180 (11.8%) of the budget remained unspent.

When matching qualitative feedback with that of individual practice data, it appears that in most instances where practices used less of their budgets, technical difficulties and/or a lack of understanding of the programme were identified or acknowledged. For some practices, it is merely a reflection that they have recently transitioned to the NHC's practice network.

Figure 24: Most practices spent the majority of their budgets



18 Note: The two practices utilising none of their budget are practices that have just enrolled with the NHC.

Operational aspects

Overall, stakeholders were satisfied with the operational aspects of the programme, and systems and processes appear to be working well.

The majority of survey respondents (25/44;57%) were satisfied that *'the administrative side of the FFP programme (e.g., claiming, reporting) is not a burden.'* Eleven respondents felt neutral about the statement, while five (GPs only) felt dissatisfied (this represents the highest level of dissatisfaction in the survey) and one person did not know/felt unsure.

On the other hand, the vast majority of survey respondents reported that they are satisfied that *'the Mōhio forms are user-friendly'* (33/44;75%). Eight felt neutral and three dissatisfied. Further, the vast majority of survey respondents (37/44;84%) were satisfied that *'it is easy to identify those eligible for services available under the FFP programme'.* Four felt neutral and three dissatisfied.

Interview feedback was consistent with survey data. The vast majority of interviewees found the claiming and reporting aspects of Mōhio user friendly. A recent upgrade of Mōhio, including 'Mōhio Express' (a sidebar that provides prompts and notifies the user of patients' eligibility to the FFP programme and what recalls are coming up) was duly noted. Some went as far as saying Mōhio was the best system they had ever worked with.

> *I love [Mōhio], really proud to say have worked with NHC, it's the best programme I have seen.* (Practice Manager/nurse)
>
> *The advanced forms that are used for reporting and claiming are very quick and easy to use and the Mōhio upgrade has made it faster and simpler to use. (Practice Manager)*
>
> *Grateful for the MŌHIO EXPRESS it does help me a lot to pick up areas that are not complete.* (Nurse; survey respondent)
>
> *The administrative processes are simple and straightforward. The ease of using these tools [Mōhio express] makes the exercise enjoyable in comparison to the rather complex idiosyncratic systems/tools [used by another PHO] which made life difficult for the clinicians to use which just made an already difficult clinical job worse.* (GP)

In contrast, a few (n=3) stakeholders were less satisfied with the Mōhio system. However, the frustrations they raised (having to check for eligibility manually, having to manually copy over patient care plans to Mōhio, not having time to make claims) appear to be more related to a lack of understanding of how to make best use of the system, than any failures of the system itself. One additional stakeholder felt she does not "understand the system very well". She acknowledged that the NHC had provided her with some support already, but thought she could benefit from more.

FFP programme specific reports (such as claims and budget reports), health target reports and real time data, were greatly appreciated amongst the majority of interviewees. They have helped streamline reporting processes, increased access to information, and enabled practices to address their status against their targets more directly. Practice managers and nurses were those who most frequently used reports and data, for keeping track of targets, budgets, and claims and for recalls respectively.

> *Before, I used to rely on the query builder in Medtech – but if you're not a data analyst and don't build correctly it takes a lot of time. Mōhio is easy.* (Nurse/Practice Manager)
>
> *We have chats all the time about how to address targets.* (Practice Manager)
>
> *The real time status for each target, its very good and useful. It just tells you very clearly where you are at.* (Practice Manager/Owner)

Some stakeholders expressed frustration with 'declines' (e.g., those who decline vaccination) not being counted towards performance targets.[19] For smaller practices with smaller populations this can impact significantly on their ability to meet targets.

> *Periodically we miss this category [vaccination], because of decliners. That loses us the top-up funding. When perhaps we have four people and one declines, that's 70% [sic] achievement. That's frustrating.* (Nurse/Practice Manager)

NHC acknowledged the frustration around this issue. However, it is a Ministry of Health requirement to count decliners in the denominator; e.g., they show up as 'not immunised' rather than declined. These are the data definitions used for the national health targets. Further, it is a Ministry of Health expectation that those who decline immunisation are asked again on a continuous basis.

Opportunities for improvement

KEQ3: What are the opportunities for improvement?

Opportunities for improvement have been identified through systematic analysis of the collected evidence against the evaluation criteria, as well as by asking stakeholders directly.

The primary concern was the issue of eligibility. At the core – defining high needs populations and thus those eligible by the area they reside in was considered flawed. Because NZDep2006 measures small area deprivation, rather than individual deprivation it does not capture high needs patients residing in lower quintile areas. Conversely, it includes people who are well off, but reside in quintile 4 and 5. This means that high needs patients who cannot afford services may be missing out – and feedback from practice stakeholders, especially in the larger practices, indicates that this is a real issue they encounter reasonably frequently.

Area measures of deprivation are complex, and while there are benefits with this approach an acknowledged weakness is measurement errors when applied to individuals.[20] Some academics have argued that an area based-strategy alone is not an appropriate measure for targeted interventions – "because not all deprived people live in deprived areas" (p.110) – and that other measures of socio-economic position should be included (in addition to ethnicity).[21]

Developments are occurring in this regard, such as the New Zealand Indices of Multiple Deprivation, which represents a shift in the theoretical and methodological approach to area measures of deprivation.[22] In the future this may bring some better measures.

19 It should be noted that this is a Ministry of Health requirement, and not within NHC's control.

20 White P, Gunston J, Salmond C, Atkinson J, Crampton P. 2008. Atlas of Socioeconomic Deprivation in New Zealand NZDep2006. Wellington: Ministry of Health.

21 Blakely T and Pearce N (2002). Socio-economic position is more than just NZDep. ***New Zealand Medical Journal***. March 8;115(1149);109-11.

22 Exeter DJ, Zhao J, Crengle S, Lee A, Browne M (2017) The New Zealand Indices of Multiple Deprivation (IMD): A new suite of indicators for social and health research in Aotearoa, New Zealand. ***PLoS ONE*** 12(8): e0181260. https://doi.org/10.1371/journal.pone.0181260

Considering it is the FFP programmes' key objective to reduce inequalities (bearing in mind that Māori and Pacific peoples are key priority populations in line with the original SIA policy purpose) the evaluators' recommend that ***NHC considers ways to address issues around eligibility for other high needs populations***. As suggested by stakeholders, this may involve:

- Introducing a discretionary pool that practices can use for those who fall outside of the eligibility criteria but they know are high needs; and/or
- Looking at alternatives to the current criteria, such as replacing quintile 4 and 5 with, or extending it to include Community Services Card Holders.

It should be acknowledged that there is likely no perfect way to ensure full equity. As acknowledged elsewhere in this report, there are flaws associated with both individual and small area deprivation measures, and NHC expressed concern that providing more flexibility to practice staff may have a reverse effect in accordance with the inverse care law theory.

As would be expected, the FFP programme appears to be working well in practices where the programme is well understood. However, evaluation findings indicate that there are some practice stakeholders who do not fully understand the policy purpose of the programme, how funding is allocated and for what, how FFP funding complements other types of funding (e.g., DHB funding) and how to best use Mōhio. This lack of understanding seems to contribute to frustration and reduced satisfaction with the programme, and is likely to also influence practice performance and claiming.

There is an opportunity for NHC to ***provide more clarity around some of the areas that are less understood*** by many stakeholders (see Appendix C) – perhaps through an updated programme guide. Additionally, some proactive outreach from NHC to a few isolated individuals who appear to be struggling with the Mōhio system may be of benefit.

Another issue amongst some stakeholders was a perceived lack of transparency around what happens to the unspent portion of practice budgets. There is an opportunity for NHC to ***be more transparent about how unspent budgets are disbursed*** (e.g., through regular reports) and be clear about how and why it works this way.

- Common themes:
  - Review, in consultation with practices, the alignment between time clinicians spend on claimable items versus amount currently allocated
  - Allow more flexibility around palliative care visits (numbers and time-frame).
- Suggestions from individuals:
  - Enable continuous follow-up visits after one year for those on LTC programme[23]. Doing another 'initial' consultation at this stage was deemed unnecessary; money saved could be used for something else
  - Hold practices accountable for ongoing management of LTCs (e.g., for CVD risk management, measure and ***award*** for dual and triple therapy – or withdraw funds if not done).

It was also suggested that more ongoing support to meet performance targets is provided by the NHC throughout the year, rather than focusing on this at the end of the financial year. At the time of writing, the NHC was already developing processes for doing so (e.g., text message and phone support had been initiated for Smoking Brief Advice and Cessation), funded through unspent FFP programme budgets.

23 Up to four visits, including one extended initial consult, per specified diagnosis can be claimed per year.

4. Conclusion

Evidence from a range of sources, including programme data, survey responses and qualitative feedback from practice staff indicate that the FFP programme is effective by supporting quality clinical care (e.g., the programme's systems and processes help ensure that clinical guidelines are more consistently adhered to; resourcing allows for enhanced nurse roles; performance payments incentivise practices to meet national health targets; and expectations around quality accreditation ensure high standards across the practice network) and reduced barriers to care (by enabling practices to offer services free or at a reduced cost).

Due to issues of attribution and the types of evaluation data available, it was not possible to directly measure clinical outcomes. However, it is reasonable to suggest that as a result of improved quality and improved access to and uptake of relevant services, the FFP programme should contribute to improvements in the management of conditions covered by the programme (for those who get access). Further, feedback from stakeholders indicates that they observe FFP contributing to improved disease management and better clinical outcomes in their practices.

Findings indicate that the programme, including its systems and processes, are better understood by some stakeholders than others, and that the programme is more effectively managed (e.g., better utilisation of budget, reports are utilised, claims are tracked and monitored) where this is the case. It is likely that providing more information about the policy purpose of the programme, and how to make the most of it, along with some targeted individual support would increase effectiveness further.

A key policy purpose of the FFP programme is to reduce inequalities, particularly for those populations that are known to have poorer health outcomes: Māori, Pacific people, and those living in quintiles 4 and 5. The programme does effectively service these target groups and appears to reach the majority of those with relevant needs but because quintiles are based on small area deprivation measures, it appears that some people with high needs who reside in the 'wrong' geographic areas are missing out. Conversely, there may be people who are not high needs but who happen to reside in a high quintile area are advantaged, effectively reducing the opportunity for those in need to benefit from an already limited funding pool. This was a key concern amongst stakeholders.

The NHC has already made attempts to address the issue of inequality by extending the Ministry of Health's definition of high needs (quintile 5) to include quintile 4. However, it appears that further adjustments may be desirable to address the access issue for patients who are eligible but who miss out on the FFP programme.

Appendix A:

Evaluation Methods

Evaluation specific methodology

Evaluation differs from research because it involves making explicit judgments about how good a programme is, and whether it is 'good enough'.[24] Making these judgments requires a clear, transparent, agreed set of criteria stating what the evidence would look like at different levels of performance. To make evaluative judgments it is first necessary to define what the intended outcomes are. Accordingly, the evaluation team facilitated a workshop with the NHC in October 2016 to understand the programme logic including its intended outcomes. A set of evaluative rubrics (Table 4) were then developed for making judgments about the expected outcomes (as set out in the outcomes logic on p. 11) – addressing KEQ 1.

24 Davidson, E.J (2005). Evaluation Methodology Basics: The nuts and bolts of sound evaluation. Thousand Oaks, California. Sage Publications.

Table 4: Evaluative rubrics

Performance level	Quality clinical care	Reduced barriers to access	Contribution to clinical outcomes
Strong	All practices meet minimum standards and achieve accreditation Practices consistently meet or exceed national health targets FFP has led to significant improvements in all of the following areas: engagement with patients, adherence to clinical guidelines (including greater consistency between practices), *and* enhanced nurse roles	FFP has led to significant improvements in access and uptake of relevant services by all target groups: Māori, Pacific, and quintile 4-5 patients	FFP has led to significant improvements in disease management as evidenced by uptake of relevant services, and quality improvements.
Moderate	Most practices meet minimum standards and achieve accreditation Nearly all practices meet most national health targets FFP has led to some improvements in adherence to clinical guidelines (including greater consistency between practices), engagement with patients, and enhanced nurse roles	FFP has led to some improvements in access and uptake of relevant services by Māori, Pacific, and/or quintile 4-5 patients	FFP has led to some improvements in disease management as evidenced by uptake of relevant services, and quality improvements.
Acceptable	All practices are working toward meeting minimum standards with a view to achieving accreditation Most[25] practices meet most national health targets FFP supports adherence to clinical guidelines	FFP has led to improvements in access and uptake of relevant services by Māori, Pacific, and/or quintile 4-5 patients	FFP has led to at least some improvements in disease management as evidenced by uptake of relevant services, and quality improvements.
Poor	Unsatisfactory results – generally does not meet targets or expectations Serious weaknesses on crucial aspects and there are signs that the FFP has led to reduced quality clinical care		

25 Well over half of practices.

Mixed methods

Triangulation of multiple data sources improves reliability and validity of findings and is vital for drawing robust evaluative conclusions in small studies (Babbie, 2007). As such, the evaluative criteria were addressed through the collection of evidence from a range of sources, including quantitative programme data, narrative from a range of stakeholder perspectives and review of programme documentation.

Stakeholder interviews

A total of 20 stakeholders participated in either an individual phone interview or group phone interview. In addition, one person provided written feedback to the interview questions via email. These stakeholders included, practice owners, practice managers, GPs, nurses, and administrators. This sample was drawn from NHC practices to get views from a range of practices, including rural/urban, small/large, low decile/high decile, etc.

Interview questions were based on the KEQs and associated evaluative criteria. Interviewees were informed about the evaluation (verbally and through an information sheet) and asked to provide verbal consent. Interviews were audio taped where consent for this was given.

Online survey

All NHC practices (N=35) were invited to take part in a short, rapid feedback online survey. An invitation to the survey was sent by NHC to one contact within each of their practices. They were asked to forward the survey to all their staff. A total of 44 stakeholders completed the survey in full.

Quantitative data

Programme data were analysed in Excel to provide descriptive analysis of patient demographics and patterns of claims and budget utilisation (by practice, professional role, condition type, etc.).

Data Analysis

Each stream of data (corresponding to the methods above) was analysed and themed separately, and then reviewed and synthesised collectively by the evaluation team to reach evaluative conclusions against the KEQs and rubrics. Top line findings were presented to the NHC November 2017, after which a draft report was prepared and submitted to the NHC for review and feedback. This document represents the final version of the report and has been delivered electronically in Microsoft Word and Adobe Acrobat (PDF) formats.

Limitations

There were some limitations to this evaluation that should be acknowledged:

- Due to issues of attribution and the types of evaluation data available, it was not possible to measure clinical outcomes directly as part of the evaluation. Therefore, the potential clinical contribution to outcomes could only be inferred from FFP effects on quality and access.
- No patients were consulted with as part of the evaluation.

Appendix B:

The FFP programme performance targets

The performance plan for the FFP programme are as follows:

- A 25% performance bonus is paid in full to practices that meet the targets in Table 5 and 6 (for 2015 and 2016 respectively).

Table 5: Programme performance plan (1 July 2015)

From 1st July 2015			
Target	Performance Indicator	Period Measured	Payment Weighting
90%	CVD Risk Assessment	Previous month	20%
90%	Diabetes Annual Review	Previous month	10%
95%	8 Month and 2 Year Childhood Immunisation	Previous quarter	30%
90%	Smoking Status Recorded	Previous month	10%
90%	Smokers Given Brief Advice or Cessation Support	Previous month	20%
80%	Cervical Screening	Previous month	10%

Table 6: Programme performance plan (1 July 2016)

From 1st July 2016			
Target	Performance Indicator	Period Measured	Payment Weighting
90%	CVD Risk Assessment	Previous month	10%
90%	New Born Enrolments	Previous 3 months	15%
95%	8 Month and 2 Year Childhood Immunisation	Previous quarter	30%
90%	Smokers Given Brief Advice or Cessation Support	Previous month	20%
80%	Cervical Screening	Previous month	20%
Participating	Patient Experience Survey		5%

Changes may be made in line with the System Level Measurements

- Part Payments are made based Table 7 and 8 (2015 and 2016 respectively).

Table 7: Part payment performance plan (1 July 2015)

Performance Indicator	No Payment	1/3 Payment	1/2 Payment	2/3 Payment	Full Payment
CVD Risk Assessment	<80%	80-84%	n/a	85-89%	90%+
Diabetes Annual Review	<80%	80-84%	n/a	85-89%	90%+
8 Month and 2 Year Childhood Immunisation	<90%	n/a	90-94%	n/a	95%+
Smoking Status Recorded	<80%	80-84%	n/a	85-89%	90%+
Smokers Given Brief Advice or Cessation Support	<80%	80-84%	n/a	85-89%	90%+
Cervical Screening	<70%	70-74%	n/a	75-79%	80%+

Table 8: Part payment performance plan (1 July 2016)

Performance Indicator	No Payment	1/3 Payment	1/2 Payment	2/3 Payment	Full Payment
CVD Risk Assessment	<80%	80-84%	n/a	85-89%	90%+
8 Month and 2 Year Childhood Immunisation	<90%	n/a	90-94%	n/a	95%+
New Born Enrolments	<80%	80-84%	n/a	85-89%	90%+
Smokers Given Brief Advice or Cessation Support	<80%	80-84%	n/a	85-89%	90%+
Patient Experience Survey	Not participate	n/a	n/a	n/a	Participated
Cervical Screening	<70%	70-74%	n/a	75-79%	80%+

Appendix C:
Concerns raised by stakeholders

Table 9: Concerns raised by stakeholders

Issues raised by stakeholders	NHC response (where relevant)
Allocated funds running out too quickly, including for specific services (particularly for Primary Mental Health).	Practices do not run out of FFP related 'claimable items' (e.g., mental health, youth sexual health) – if items cannot be claimed, it is because the overall allocated FFP budget has been exhausted. Most mental health is DHB funded, not FFP funded; in addition to FFP services, Mōhio is used to claim for things covered by other funding streams (e.g., DHB funding). Many services, such as mental health and podiatry are dually funded. The Mōhio system automatically prioritises the correct funding streams.
A desire for greater flexibility around how to spend the funding; with a preference amongst some interviewees to get a set amount of funding for their practice based on their population so that funding can be dispersed at their discretion to those in need.	The 'flexible' in the FFP refers to flexibility for PHOs sitting in an alliance to distribute SIA and Care+ funding, not necessarily flexibility for individual GPs or practices.
Unused budget not being rolled over to the next funding period; practice FFP allocations were perceived by some as 'practice money' rather than a PHO-wide funding pool – and some stakeholders questioned why NHC should retain this and what it is being used for.	The policy purpose of the FFP is to meet population health needs – if a practice does not meet expectations/targets, unspent funding is used by NHC for that purpose. This is briefly mentioned in the NHC's programme guide (see: Flexible Funding Pool (FFP) V3 | July 2015).
Funds for insulin starts having been withdrawn. Calls for funding for insulin starts; where consultations are long and frequent ongoing contact is necessary over the first month	Insulin starts were never part the FFP suite of services; it is/was DHB funded.
Smears no longer being available free for all women	While smears used to be free, there was no improvement in smear completions. Hence, full coverage was withdrawn.

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