A Review of the CarePlus Survey Process at Manaia PHO.

Practice Project.

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Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any degree or diploma of a university or other institution of higher learning."

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Abstract

CarePlus is a client-centred primary health care programme initiated by the Ministry of Health (MOH) and managed through New Zealand Primary Health Organisations (PHOs). Patients are offered four free visits annually but not everyone takes full advantage of the programme. Manaia PHO wanted to explore reasons for this and to adapt and further improve the programme.

This practice project has retrospectively reviewed a survey used to determine the extent to which the implementation of Care Plus at Manaia PHO was making a difference to its client's lives. The survey process was evaluated using a quality improvement tool known as the IHI Simple Data Collection tool (IHI, 2004). This enabled examination of the processes being used and drew attention to potential improvements in the ways data was being collected, analysed and reported. The IHI tool has also provided insight into the potential use of other methods to evaluate the CarePlus programme.

Section one

Introduction

This project has evaluated the collection of patient feedback about the 'CarePlus' programme delivered by Manaia Primary Health Organization (PHO). CarePlus is a Ministry of Health initiative for managing patients with long term conditions such as diabetes, heart disease, terminal conditions and mental illness. Currently there are over 3,500 patients enrolled in the Manaia PHO Care Plus programme.

A questionnaire, as part of quality improvement, was used to collect information from patients annually about the CarePlus programme between 2006 and 2010. It sought to find out how well CarePlus in Manaia PHO was achieving its goal of providing a patient – centered approach to service delivery. 'Patient - centred' means involving people and being receptive and responsive to their needs and values. It includes both individuals and population groups receiving services (Ministry of Health, 2003). Patients enrolled on the CarePlus programme were selected randomly to be surveyed. The sample comprised patients that had been enrolled for different lengths of time, and who differed according to gender, age and ethnicity.

In order to evaluate the process by which client feedback about CarePlus was collected at Manaia PHO, I have retrospectively applied the "Simple data collection planning tool" developed by Institute for Healthcare Improvement in 2004.

Situating the Project

Ministry of Health

As principal advisor to the government on health and disability policy, the Ministry of Health leads and supports the health and disability sector to achieve better health for New Zealanders. This includes reducing inequalities, achieving better participation, greater independence, trust and security (MOH, 2004).

Its main responsibilities are:

- strategy, policy and system performance – providing advice on improving health outcomes, reducing inequalities and increasing participation, nationwide planning, co-ordination and collaboration across the sectors
- servicing Ministers' offices and ministerial advisory committees
- monitoring and improving the performance of health sector Crown entities and District Health Boards, which are responsible for the health of their local communities
- funding and purchasing of health and disability support services on behalf of the Crown including maintenance of service agreements, particularly for public health, disability support services and other services that are retained centrally
- administration of legislation and regulations, and meeting legislative requirements
- information services
- payment services.

(Ministry of Health, 2009).

The New Zealand Health Strategy, published in 2000, defined high-level principles for the health system, including the need to reduce health disparities. It specifically emphasized the need to reduce the impact of cardiovascular disease, diabetes, and mental illness, amongst other conditions (King 2000). Since then, policymakers have increasingly recognised the importance of chronic care management and integrated care in addressing disparities traditionally considered outside the domain of 'personal health services'. The notion is clearly expressed by Starfield (2005) "Personal health services have a relatively greater impact on severity (including death) than on incidence. As inequities in severity of health problems (including disability, death and co-morbidity) are even greater than inequities in incidence of health problems, appropriate health services have a major role to play in reducing inequities in health." (41).

The Primary Health Care Strategy (2001), focused more definitively on chronic disease management and its delivery via strengthened primary care (King, 2001). PHOs replaced Independent Practitioner Associations (IPAs) as the organising focus within primary care taking greater community and population-health responsibility. Funding to GPs shifted from fee-for-service to capitation, with greatly increased patient subsidies and decreased patient fees. According to the MOH (2004) this funding change was the most dramatic rearrangement of primary care payments and incentives in the last 60 years. Some form of capitation payment is now paid to 90% of New Zealand's GPs.

Primary Health Organisations

Primary health organisations (PHOs) are not-for-profit organisations (MOH 2004) that provide health services either directly by employing staff or through provider members. They vary widely in size and structure and are funded by District Health Boards (DHBs) to provide essential primary health care services to people enrolled with the organisation. PHOs bring together doctors, nurses and other health professionals (such as Maori health workers, health promotion workers, dieticians, pharmacists, physiotherapists, psychologists and midwives) to serve the health needs of their enrolled populations.

First established in July 2002, there are now 81 PHOs in New Zealand (MOH 2004). DHBs have worked with local communities and provider organisations to establish PHOs that meet the minimum requirements laid down by the Ministry of Health. One such requirement is that PHOs will give communities, iwi and enrolled people the opportunity to provide feedback about the services they receive (Ministry of Health 2004)

PHOs receive subsidies from the government for a range of health services. This funding is based on the numbers and characteristics (e.g. age, sex, and ethnicity) of people enrolled with the PHO. The funding pays for:

- Providing care and treatment when people are ill
- Helping people stay healthy
- Reaching out to those groups in their community who have poor health or who are missing out on primary health care.

PHOs receive CarePlus as extra funding dependant on the number of patients they have enrolled in the programme.

Another significant and more recent change is the national implementation of a Performance Management Programme. This programme introduces payment for performance against a small number of agreed performance indicators and targets have been introduced for the first time. If the PHO and its practices reach the targets agreed by the DHB and PHO, they are financially rewarded for certain indicators, over and above capitation. However, this only accounts for a small amount of income to most general practitioners. Currently, in addition to approximately 10 indicators for information, there are 15 paid indicators. These include cervical screening, breast screening, two year immunizations, cardio vascular disease (CVD) risk assessments and diabetes detection and follow up. This compares with the 2004 UK Quality Outcomes Framework that includes 8 for Chronic Obstructive Pulmonary Disease (COPD), 18 for diabetes, and three for left ventricular dysfunction (NZMJ, 2007). Furthermore, in the UK, performance incentives are paid to the practice and may account for a quarter or more of a GP's income. In New Zealand the payments are proportionately less and they are paid to the PHO not to individual practices.

Manaia Primary Health Organisation

Manaia Health is the Primary Health Organisation (PHO) operating within the Whangarei District of Northland, New Zealand. It provides health services to a population of 80,538 patients, 24% of whom are identified as Maori and it was established on 1 July 2003 with two equal shareholders:

- Terenga Paraoa Ltd - which is a grouping of Maori Health Providers and local Hapu.
- Whangarei Healthcare Ltd - which consists of GPs and practice nurses working in the Manaia coverage area.

Each of these shareholders appoints three directors to the board. The board also has two 'community directors' who are nominated from the Manaia Community Advisory Group (COAG).

Manaia Health PHO funds and co-ordinates services, provides resources and expertise for providers, and delivers some specialised primary healthcare services. First level primary healthcare is provided by 21 General Practices and two Maori Health Organisations. The PHO also works closely with a number of other health, social services, iwi, sport, housing, education and local community organisations and the local territorial authority, to improve the overall health and wellbeing of their enrolled population.

Specific goals include child and adolescent health, immunisation, mental health and effective management of chronic diseases such as diabetes and cardiovascular disease. Manaia recognises that achieving such goals requires a patient centered approach to health care and robust relationships with key stakeholders: general practices and Maori partners, the Northland DHB, key government agencies such as Ministry of Housing NZ, Social Development, Education, Police, the Whangarei District Council and the large number of NGOs who work in the region.

National overview of the CarePlus programme

CarePlus was introduced nationally via PHOs in July 2004. The purpose was an overall reduction in the costs to the health service associated with effectively managing people with long term conditions. The CarePlus service targets people visiting their General Practitioner or nurse frequently for one or more of the following reasons: significant chronic illnesses such as diabetes or heart disease, acute medical or mental health needs, or terminal illness. It was

envisaged that people using CarePlus would also be supported to make lifestyle changes. A person is eligible for CarePlus if he/she is enrolled in a PHO and has:

1. been identified by a doctor or nurse at their general practice as potentially benefiting from "intensive clinical management in primary care" (at least two hours of care from one or more members of the primary health team) over the following six months; and either
2. two or more chronic health conditions so long as each condition is one that: is a significant disability or has a significant burden of morbidity, creates a significant cost to the health service, has agreed and objective diagnostic criteria, and continuity of care and a primary care team approach has an important role in management; or
3. a terminal illness (defined as someone who has advanced, progressive disease whose death is likely within 12 months) or;
4. had two acute medical or mental health related admissions in the past 12 months (excluding surgical admissions); or
5. had six first level service or similar primary care visits in the past six months (including emergency department visits).

It was intended that CarePlus would firstly fund and protect practice team time, predominately nurse time with patients, but it can also be nurse and doctor time or just doctor time. Resources are intended to enable planned time to be spent with CarePlus patients, to be directed at better health outcomes and to focus attention on the health status of patients and their personal health related goals. Secondly, the intention was to focus systematic attention on objective measures of health status of patients, carefully defining their health needs and risk factors (physical, social, lifestyle and behavioral),

creating a composite management plan with them, and re-measuring their health outcomes after set periods of time. Thirdly, CarePlus would provide an opportunity to implement interdisciplinary and clinical/cultural approaches to primary health care. Finally, it would provide an opportunity to improve or develop relevant tools, processes and guidelines to support this systematic approach to delivering and measuring health care services (MOH, 2004).

CarePlus within Manaia Primary Health Organisation

CarePlus was introduced to Manaia Health PHO in October 2004, with the underlying premise that a carefully planned and supported implementation was essential.

Key principles which have guided the initial and on-going implementation of CarePlus within Manaia Health PHO have included maintaining:

- the integrity of the purpose of CarePlus through an implementation focused on quality as opposed to meeting arbitrary enrolment targets.
- a central focus on the patient and his/her family/whanau.
- a team approach to implementation, both at the general practice level, and across the primary/secondary interface and ;
- adequate electronic and administrative support to the general practice.

Key strategies have also guided the development of CarePlus at Manaia. Team work is central to CarePlus implementation and practice nurses have been well supported in their delivery of this programme. Individual practices within the PHO were encouraged to take ownership of their CarePlus programme and adapt it to suit their enrolled population.

Current Challenges

The most significant challenge faced in implementing the CarePlus programme is fitting a Ministry driven programme into an existing business model. Most general practitioners in the Manaia PHO operate their practices as private businesses. Thus it has been difficult for them to change the way they practiced and the way they ran these businesses. Many practices in Manaia have had to extend their premises to accommodate the CarePlus clinics; others have had to employ extra practice nurses. Moreover, in addition to believing that this new way of working would benefit patients it needed to continue to provide the income necessary for maintaining a successful business.

There is an increasing body of knowledge that validates the difference a patient centred approach makes to health outcomes and quality of life for patients and their families/ whanau who live with a chronic condition (Little, Evertt, Williamson, Warner, Moore, Gould, Ferrier, & Payne, 2001).This has always been a priority to Manaia and it remained so with the introduction of CarePlus.

Statistics collected over the past four years show a steady upward progression of enrolments in the programme.

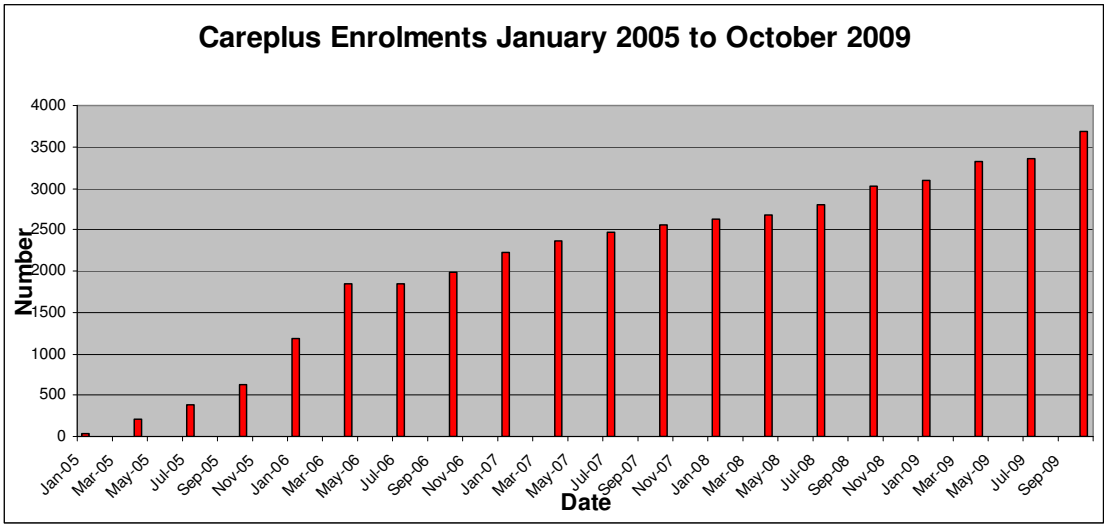


Figure 1 Manaia Health PHO CarePlus enrolments 2005 – 2009. This shows the gradual progression of CarePlus new enrolments in Manaia PHO from 2005 – 2009.

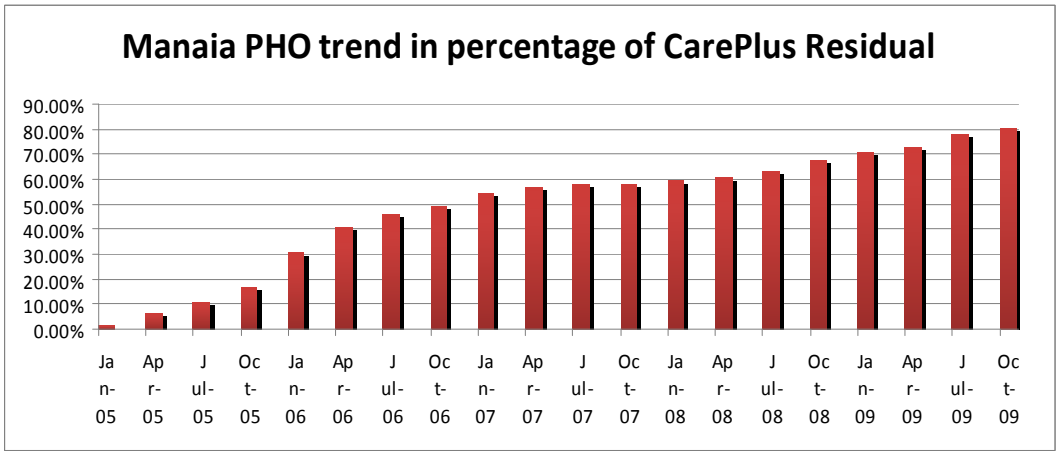


Figure 2 Manaia PHO trend graph of CarePlus residual as a percentage. This shows the gradual progression of patients who are eligible and enrolled on to CarePlus in Manaia as a percentage.

The residual is 4697 patients that are eligible for the CarePlus programme of that, 1197 patients who are eligible haven't been formally identified however it has been suggested that reasons may include time restraints if they are working with no after hours service offered, relationships with

the practices may be strained and the client may be reluctant to attend general practice when they owe money.

My interest in this project

I have been responsible for the introduction and implementation of the CarePlus programme in the 21 general practices in Manaia PHO over the past five years. This has included education and training for all practice nurses. I have also been collecting data and seeing trends in the results but wanted to engage in an evaluation of processes to ensure robustness of the survey. That is the goal of this research project.

Overviews of the project report have commenced this report by situating the project in relation to Care Plus and the survey undertaken by Manaia PHO. The next section will examine literature relating to this subject. The report will then provide an outline of the research design and methods, present and discuss the findings of the project, and provide recommendations for practice and further research. The literature review in the next section examines chronic care internationally, provides definitions of chronic care in NZ, quality improvement and factors influencing the increased burden of chronic illness. It also describes models of service delivery, team work, chronic care models and their implementation.

Section two – Literature Review

Introduction

This section reviews the literature relating to chronic care internationally, nationally and locally. The databases and search engines for this search included, Medline (via Pubmed), CINAHL, Cochrane Database of Systematic reviews (via OVID), Cochrane Library (via OVID).

Chronic care internationally

In Britain, six out of ten adults report having a long term condition that cannot currently be cured. Moreover, people with long term illnesses often suffer from more than one condition. (Department of Health, (DOH) 2004) A report entitled 'Supporting people with long term conditions', published in 2005, set out the British governments plans to assist people with long term conditions to live healthy lives (Statutory Office, 2005) and introduced the National Health Service and Social Care Model. This model outlines how people with long – term conditions will be identified and receives care according to their need, it also outlines how the 'Expert patient programme' would be expanded throughout England to promote self management. The specialist nurse role was being expanded to support people with complex conditions (DOH, 2004).

Similarly, by 2030 nearly 150 million Americans are projected to have a chronic condition. 42 million of those will be limited in their ability to go to school, work or to live independently. The question of how to provide adequately for people with chronic conditions has significant implications for national health care expenditure. The U.S.A is currently spending

$470 billion, yet much of the care that is available is fragmented, inappropriate and difficult to obtain (Johnson, 1996).

In Australia, Walker and Patterson (2000) have expressed similar concerns regarding the ageing population and the impact chronic conditions will have on the health system, again there are calls to move from acute focused care to a focus on families/whanau and community as a whole. Existing incentive programs for General Practitioners such as "Enhance Primary Care" are not delivering systematic and coordinated programs. According to Duckett (2000), the trials which began in 1997 have not produced sustained or systemic results. Thus, like the rest of the world, the Australian health system is struggling to provide primary and chronic care services to this population in an appropriate, cost effective and timely manner (Walker & Patterson, 2000).

Chronic care in New Zealand

Chronic illnesses (also known as long term or lifelong conditions) are a significant health burden. It is estimated that in New Zealand approximately 70% of health care users have one or more chronic illnesses. They are the leading cause of hospitalizations, use 70% of health funds and account for 80% of all deaths (National Health Committee, 2005; Ministry of Health, 1999).Responding to such statistics Wagner, Austin, Davis, Hindmarsh, Shaefer & Bonomi(2001), recognized that effective and efficient management of chronic illness required a change in service delivery It was argued that the incidence of chronic health conditions could be decreased if health promotion and disease prevention education was included in every health care encounter (Cumbie, Conley & Burman, 2004; WHO, 2005).

There is a considerable body of evidence to suggest a relationship between socioeconomic factors and chronic illness and all cause mortality. During 40 years of study in America, Kaplan & Keil (1993) demonstrated a consistent inverse relation between

cardiovascular disease, primarily coronary heart disease, and many indicators of social economic status. A number of other studies suggest that poor living conditions in childhood and adolescence contribute to increased risk of arteriosclerosis (Armstrong, 2005; Brooker &Nicol, 2003)

In New Zealand, Janssen (2008) has reported that designated Maori health service providers have provided "culturally appropriate practices to address health disparities"(p25) yet, the New Zealand Health Care system, like that of other countries from Europe to Americas, still does not provide equal health outcomes to all members of its population (Ajwani, 2003). Research shows that numerous disparities exist among different cultural communities in New Zealand, with the most dismal health status consistently noted among Maori. These overall disparities persist even after controlling for associated factors such as poverty and education, indicating that culture is an independent determination of health status (Medical Council of New Zealand, 2006). Research has documented that cultural misunderstandings and unconscious bias on the part of some clinicians are partly responsible for these disparities, so improved cultural competence should yield improved outcomes (Scott, Marwick & Crampton, 2003). Helping patients to feel more comfortable in the health care setting may enable clinicians to work more effectively with patients and families to achieve the best possible clinical outcomes. Nixon, Smith & Chamberlain (2006), argue that quality Improvement is essential in chronic care management and improving health outcomes. Activities that are currently being implemented via primary health service in NZ include The Foundation Programme which has proven to deliver improved chronic disease outcomes and primary CVD risk management in an affordable and achievable way within a primary care setting (Quality and Audit report, 2004). The PHO Performance Programme is also being implemented to improve clinical outcomes.

Quality Improvement

Quality of care is the degree to which services for individuals and populations increase the likelihood of desired outcomes and is consistent with current professional knowledge (National Health Committee, 2001). Quality improvement activities focus on aspects of day–to–day operation of services delivering the expected outcomes. Quality assurance is concerned with helping professionals and organizations continually improve their performance, reducing the risk of errors and when identified, managing errors effectively as an organizational learning experience. Both of these have a focus on systems improvements and ask; is what we are doing making any difference to better the lives of the patients we serve? (National Health Committee, 2001). Quality is important in the New Zealand health and disability service. It is identified as a cornerstone of a high performing system in the New Zealand Health strategy and is an objective of the New Zealand Disability Strategy. Improvements in quality are necessary to support a vision of people in the New Zealand health and disability system receiving people – centred, safe and high quality services that continually improve and that are culturally competent (MOH, 2003).

A systems approach to quality improvement is necessary because the health and disability system is complex, with decision making and actions occurring across people, individuals, teams and organizations. Within a systems approach, quality can be defined as the degree to which the services for individuals and populations increased the likelihood of desired health outcomes (Epping- Jordan, Pruitt, Bengoa & Wagner, 2004)). Quality is the cumulative results of the interactions of people, individuals, teams, organizations and systems. The key dimensions of quality in the health and disability system rest on the foundations of the Treaty of Waitangi principles of partnership, participation and protection principles. They are:

- People – centred
- Access and equity
- Safety
- Effectiveness
- Efficiency

(MOH, 2003).

These principles need to be considered alongside the numerous factors influence the increasing burden of chronic illness.

Factors influencing the increased burden of chronic illness

The increase in chronic diseases is being contributed to by a range of factors at global, national and local levels. Many are linked to fundamental societal changes including urbanization and economic globalization; political and social policies; and issues of social injustice as well as population ageing. Rapid urbanization results in lack of facilities and services for the 'urban poor' that is essential for good health including infrastructure and basic services (WHO, 2002).

The rural poor, including indigenous peoples, suffer from progressive under investment in infrastructure and amenities, with disproportionate levels of poverty and poor living conditions. These avoidable health inequalities arise because of the circumstances in which people grow, live, work and age, and the systems put in place to deal with illness. The final report of the WHO Commission on Social Determinants of Health contends that social justice is indeed a matter of life and death (WHO, 2008). Associated with these changes is an increase in the prevalence of the main modifiable risk factors: smoking, poor diet, lack of physical exercise, excessive use of alcohol, unsafe sexual practices, and unmanaged psychosocial stress. These are

often associated with intermediate risk factors including raised blood pressure, raised blood glucose, raised cholesterol and obesity. Many models of service delivery are used within New Zealand and throughout the world to help address the burdens of chronic illness.

Models of service delivery currently being used in Primary Care

The Chronic Care Model (CCM) developed by Ed Wagner and his team in the US in 1998, is one of the best known frameworks about care for people with long term conditions. The model focuses on linking informed, active people with long term conditions with proactive teams of professionals. It acknowledges that a substantial portion of chronic care takes place outside formal healthcare settings and suggests that six elements are of central importance in initiatives to improve chronic care: community resources; the healthcare system; patient self management; decision support; delivery system redesign; and clinical information services (Bodenheimer, Wagner, Grumbach, 2002). The Chronic Care Model is an organizing framework for improving chronic care at both the individual and population level (Fiandt, 2006). It has been implemented in many different settings (e.g. community, GP practices, and hospital settings). Most chronic care policies in developed countries (including New Zealand) draw on this model (Fulton, Penney & Taft 2001) because of its effectiveness in teams (Pullon, 2008).

Team work and Chronic care delivery

Much of the growing burden of chronic illness is preventable through focused prevention strategies and better management of chronic illness (Glasgow, Orleans & Wagner, 2001; WHO, 2005). Effective management of chronic conditions is dependent on purposeful, coordinated and longitudinal team work (New Zealand Guideline Group, 2004).To do justice to the needs of patients with chronic conditions; Singh (2005) argues that a range of primary health care

professionals should be involved because no single discipline can address the multiplicity of skills required. Furthermore, as Pullon (2008), states, teamwork is a fundamental principle of primary health care and an essential prerequisite for effective management of chronic conditions. Teamwork facilitates best use of disciplinary skill sets particularly around the role margins where the different disciplinary competencies are similar and meets the imperative to use the scarce human health professional resource wisely. (Epping- Jordan, Pruitt, Bengoa & Wagner, 2004).

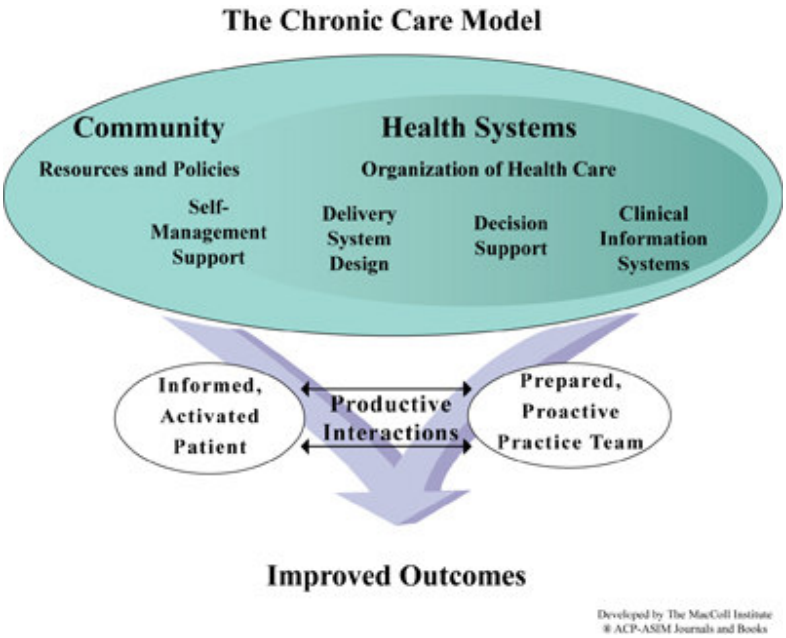
The WHO (2005), outlines the following basic principles of effective chronic care. Developing a treatment partnership with the patient focusing on the patient's concerns and priorities requires the use of Five A's:

- Assess
- Advice
- Agree
- Assist
- Arrange

Other essential aspects for inclusion are:

- Support for patient self management.
- Organizations of proactive follow up. Involve "expert patients ", peer educators and support staff in your health facility.
- Linking the patient to community based resources and support.
- Use of written information, registers, treatment plans, treatment cards to document, monitor and remind patients.
- Working as a cohesive team and endeavoring to provide continuity of care.

The Chronic Care Model



Wagner, Davis, Schaefer, Korriff & Austin (1999 p.11)

Canadian policy makers have criticized the Chronic Care Model (CCM) model for focusing on clinically orientated systems, making it difficult to apply to prevention and health promotion activities. They therefore expanded the Model to include population health promotion components such as the social determinants of health and community participation. The expanded CCM supports the intrinsic role that the social determinants of health play in influencing individual or group. It facilitates a fundamental shift in understanding how an individual client fits within this configuration, integrating the CCM with population health promotion supports self management for clients. Prior to CarePlus funding being available in New Zealand in 2004, there was limited focus on organized forms of chronic condition care in

primary care, particularly care that focused on those with multiple or complex chronic conditions. Counties Manukau District Health Board had instituted a formal CCM model in 2001 targeting care to those unable to self manage. The Wagner model is an adaptation of the CCM model and has been expanded in to Counties Manakau and other areas in New Zealand to include cultural competency and an increased emphasis on the patient, including their family and community (Wellingham, Tracey, Rea & Gribben, 2003). Nurses bring to all of these chronic conditions programmes their ability to broadly assess the overall context of patient and family as well as the illness in question (Ministry of Health, 2005). They consider the patient's ability to adjust to illness as well as health and then commit to work with patient and family to promote and support health improvement over time (Schoenhofer, 1995). Such work includes the ability to broadly and specifically assess health and illness status, to formulate and undertake clinical activities in consultation with patient and family addressing the 'risks and consequences of illness and the risks and consequences of treatment' (Armstrong, 2005), to skillfully engage in therapeutic communication with patient and family and to support the development of self – management strategies (Von Korrff, Glasgow & Sharpe, 2002).

Self Management

Self Management refers to support in coping with a disease for health and wellness. Self management is defined by the Centre of Advancement of Health (2001) in South Australia, as involving the person with chronic disease in activities that protect and promote health, monitor and manage the symptoms and signs of illness, its impact on functioning, emotions and interpersonal relationships and adhering to treatment regimes. Bodenheimer, Lorig, Holman, & Grumbach (2002) argue that all patients with chronic conditions make day to day decisions about their condition and thus they self-manage their illnesses. This reality introduces a new

component to the chronic disease paradigm; the patient / professional partnership, involving collaborative care and self management education. Self – management education complements traditional patient education in supporting patients to live the best possible quality of life with their chronic condition. Lawn, Battersby, Harvey, Pols & Ackland (2009), outlines six principles of self management:

- Having knowledge of their condition.
- Following a treatment plan agreed with their health professionals
- Actively sharing in decision making with health professionals.
- Monitoring and managing signs and symptoms of their condition.
- Managing the impact of the condition on their physical, emotional and social life.
- Adopting lifestyles that promote health.

Based on the evidence that describes the significant impact of social supports on overall health and quality of life, working to generate living and employment conditions that are safe, stimulating, satisfying and enjoyable (Rootman & Goodstadt, 1996.)

When Manaia adopted the CCM and expanded CCM tools in relation to the introduction of CarePlus, the Flinders Model of self management formed the basis of care delivery for all chronic care patients in Manaia. The Flinders model advances, complements and / or allows a specific focus for health professionals to plan a care plan with clients. Flinders self management workshops are offered three times a year and are available to fifteen clients at each workshop. According to Eggleton (2009) there is some evidence that the Flinders model leads to improved outcomes when used in conjunction with the CCM model/tools. Two thirds of practice nurse involved in CarePlus at Manaia have now been trained to use the Flinders Model.

The Flinders Model

The Flinders Human Behaviour and Health Research Unit in Australia developed a generic set of tools and processes that enables clinicians and clients to undertake a structured process that allows for assessment of self management behaviours. This model has helped structure the CarePlus visit at Manaia. It assisted collaborative identification of problems and goal setting leading to the development of individualized care plans essential to enhancing the self management skills of people with chronic conditions. The Flinders assessment tools consist of the Partners in Health Scale (PIH), Cue and Response (C&R), Problems and Goals (P &G) and the Care Plan. They provide a consistent, reproducible approach to assessing the key components of self management that:

- Improves the partnership between the client and health professional.
- Collaboratively identifies problems and therefore more successfully targets intervention.
- Is a motivational process for the client and leads to sustained behaviour change?
- Allows measurement over time and tracks changes.
- Has a predictive ability, i.e. improvements in self management behaviour as measured by one of the assessment tools, the Partners in Health scale, relates to improved health outcomes. (The Flinders Human Behaviour and Research Unit, 2009).

Other similar models have also been drawn on to develop the services provided by Manaia PHO. A diabetes self management model developed by the Manaia Diabetes Specialist nurse and dietician and the Stanford Model are currently being trialed to see which works best with CarePlus and the Flinders Model. The Diabetes Self Management course has worked well in the past in Manaia PHO, but it has needed to be expanded to include other chronic conditions to

benefit the Manaia community, and it was for this reason, that the Stanford Model was introduced.

The Stanford Model

The Stanford Model was developed by Kate Lorig and associates at Stanford University, USA in the 1990s. It is designed so that clients work in a group setting to understand living with their chronic condition by learning from other people. It assists people to acquire learn skills and strategies through learning from each other about their conditions and coping mechanisms. Sessions of two hours duration are provided weekly for six weeks.

Manaia PHO is using the Stanford and Flinders models to deliver the Care Plus programme because of their complimentary approach to chronic condition self management. In Manaia PHO the Diabetes 6 week self management course is being expanded based on the Stanford Model, with the longer term intention of including all chronic conditions in 2011. The course has shown some good outcomes. Many patients understand their condition and medication more clearly and the feedback from participants has been very positive. Other District Health Boards, such as Counties Manukau, have adapted these models and successfully established ways to support and extend to include all chronic conditions (Rea, Keanealey, Wellington, Moffitt, Sinclair, McAuley, Goodman & Arcus, 2007).

Literature relating to CarePlus in New Zealand

In New Zealand, it is estimated that approximately 80% of health care funds are spent on treating people with chronic conditions. This increases to approximately 95% in the care of older adults (Boyd, 2005). Living with a chronic health condition can negatively impact on a person's life, affecting the person's ability to manage their day to day activities, care for family or go out

to work (Brooker & Nicol, 2003). A chronic condition not only affects physical health but also impacts on a person's mental, emotional and spiritual wellbeing (Walsh, Crumbie & Reveley, 1999).

The models of care developed to implement CarePlus vary significantly across PHOs (Boyd, 2005). However, all include additional funding for four CarePlus appointments with a doctor or nurse, for patients with a chronic condition.

Improved Clinical outcomes and CarePlus

The characteristics of a practice or an individual health provider that result in improved clinical outcomes are hard to define and quantify and there have been a few studies attempting to answer this question. A study by Eggleton (2009), in Manaia PHO, identified a number of characteristics as potentially associated with improved clinical outcomes specific to CarePlus, although the clinical indicators were not defined in this study. A focus group interview was conducted with 5 practice nurses, the CarePlus Coordinator and a GP. A questionnaire was also sent out to all practice nurses in the PHO involved with CarePlus. This study aimed to explore characteristics within practices that may contribute to improved clinical outcomes for CarePlus. From the research three major themes emerged: nursing factors, practice organisation factors and General Practitioner factors. Sub themes identified as patient centredness, assertive follow up, nursing knowledge, referral to other health professionals, dedicated appointment times, long consultation time, low cost, GP commitment and teamwork were all considered to be characteristics that could lead to improved clinical outcomes. One of the limitations of this research was that only one GP was asked about his involvement, although there are over fifty GPs working in Manaia PHO. Clinical indicators have been defined by Nixon, Smith &

Chamberlain (2006) as a decrease in the CVD risk for patients, lower HBA1C, measurement of BMI and smoking status has also been stated. However in addition to clinical indicators, it is also important to glean information about how patients feel about the services they are receiving. .

"Patient-centred" care delivery

Wagner (2005) describes patient centeredness as promoting 'a fuller understanding of the patients life and preferences, activation and empowerment of patients and tailoring of management to patient preferences' (p.22). There is evidence in the literature that a patient – centred approach improves management of chronic conditions and leads to improved clinical outcomes (Glazier, Bajcar, Kennie &Wilson, 2006).

Positive outcomes have been shown between practices in the UK and Australia that are group practices and teaching practices with higher performance indicators (Ashworth & Armstrong, 2006). However, other studies in the USA have shown no difference (Hippisley-cox, Pringle, Coupland, Hammersley & Wilson, 2002).There is also some evidence of poorer outcomes with a patient centred approach. Baldwin, Cvengros, Christensen, Ishani & Kaboli (2008), studied 189 patients with hypertension and showed that those patients who identified as preferring a more patient – centred approach had higher systolic and diastolic blood pressure and higher LDL cholesterol levels. It was concluded that in treating asymptomatic conditions such as hyperlipidaemia or hypertension, which are treated more effectively with medication, there may be little opportunity, beyond compliance, to have control or involvement in their treatment.

CarePlus and changes in the role of the practice nurse

The role of practice nurses has changed in New Zealand with the implementation of CarePlus. Previously, practice nurses had only played a minor role in the management of chronically ill patients. According to Vause (2005), Wiles (1997) and Willis et al (2000), most practice nurses in New Zealand have been employed as an assistant to the busy GP, supporting the doctor in his work. However, with access to ongoing education and the advent of Nurse Practitioner registration, thinking is changing in relation to nursing roles, especially in primary care.

Research by Henty (2005) showed that following the introduction of CarePlus, the nurse's role became more defined and provided greater job satisfaction. Following implementation of CarePlus, many practice nurses have taken on a new and extended role of monitoring and managing people with long term conditions. They have undertaken postgraduate education (Wiles, 1997) and have particularly focused on patient centred approaches to chronic care (Eggleton, 2009). They are seeing patients on their own, liaising with doctors as required. Nurse-led clinics have begun, providing services to people with conditions such as diabetes and asthma. A major aspect of the nurse's role in such clinics is to form a relationship with the patient to guide and support them to manage their health care effectively (Boyd, 2005). Nurses in primary health settings have been shown to be particularly effective at providing this type of care (Boyd, 2005; Lubkin & Larsen, 2002; Wagner, Austin, Davis, Hindmarsh, Schaefer & Bonomi, 2001).

Patients' involvement in Self care

Boyd (2005) argues that people in New Zealand with Chronic conditions are increasingly being expected to take more responsibility for their own health and make day to day decisions about their illness. This reality introduces a new chronic disease paradigm: the patient-professional partnership, involving collaborative care and self management education. (Bodenheimer et al, 2002). Henty's (2005) study showed that patients enrolled in the Care Plus programme were increasingly seeing the practice nurse when well, rather than going to the GP when unwell. This suggests that they are more proactively involved in managing as a "social process of recognizing, promoting and enhancing people's abilities to meet their own needs, solve their own problems, and mobilize necessary resources to take control of their own lives"(p.10). In other words, patient empowerment is a process of helping people to assert control over factors that affect their health. Health care providers need to surrender the need for control and involve patients in making decisions and exert control over his/her health needs (Lau, 2002). In the UK, a visible shift in the balance of power towards greater involvement of patients in health care is underway; the Department of Health (2002) has set out proposals for implementing the vision of patient centred care in the National Health Service (NHS). Similar aims and philosophies are evident in New Zealand. Patients are being encouraged to manage their own health care through prevention and lifestyles changes leading to improved participation and satisfaction both in the short and long term. Patients are recognized as having capabilities identifying risk and managing events to slow the progress of their condition and help prevent medical crises before they happen. Lau (2002) argues that the working partnership between patients and health care professionals is essential to successful patient empowerment. Finding out what matters to patients, making use of information technology to disseminate knowledge,

establishing standards for disease management and promotion of clinical research are likely to increase the benefit of the health care provided (Lau, 2002). Brown, Stewart & Tessier (1995), found that a patient centered model of consultation with a doctor encompasses five principal domains: exploring the experience and expectations of disease and illness, understanding the whole person, finding common ground regarding management including partnership, health promotion, and enhancing the doctor - patient relationship; and a sixth domain, the realistic use of time (Brown et al, 1995).

- Exploring the experience of disease and illness: patient's ideas about the problem, feelings, expectations for the visit, and effects on function.
- Understanding the whole person: personal and developmental issues (for example, feeling emotionally understood) and the context (the family and how life has been affected).
- Finding common ground (partnership): problems, priorities, goals of treatment, and roles of doctor/nurse and patient.
- Health promotion, risk reduction, early detection of disease.
- Enhancing the doctor/nurse patient relationship: sharing power, the caring and healing relationship (Brown et al, 1995).

These findings have assisted decision making in Manaia PHO and the domains have been used as a base for development of a patient centred approach to care. The questionnaire developed by Manaia to find out how clients perceived Care Plus was drawn from this literature. In particular, question 9 asked if the client felt they "were fully listened to during their CarePlus visit". Question 10 asked if "they talked about all the issues they wanted to". As previously stated, the aim of the questionnaire was to see if and how CarePlus was

making a difference to service delivery within Manaia PHO. The following section explains and critiques this survey process.

Section Three

Project Plan

A questionnaire has been posted to thirty percentage of patients enrolled on the CarePlus programme annually since 2006 (see appendix A & B). Its purpose was to collect information about clients' perceptions of Care Plus and to gain more objective feedback to help Manaia continually improve the service and meet patient's needs. The collection of data via an anonymous questionnaire is a pre existing part of practice in Manaia PHO. Low risk ethics approval was discussed with the AUTEC coordinator and deemed unnecessary because the data being analysed was already being entered and aggregated as part of normal practice. The questionnaire was developed by the CarePlus Coordinator and the Clinical leader having integrated suggestions from patients, General Practitioners and Practice nurses. It included both quantitative (closed – ended) and qualitative (open – ended) questions. Data was collected and collated in November each year and a report on the aggregated findings, including spread sheets and graphs, was written and distributed to the 21 practice managers annually. Where requested, practice specific data was provided. An executive summary was also written for the CEO and the Board of Trustees highlighting findings with recommendations for programme improvements. Results have demonstrated improvement in the delivery of CarePlus at Manaia PHO over time (see appendix C). Anecdotally, the CarePlus Coordinator, Clinical leader, practice managers and clinicians have found the questionnaire to be useful in terms of obtaining feedback on how clients feel about the CarePlus programme.

After 4 years, however, it was essential to review the survey process and critically appraise the process using a formally structured quality improvement framework.

Project purpose

In this project, an information gathering tool developed by the Institute for Health care Improvement (IHI) (2004) known as the Simple Data Collection Planning Tool has been used retrospectively to evaluate both the questionnaire and the survey process used to collect information about Manaia PHO Care Plus within Manaia PHO. The tool has been trialed in a variety of quality improvement contexts and has found to be reliable (Israel, 2007; Boyle, 2006). IHI (2004) describes simple data collection planning as "a process to ensure that the data you collect for performance improvement are useful and reliable, without being unnecessarily costly and time-consuming to obtain". They cite three benefits of simple data collection planning:

"(a) It helps to ensure that the data gathered contain real information, useful to the improvement effort;

(b) It prevents errors that commonly occur in the data collection process; and

(c) It saves time and money that otherwise might be spent on repeated or failed attempts to collect useful data" (p.3).

The IHI tool involves an 8 step process (Figure 1). In this practice project, the 8 steps have been applied retrospectively to critique the Manaia PHO CarePlus Client Feedback questionnaire and process (2006-2009).

Simple Data Collection Planning

Directions

1. Begin your data collection planning by answering these key questions:
   1.1. What question do we need to answer—that is, why are we collecting these data?
   1.2. What data analysis tools do we envision using to display the data after we have it? (Note: The run chart is the recommended tool for displaying data showing the performance of a process over time.)
   1.3. What type of data do we need in order to construct this tool and answer the question?
   1.4. Where in the process can we get this data?
   1.5. Who in the process can give us this data?
   1.6. How can we collect this data from these people with minimum effort and chance of error?
   1.7. What additional data do we need to capture for future analysis, reference, and traceability?
2. Keep the following points in mind when planning for data collection:
   2.1. Seek usefulness, not perfection! Remember, data for improvement are different from data for research. Confusing the two can slow down improvement work. We need data that are "good enough" to permit us to take the next step in improving a process. These data are for learning, not judgment.
   2.2. Data recording must be easy. Try to build it in to the process under study.
   2.3. Use sampling as part of the plan to collect the data.
   2.4. Design the form with the collector's needs in mind.
   2.5. Minimize the possibility of errors.
   2.6. Provide clear, unambiguous directions.
   2.7. Use existing data whenever possible.
3. Develop your plan by answering the following questions:
   3.1. Who will collect the data?
   3.2. What data will be collected?
   3.3. When will the data be collected?
   3.4. Where will the data be collected?
   3.5. How will the data be collected? (Note: It is helpful to put operational definitions of the data to be collected somewhere on the data collection form—for example, noting that "Surgery Start Time" is defined as when the first incision is made.)
4. When you have developed a method to collect the data, test it with a few people who will actually be collecting the data and incorporate their ideas for improving the data collection plan.
5. Be aware of the cost of collecting the data relative to the benefit gained from having the data.
6. Teach all of the data collectors how to collect the data correctly.
7. Record what went wrong during the data collection so that learning can take place.
8. Audit the data as it comes in for accuracy and completeness. Correct errors early.

Figure 3. Simple Data Collection Planning (IHI, 2004).

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(Downloaded from website 28th May 2010.)

1. Questions to begin data collection

1.1. "What question do we need to answer—that is, why are we collecting these data?"

Before data was collected the staff had identified specific questions that they wanted to answer. In the July 2006 annual CarePlus report (see appendix E). It was reported that the primary question was "Is CarePlus making a difference in Manaia?"

It had been anecdotally reported that patients were reporting that the additional time available to discuss their condition, medication regime and set achievable goals was impacting positively on their ability to manage their condition and make some lifestyle changes. However, it was recognized that such feedback needed to be formalized. A patient questionnaire was therefore developed to gather feedback on a range of CarePlus related issues – for example, timing of visits, value (or otherwise) of the wellness plan, perception of the patient/practitioner interaction, and any health related behavioral changes resulting from the programme.

1.2".What data analysis tools do we envision using to display the data after we have it?"

Bar Tables and graphs were initially thought the best way to display the quantitative data after it had been collected. This was useful because results could be seen at a glance and were easy to understand. I had previously used and was familiar with these modes of data presentation. The Simple data collection tool suggests using run graphs, also known as run

sequence plots, to display observed data in a time sequence. These have the additional capacity to look at trends over the years and compare; it is certainly something we could use in the future. A list was used to record the qualitative data and key elements, themes were then identified from the qualitative data and reported on in bullet points with examples of original text. Although it was quite lengthy to read it did provide valuable insight into how the clients felt about the programme. For example, question 14 it asked about the most useful part of CarePlus? The following themes emerged from answers given:

- Enhanced understanding of condition
    - "I enjoy my CarePlus programme for it gives me the opportunity to meet regularly with my nurse and sometimes my doctor as a person and talk about my well being."
    - "Being kept up to date and discussing my general health and with any advice on how to improve it".
- Being listened to
    - "It's an ideal opportunity to ask questions, get answers and be listened to."
    - "Being 82 years old and living alone to have someone to discuss ones health problems with who listens to me. Regular health monitoring."
    - "Quality of awareness and assurance of progress and reports."
    - "Keeps me informed and up to date of my health issues."
- Goal setting.
    - "Checks on whether goals have been kept up."
    - "Setting goals and keeping me on track."

1.3 "What type of data do we need in order to construct this tool and answer the question?"

A self reported questionnaire was believed to be the most appropriate way to gain the information required to answer the question about whether or not CarePlus was making a difference. This method can be less intrusive and allows the client to fill it in, in their own home and in their own time. Kephart and Bressler (2009) believe that despite increasingly sophisticated methods the questionnaire is still widely favoured by many social scientists.

Answering this question required a mixture of quantitative and qualitative data. Quantitative data was required for questions such as:

- How long have you been on the CarePlus Programme?
- Do you feel the length of time between each visit was too long, too short or just right?

Yes/no and likert scale answers were appropriate. The qualitative questions collected more detailed and variable information allowing respondents to write as much as they wanted. Such as:

- Do you feel you were listened to during your CarePlus visits?
- Was your CarePlus visit interrupted?
- What has been the most useful part of CarePlus?

Other questions asked, more specifically, about what the client had changed in terms of lifestyle since being enrolled on the CarePlus programme and whether knowledge of their condition and medication had improved.

1.4 "Where in the process can we get this data?"

It was decided that this would be an annual survey sent out in November. There was no rationale for selecting November other than the fact that this was the month that followed development of the questionnaire. In retrospect, I wonder if another time of year would be more appropriate. People are very busy with pre Christmas preparations in November and December and this may adversely affect response rate.

Moreover, because the questionnaire was sent to a random selection of patients on the CarePlus programme, the length of time patients had been enrolled on CarePlus was not taken into consideration. Some clients may have only had one or two CarePlus visits, whilst others could have had anything between four to twenty visits. Retrospectively it would have been more appropriate to send the questionnaire to patients who had been enrolled on the programme at least a year and thus had attended at least four visits. Responses from patients who had just started on the programme may not have been as informed as those who had been on the programme longer.

1.5. "Who in the process can give us this data?"

Although the questionnaire is sent to the person enrolled on the CarePlus programme, it is not certain whether that person actually fills in the questionnaire. It is possible that a family member does so either with or without the client. Thus a useful improvement would be to include a response item that asks who has completed the form. There is also potential for bias because those who responded to the questionnaire may have been the more healthy and able

clients. Manaia therefore needs to consider how to gain feedback from patients who are less well and/or do not attend appointments.

1.6. "How can we collect this data from these people with minimum effort and chance of error?"

The plan was to obtain the information as easily as possible with the most minimum of effort. The perception of Manaia staff was that a questionnaire sent out to clients would be cost effective and take the least time. The following table provides a breakdown of costs (see also question 5 on page 43).

Effort	**Time**	**By Whom**
Developing questionnaire	10 hours	CarePlus Coordinator and Clinical Manager
Printing out questionnaire	3 hours	CarePlus Coordinator.
Sorting out addresses	5 hours	IT Manager
Addressing envelopes, and put questionnaires in envelopes	5 hours	Administration support
Opening responses and entering data	20 hours	Administration support.
Analysing data	20 hours	CarePlus Coordinator
Writing up reports and	25 hours	CarePlus Coordinator

recommendations.		

Having reviewed the time, effort and costs associated with an annual postal survey it is clear that we need to explore more effective ways of determining the positive impact of the patient centered CarePlus programme in Manaia PHO.

1.7 "What additional data do we need to capture for future analysis, reference and traceability?"

In the second year the survey was sent out, an additional question asked clients how long had they been on the CarePlus programme. This question was added because we recognized that length of time on the programme was relevant to other questions.
(See questions 3, 4, 5 and 13 in appendix B).
A person who has been on CarePlus for a year or longer should have a better understanding of their condition and medicines than somebody who has just started on the programme. The client may have seen the doctor or nurse for other visits in between their CarePlus visits which may have contributed to some of the positive changes and clinical outcomes. Seeing other health professionals could also contribute to a client's better understanding of their condition and medication.

Each questionnaire was coded with a number at the bottom of the questionnaire that linked the client to the practice he/she attended. This was done to facilitate traceability and enable comparisons to be made. For example, if the answer to question 12 (see appendix B) revealed that the CarePlus visit had been interrupted, this provided an opportunity to broach the

subject, visit the practice and provide support and education. In this way, the questionnaire was being used as a quality assurance tool as well as an education tool thus linking quality assurance with quality improvement.

2. Keep the following points in mind when planning for data collection

2.1. "Seek usefulness, not perfection".

The data, although useful for quality improvement and education, has also been used to enhance service to clients from the client's point of view. However, to date, the findings have only been presented annually and have not been reviewed across the four years. This has prevented examination of trends.

2.2 "Data recording must be easy Try to build it in the process under study"

The process for data entry was from hard copy questionnaire to Excel spread sheets (see appendix F). Spread sheets have been developed each year for data collection; the spreadsheet has been identified and simplified each year by administration support. It would have been easier to develop a template spreadsheet at the outset, then clear it each year and fill in the new data. Starting a separate spread sheet each year prevented us seeing cumulative trends. Using the same template and deleting the original data would make data entry less time consuming and reduce the likelihood of errors. Data was entered sequentially as the questionnaires were returned. Administrator support was introduced to the clinical team in 2008. Although she was employed

to support all clinical staff, I was used to doing my own administrative work and only requested her assistance for the questionnaire. Consequently no specific time was set aside by this person and the survey work was fitted around other daily tasks. The administrator support person found the process fairly easy once she had established a system to enter data and divide raw data into separate practices, but she also found she was interrupted by telephone calls and other requests.

2.3. "Use sampling as part of the plan to collect the data"

30% of each practices enrolled population of CarePlus clients were chosen randomly in October each year (see also 1.4).The clients were selected randomly as long as they were enrolled on CarePlus with a chronic condition. Patients with terminal illness were excluded. As previously mentioned, this did not take it to account how long a client had been enrolled on the programme.

2.4." Design the form with the collectors needs in mind."

The questionnaire was designed with the clients' needs in mind rather than the collectors. The focus was on ensuring that the form would be easy to understand and able to be completed by the clients. Most of the questions asked the client for information re their CarePlus visits. Although the questions were congruent with the purpose of the survey, we had not developed a sufficiently clear process for the collectors (see also 2.2 re data entry).

2.5."Minimize the possibility of errors."

Efforts were made to minimize errors but there is room for improvement.

Clear, unambiguous directions were included with the postal survey and a return date was provided. However, there was no follow up of the non returned questionnaires because this was not believed to be cost effective. There was little missing data from the questionnaires returned, and many who completed the questionnaires made additional comments.

The questionnaires were sent annually, but subsequent analysis of data sets has been done separately rather than comparatively.

In 2008 the programme introduced an additional tool; the CarePlus tool (CAPT) which required practice nurses to fill in a template on their Patient Management System. This provides consistent information recording on CarePlus visits throughout Manaia PHO. It also provides information regarding how long the CarePlus visit was for, what was discussed and any referrals that were made. It provides information on blood tests, weight and goals set, these results can be extracted and compared to see if clinical outcomes have been achieved. This tool also documents and shows over time knowledge of medication and conditions. It also documents goals set and achieved. All of these could be synthesised to determine whether. CarePlus is making a difference to clients in Manaia PHO.

3. Develop your plan by answering the following questions:

3.1 "Who will collect the data"

The CarePlus coordinator developed and disseminated the anonymous questionnaires. When the survey began in 2006, it was decided the CarePlus nurses could randomly give out the questionnaires to patients following their CarePlus visits. This did not work well in some practices because the nurse forgot to give the questionnaires out. The following year, a decision was made to randomly select clients from the PHO data base and send out the questionnaires by post.

In 2007, six people were involved with the survey mail out. Some were sent to incorrect addresses and although these were returned they were not redirected. Unfortunately some were also sent out without the questionnaire and only the stamped addressed envelope. Following this, a more robust system was introduced. Since 2008, the administration support and the CarePlus Coordinator have mailed out of the questionnaires. This has been a slower process, but fewer mistakes have been made however, one person has always entered all of the data and only one person has collated, analysed, and written the reports. However some may argue that the more people that have entering the data the better as they are able to cross reference(Bodenheimer et al, 2000) Perhaps we need to trial this at Manaia PHO?

3.2 "What data will be collected?"

A mixture of quantitative and qualitative data was collected. Upon reflection, other data could also assist in providing answers to our overarching question. Some of the information from the CAPT tool is relevant and could be incorporated (see also 2.5). For example, clients' blood results could be serially obtained and analysed to determine improvement, or otherwise, since being on the programme.

3.3. "When will the data be collected?"

Data has been collected in November as an annual occurrence (see also1.4). As previously mentioned, this timing needs reviewing because it lacks rationale.

3.4. "Where will the data be collected?"

The first year, the questionnaire was distributed by the 'CarePlus' nurses from their respective practices (see also 2.4). In other practices nurses insisted that clients fill out the questionnaire prior to them leaving their appointment. It is possible that a client may not feel able to be completely truthful under such circumstances. Bias may also result from the nurses' decisions as to who was given or not given a questionnaire.

3.5. "How will the data be collected?"

The data was collected from a randomized selection of CarePlus clients enrolled on CarePlus, regardless of the length of time on the programme. Data was collected from a returned postal questionnaire. It was sent out on November 4th with a request for return by 25th November each year.

4. "When you have developed a method to collect the data, test it with a few people who will actually be collecting the data and incorporate their ideas for improving the data collection plan"

Draft questionnaires were sent out to Practice Nurses for feedback, and alterations and corrections were made prior to sending it out. In 2006 the survey was revised to ask how long clients had been on the CarePlus programme. Questionnaires have always been the chosen method to obtain data from clients for feedback on CarePlus in Manaia PHO (see also 1.3). However I believe it may be beneficial to consider using face to face and / or telephone interviews. This could encourage greater detail as we could ask clients what they actually mean by the answers they give. It may also be a more effective way of reaching clients that do not attend or do not attend regularly.

5. "Be aware of the cost of collecting the data relative to the benefit gained from having the data"

The cost of the survey was not calculated before embarking on this project. In addition to the cost of staff time, other costs have included: Stationery to print off questionnaires, including paper and envelopes - 1,400 questionnaires of two pages long and 2,800 envelopes - $1635. It was decided to print the questionnaire off on two pages rather than double sided because of concerns that double sided printing may mean that respondents would fail to complete the second page. Postage to send out questionnaires with a stamped addressed envelope to help increase

return rate (Edwards, Roberts, Clarke, Diguiseppi, Kwan, Cooper, Felix, Pratap, 2007) came to $1400 each year

6.”Teach all of the data collectors how to collect the data correctly.”

As the method used to collect the data was a questionnaire, data collectors were not required. However the first year errors in distribution related to an incorrect assumption that nurses had experience with survey research. It is important that training in these procedures is provided and if a decision is made to interview by phone in the future, then the cost of training the data collectors will have to be taken in to consideration. Keeping data collectors to a minimum would assist achievement of consistency.

7. “Record what went wrong during the data collection so that learning can take place”

Input of data was fairly straight forward in that only one person was involved (see also 3.1 and 3.4). I was able to recognize and respond to inconsistencies in the data collection process. In future I would draw up a more formal plan re data collection.

8. “Audit the data as it comes in for accuracy and completeness. Correct errors early.”

The data was regularly checked for accuracy and completeness by me as it was being entered against the raw data from the questionnaire. As the CarePlus Coordinator, I was the person who took responsibility for ensuring accuracy of data entry. I am a senior nurse with five years of project management experience and am undertaking post graduate study. It was therefore appropriate that I take on this role.

Section four

Discussion

Findings and Learning

This project has re-examined the CarePlus questionnaire that has been used in Manaia PHO for the past four years and, using the IHI Simple Data Collection tool, has reviewed the survey process that has collected information from clients enrolled on this programme.

This was a useful and very interesting exercise. The IHI planning tool has facilitated critical appraisal of a process that Manaia PHO had undertaken relatively naively. Systematic critique of all stages of the survey has generated a number of important findings and prompted some stimulating discussions about the relevance of the CarePlus questionnaire as a quality improvement tool.

- The questionnaire recorded previously known anecdotal evidence on a more formal basis. Presentation of the results in simple and concise bar graphs and tables has allowed the information to be interpreted quickly and easily. It has also assisted dissemination of information to the various practices, which in turn, has promoted use of the CarePlus programme.
- Overall, patients in the Manaia PHO are extremely satisfied with the CarePlus programme and its role in supporting them to make changes in their lifestyles. The establishment of a partnership between patients and health professionals is a key success

factor. This seems to have strengthened since the commencement of CarePlus and continues to improve each year. The results of the survey since 2006 reinforce the positive impact that CarePlus is making on the health and wellbeing of individuals and whanau living within the Manaia Health PHO boundaries.

- Staff in the PHO has gained greater understanding of clients' perceptions of the Care Plus programme. Patients felt fully listened to as a result of their CarePlus visit and appreciated the explanations they received. They also became more positive about their health and more able to set appropriate goals (see appendix C).
- In the second year, minor difficulties associated with the first questionnaire were rectified and elements were added to facilitate traceability to practices within the PHO. This was an important addition because it allowed for comparisons between practices and thus better linked quality assurance with quality improvement, something which is fundamental to the ongoing success of any programme (Boyle, 2006).
- The decision to collect information via a postal questionnaire minimised intrusion and enabled participation without any pressure. However, one of the limitations of this method relates to uncertainty as to whether the patient or a family member or friend filled out the questionnaire. Experience of the CarePlus programme is likely to be different depending on whether you are a patient or someone else thus this is something that needs to be addressed in the future.
- It is also possible that randomised sampling limited the survey findings because some of the participants randomly selected had not been on the programme long and thus had little experience to draw from.

- One of the major goals of the CarePlus programmes nationally is to reduce health disparities (MOH 2004). Ajwani (2003) also suggests that New Zealand health care is failing to address the health inequalities for the Maori population. The Manaia questionnaire did not collect information about ethnicity, gender, age or income and thus doesnot enable such comparisons to be made. Working through the IHI process has identified this as an area for future consideration.

- The outlay of an annual postal survey in terms of time and money is not insignificant and needs to be balanced against the positive impact of the patient-centred CarePlus programme in Manaia PHO. This is something else the PHO needs to consider.
- Data entry was a sizeable task but time has refined the process. The simplification of recording methods and the addition of administration support to the CarePlus team have helped the process to become more manageable. This would have been further assisted had the form been developed with the collector in mind as well as the patient.
- Limited personal experience with graphs and minimal experience with the Excel spreadsheets meant that I under-utilized functions that could have improved data entry and collation. These spreadsheets could be more useful and would have been easier to report and analyse if I had worked collaboratively with the Information Technology Team in Manaia. The way the Excel sheets were set out made them hard to import. If an analysis tool pack had been used, we would have had the benefit of obtaining different graphs with more useful information.e.g barr graphs, pivot tables and pie graphs.
- The response rate for the questionnaires sent out for the research undertaken was 45%. In a postal questionnaire the respondent receives all communications in writing; the instructions, the questionnaire and the instructions for submitting the replies. The

researcher does not have direct contact with the respondent. Anonymity may make questionnaires easier for people to respond to because they do not know or see the researcher. However, receiving a questionnaire through the post rather than through direct contact with the researcher may mean that a person less inclined to fill in the questionnaire. There is a varied opinion regarding acceptable return rates for questionnaires. Some researchers have argued that 30- 40 % is acceptable (Duckett, 2000; Boyle, 2006) while others like Edwards, Roberts, Clarke, DiGuiseppi, Pratap, Wentz and Kwan, (2002) claim bias is likely if the rate falls below 80% bias. This highlights the limitations of small studies and the extent to which they can be generalized from.

- Finally, the use of survey, as a tool alone, allows certain information to be gathered but also has limitations. As new tools, such as CarePlus Tool (CAPT) is added to the CarePlus programme it is important that a way is found to incorporate all information into the annual reports. The CAPT tool provides outcome information such as blood results and weight measurement which can be analyzed alongside other patient data to better determine the effectiveness of the CarePlus programme. Drawing from all available information will provide a more comprehensive indication of progress and thus a stronger basis for deciding the future direction of services within Manaia PHO.

Going Forward

The IHI tool has helped to facilitate a step by step quality improvement process in relation to use of the CarePlus questionnaire at Manaia PHO. It has been a focused, clear and precise process that has resulted in a detailed review of an existing survey process.

Meetings between the Chief Executive Officer, Clinical leader, Quality leader and CarePlus Coordinator will now need to take place to discuss the findings of this project. Decisions will need to be made regarding costs/benefits and future changes. As previously mentioned, the CarePlus programme entitles people with chronic health conditions to four free visits to their GP or Practice Nurse annually. Yet there are significant numbers who are not attending these visits. Exploring the reasons for this would assist Manaia to adapt the programme appropriately. Feedback has been received from practice nurses suggesting reasons for client non attendance. Some clients are believed to have difficulty getting to the practice clinics. Others are doing well and do not need four visits a year and some only attend the general practices when they are ill because they do not understand the preventative benefits of CarePlus. Manaia has already responded to this feedback by trialing telephone consultations and assessing the possibility of clients attending lifestyle group sessions as a pathway to being discharged from CarePlus. Telephone contact will be considered as a means of contacting hard-to-reach clients, but consideration will need to include the time needed to adequately train the data collectors.

Use of the tool has also provided insight into other possible applications; The IHI tool could be used, for example, to review the immunisation outreach and youth health programmes to further enhance quality improvement throughout the PHO.

In Conclusion

The CarePlus questionnaire clearly has a place in evaluating the effectiveness of the Manaia programme. Yet there is room for improvement and critical appraisal, using the IHI tool, has illuminated a number of deficiencies.

It has facilitated systematic review of a client survey and illuminated the need to incorporate other forms of data to gain a more comprehensive appraisal of CarePlus. It has also revealed the benefit of collecting demographic data to ensure that relevant information is being obtained, from the right people and in a way that assists analysis and reporting. Insight into other potential uses of the tool has also been recognised.

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Appendix A

2006 CarePlus questionnaire

2006 Manaia Health Primary Health Organisation (PHO)

Manaia Health
CARE PLUS

You are receiving this questionnaire because you are enrolled on the CarePlus Programme. To help us improve the services we provide and better meet your needs, we would be grateful if you could complete this questionnaire and return it in the stamped, self addressed envelope provided. *This is an anonymous questionnaire; therefore we do not need your name or address*. Thank you.

Questionnaire

1. Who do you see for your CarePlus visit
   Doctor ☐ Nurse ☐ Both ☐

2. Usually the time spent at your CarePlus visit is around 45 minutes. Do you believe the length of time is

   Too much time ☐ Not enough time ☐

   Just right ☐

3. CarePlus entitles you to 4 free visits a year, (ie 1 every 3 months). Do you feel the length of time between each visit is

   Too long ☐ Too short ☐

   Just right ☐

4. As a result of your CarePlus visits, has your understanding about your medicines

   Improved a lot ☐ Improved slightly ☐

   Stayed the same ☐ Decreased ☐

5. As a result of your CarePlus visit has your understanding about your medical condition

   Improved a lot ☐ Improved slightly ☐

   Stayed the same ☐ Decreased ☐

6. Do you find the wellness plan useful to you?

   Very useful ☐ Somewhat useful ☐

   Not useful at all ☐ Neither useful or useless ☐

7. What suggestions (if any) do you have to improve the wellness plan?

……
……
……..

8. Do you take your wellness plan with you when you visit other health professionals?

Yes ☐ No ☐ If not, why not?.....

……..

9. Do you feel that you were listened to during your CarePlus visit?

Fully listened to ☐ Felt listened to some of the time ☐

Not listened to at all ☐

10. Did you talk about issues you wanted to discuss?

I discussed everything I wanted to ☐
I discussed a lot of what I wanted to ☐
I discussed some issues that I wanted to ☐
We did not discuss any issue that I wanted to ☐

11. Was your CarePlus visit uninterrupted?

Yes ☐ No ☐

12. Overall please rate your satisfaction with the CarePlus service you have received

Very satisfied ☐ Somewhat satisfied ☐ Satisfied ☐

Somewhat dissatisfied ☐ Dissatisfied ☐

What has been the most useful part of CarePlus for you?

……
……
……..

What is one thing if any, about your health that you have changed or altered since being on the CarePlus Programme?

……
……
……..

Are there any areas we could improve on?

……
……
……..

Thank you for taking the time to complete this questionnaire.

Appendix B

2007 CarePlus questionnaire

Manaia Health Primary Health Organisation (PHO)

CARE PLUS

You are receiving this questionnaire because you are enrolled on the CarePlus Programme. To help us improve the services we provide and better meet your needs, we would be grateful if you could complete this questionnaire and return it in the stamped, self addressed envelope provided. *This is an anonymous questionnaire; therefore we do not need your name or address*. Thank you.

Questionnaire

1. How long have you been on the CarePlus Programme?
☐ <3 months ☐3-6 months ☐6-12 months ☐>12 months

2. Who do you see for your CarePlus visit
Doctor ☐ Nurse ☐ Both ☐

3. Do you believe the length of time you are given at each appointment is:

Too much time ☐ Not enough time ☐ Just right ☐

4. CarePlus entitles you to 4 free visits a year. Do you feel the number of visits is:

Too many ☐ Too few ☐ Just right ☐

5. As a result of your CarePlus visits, has your understanding about your medicines

Improved a lot ☐ Improved slightly ☐

Stayed the same ☐ Decreased ☐

6. As a result of your CarePlus visit has your understanding about your medical condition

Improved a lot ☐ Improved slightly ☐

Stayed the same ☐ Decreased ☐

7. Do you find the wellness plan useful to you?

Very useful ☐ Somewhat useful ☐

Not useful at all ☐ Neither useful or useless ☐

8.What suggestions (if any) do you have to improve the wellness plan?

.....

.....

.....

9.Do you take your wellness plan with you when you visit other health professionals?

Yes ☐ No ☐ If not, why not?.....

.....

10.Do you feel that you were listened to during your CarePlus visit?

Fully listened to ☐ Felt listened to some of the time ☐

Not listened to at all ☐

11.Did you talk about issues you wanted to discuss?

I discussed everything I wanted to ☐
I discussed a lot of what I wanted to ☐
I discussed some issues that I wanted to ☐
We did not discuss any issue that I wanted to ☐

12.Was your CarePlus visit uninterrupted? Yes ☐ No ☐

13.Overall please rate your satisfaction with the CarePlus service you have received

Very satisfied ☐ Somewhat satisfied ☐ Satisfied ☐

Somewhat dissatisfied ☐ Dissatisfied ☐

What has been the most useful part of CarePlus for you?

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What is one thing if any, about your health that you have changed or altered since being on the CarePlus Programme?

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Are there any areas we could improve on?

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Thank you for taking the time to complete this questionnaire. Please return in the envelope provided by 4th November.

Appendix C

Example of a CarePlus Report

CarePlus Patient Questionnaire Report.

Introduction

CarePlus was introduced into Manaia Health PHO general practices in October 2004, with implementation been based on the underlying premise that a carefully planned and supported rollout was essential. The central focus has always been on supporting the patient living with a chronic condition, together with his/her family/whanau.

Since its inception, anecdotal feedback from patients regarding the difference that CarePlus was making in their lives has been very positive. A questionnaire was developed in 2006 to gain more objective feedback and this was repeated in October 2007.

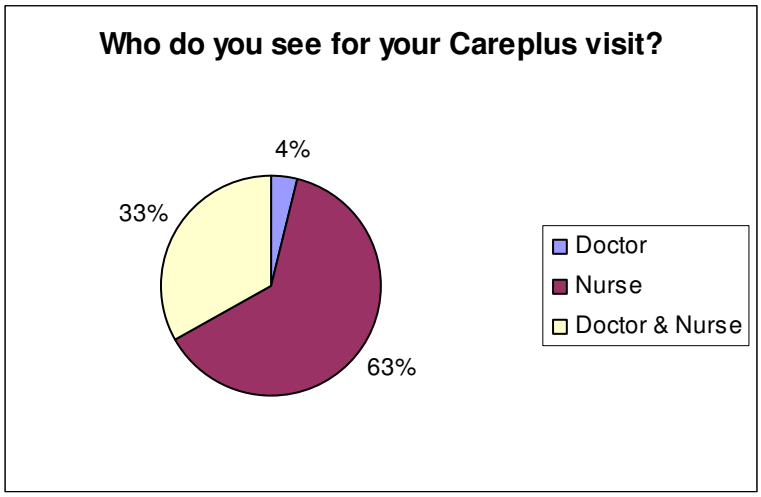
Process:
861 questionnaires were distributed to the 21 practices participating in CarePlus – this equated to approx 30% of the total number of patients enrolled in CarePlus within each practice. A random sample of patients was selected, and with the full consent of each Practice Manager, the CarePlus Coordinator sent the questionnaires to the participants. To ensure anonymity, all questionnaires were returned to the CarePlus Coordinator in a stamped addressed envelope.
360 questionnaires were completed and returned, giving a **return rate of 42%.**
The following results are presented using the same format as the questionnaire which is appended to this report.

Question 1: How long have you been on the CarePlus Programme?

9 Patients answered less than 3 months.
19 Patients answered between 3 – 6 months.
50 Patients answered between 6 – 12 months.
282 Patients answered more than 12 months.

Question 2 : Who do you see for your CarePlus visit?

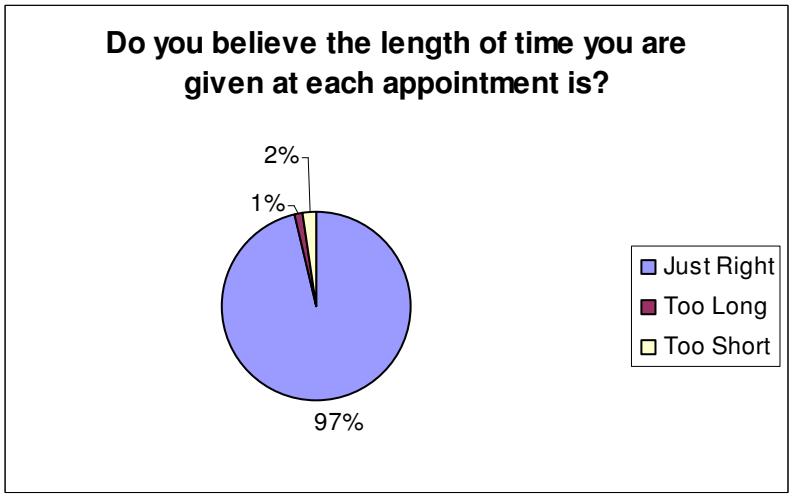
14 patients answered the Doctor
227 patients answered the Nurse
119 patients answered they saw both the Doctor and the nurse.



63% of the patients surveyed see the Practice Nurse for their CarePlus visits, with a further 33% seeing both GP and Practice Nurse.

Question 3: Do you believe the length of time you are given at each appointment is :

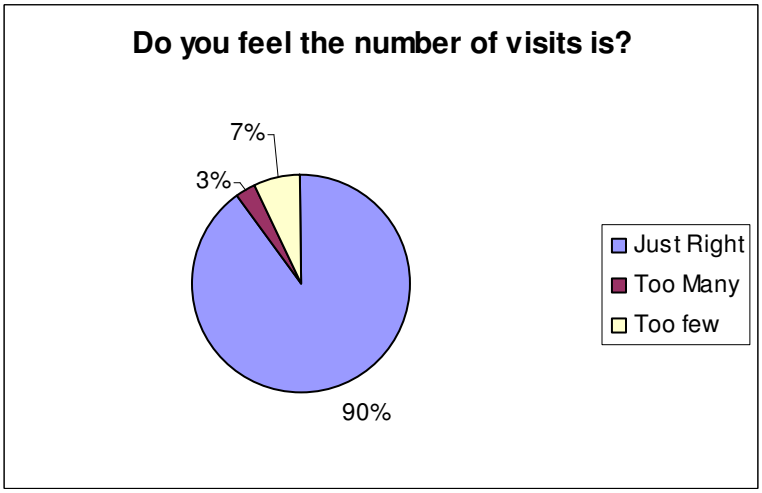
347 patients answered just right.
5 patients felt the length of time was too long.
8 patient felt the length of time was too short.



97% of patients surveyed felt the length of time they were given at each appointment was just right

Question 4: CarePlus entitles you to 4 free visits a year .Do you feel the number of visits is :

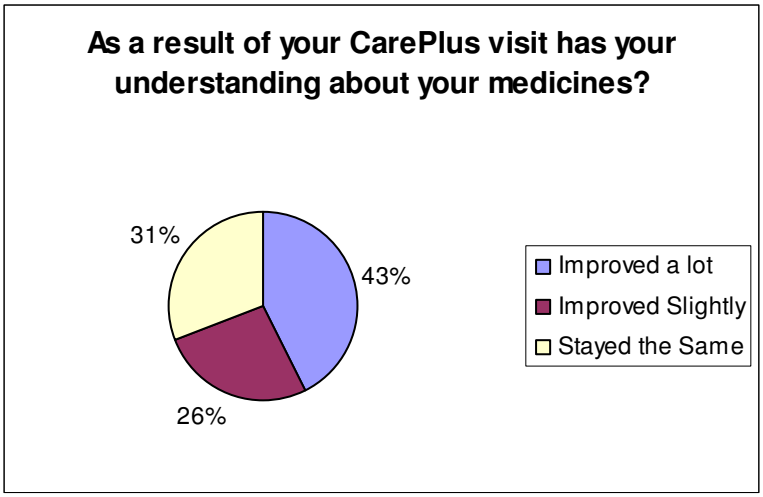
324 patients felt the number of visits was just right.
11 patients felt it was too many
25 patient felt it was too few



90 % of patients felt the number of visits was just right.

Question 5: As a result of your CarePlus visit has your understanding about your medicines:

154 patients felt their understanding of their medicines had improved a lot.
95 patients felt their understanding of their medicines had improved slightly.
111 patients felt their understanding of their medicines had stayed the same.

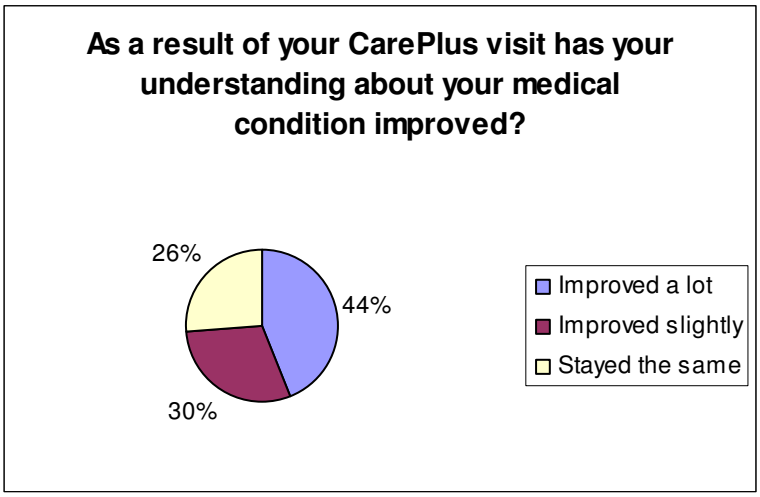


69% of patients surveyed felt their understanding of their medicines had improved either a lot (43%) or slightly (26%), as a result of CarePlus visits.

Question 6: As a result of your CarePlus visit has your understanding about your medical condition improved.

158 patients surveyed felt there understanding of their medical condition had improved a lot.
107 patients felt their understanding had improved slightly.

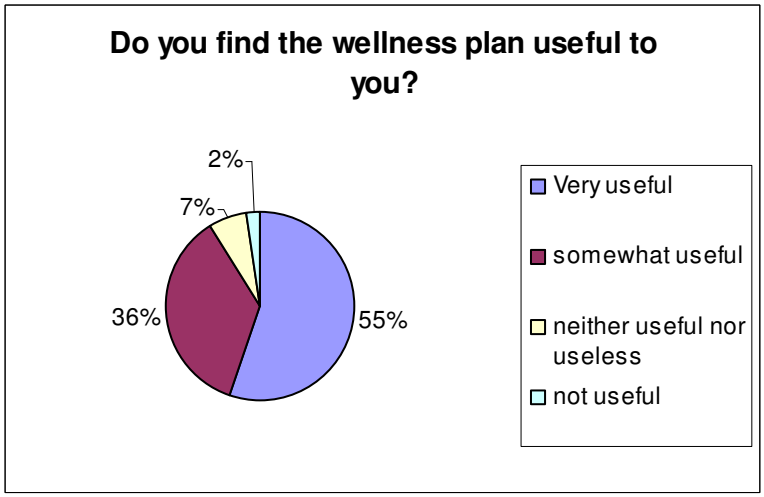
95 patients felt their understanding had stayed the same.



74% of patients felt their understanding of their medical condition had improved a lot (44%) or slightly (30%) as a result of CarePlus visits.

Question 7: Do you find the wellness plan useful to you?

199 patients surveyed found the wellness plan very useful.
129 patients surveyed felt it was somewhat useful.
24 patients found the wellness plan neither useful nor useless.
8 patient found the wellness plan not useful at all.



Overall 91% of patients found the wellness plan very useful (56%), or somewhat useful (35%).

Question 8: What suggestions (if any) do you have to improve the wellness plan?

From the answers/comments made, patients are extremely happy with the wellness plan. All comments were positive and no suggestions were made about how the wellness plan could be improved.
Example of answers: “The care plan is excellent as it is”, “Gives great communication when admitted to hospital”.

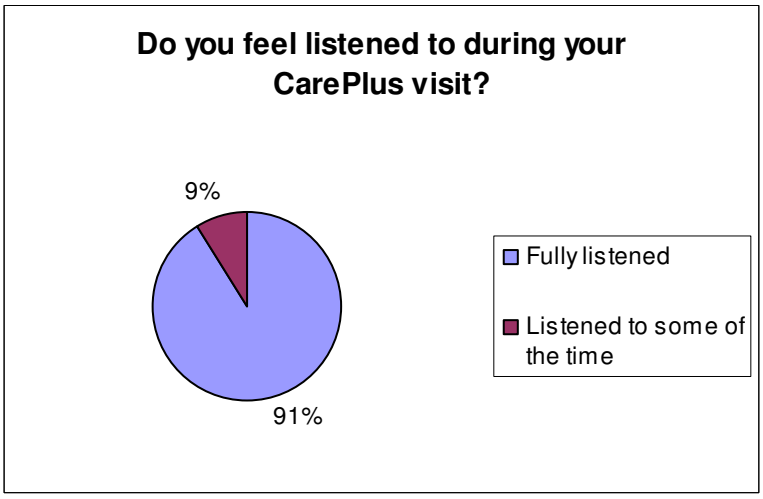
Question 9: Do you take your wellness plan with you when you visit other health professionals?

234 patients said yes they did take their wellness plan with them when they visited other health professionals.
126 patients surveyed said no they didn’t.

Overall 65% of patients take their wellness plan with them when they visit other health professionals.

Question 10: Do you feel that you were listened to during your CarePlus visit?

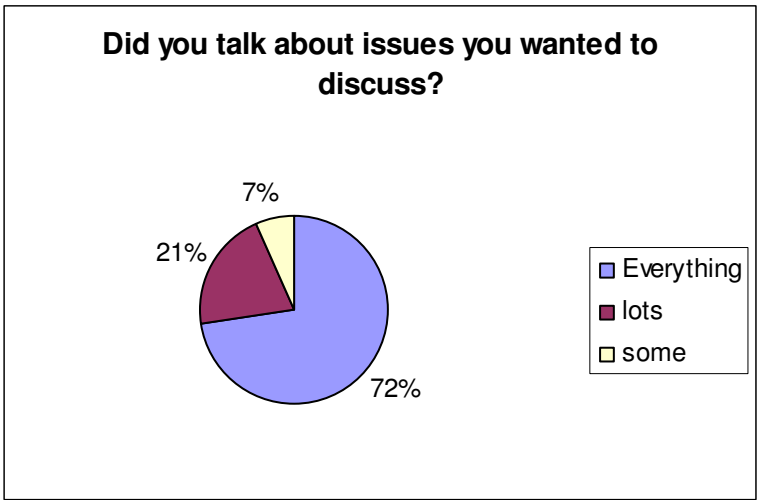
337 patients felt they were fully listened to.
23 patients felt listened to some of the time.



All the patients who completed the questionnaire felt either fully listened to (94%), or listened to some of the time (6%) during their CarePlus visit.

Question 11: Did you talk about issues you wanted to discuss?

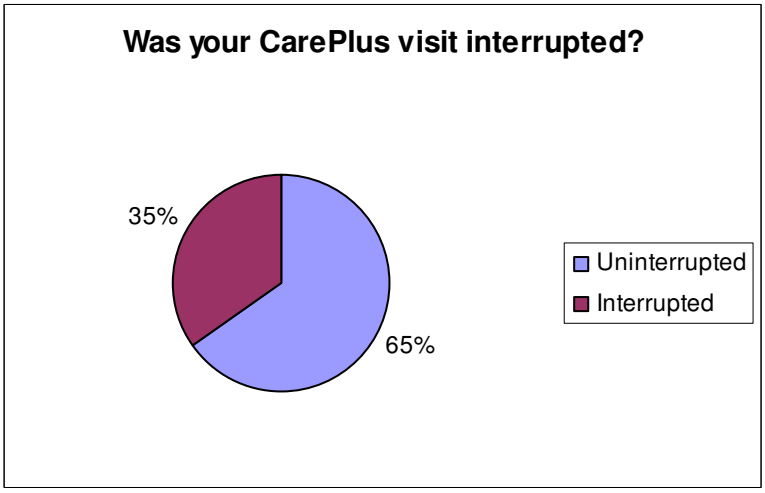
259 patients surveyed discussed everything they wanted to discuss
74 patients felt they discussed a lot of issues they wanted to.
27 patients discussed some issues they wanted to.



All the patients who completed the questionnaire felt they had discussed at least some of their issues during their CarePlus visit/s, with 72% having discussed everything they wanted to discuss.

Question 12: Was your CarePlus visit uninterrupted?

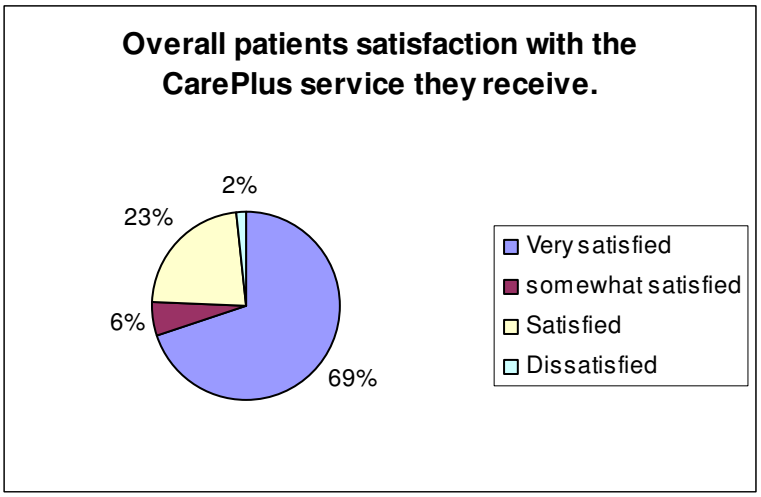
235 Patients surveyed said their visits were uninterrupted.
125 Patients said their visits were interrupted.



Overall 65% of patients surveyed said their CarePlus visits were uninterrupted.

Question 13: Overall please rate your satisfaction with the CarePlus service you have received.

252 Patients surveyed said they were very satisfied with the CarePlus service they received.
20 Patients were somewhat satisfied.
82 patients were satisfied.
6 Patients dissatisfied.



Overall 98%, of patients were satisfied with their CarePlus service they receive.

Question 14: What has been the most useful part of CarePlus for you?

Patients who completed the questionnaire made a range of comments in response to this question – from these comments, four key themes emerged. These are presented below together with some examples of the words patients used to describe these aspects:

- ***Enhanced understanding of condition / medication.***

Examples:

- I enjoy my careplus programme for it gives me the opportunity to meet regularly with my nurse and sometimes my doctor as a person and talk about my well being.
- The importance of learning to eat in a more healthy way. I have a much better understanding of my well being.
- The general information given to obtain a better understanding of the illness.
- Being kept up to date and discussing my general health and with any advice on how to improve it.
- Finding out my health problem and making it better and healthy.

- ***Being listened to***

Examples:

- I feel CarePlus is a great help to the elderly .It is so good to have someone explain things re medication, also good to have someone to take time to listen to our moans about our aches and pains. Really great.
- A good listener to talk about my problems.
- It is an ideal opportunity to ask questions, get answers and be listened to.
- The well nurses and Drs have listened and explained a lot of things.
- Being 82years old and living alone to have someone to discuss ones health problems with who listens to me.

• ***Regular health monitoring***

Examples:

- quality of awareness and assurance of progress and reports.
- psychological , somebody is professionally and knowledgably interested.
- keeps me informed and up date on my health issues.
- most informative for me to have problems and medications discussed with me as they are very caring people and put me at ease, and don't make me feel as though im wasting their time.
- can discuss minor health niggles and if necessary made appointment to take it further with the doctor. Also have regular blood pressure, weight checks.

– I have found the CarePlus service excellent in everyway.
– Knowing I have regular 3 monthly checks. Someone friendly to help me understand my conditions, the whys and how to help maintain the situations.
– Information about my wellness that I did not understand before visiting CarePlus.
– The mere fact that the information is shared and everything is explained clearly gives me the feeling that im valued and that my life is worth saving.
– Being able to sit and discuss things to do with your health on a personal basis. we are where we are now with the help and kindness and the valuable time they take with you – awesome.

• ***Goal setting***

Examples:

- Checks on whether goals have been kept up.
- setting goals and keeping me on track.
- I have introduced regular multi vitamin, and a combination of antioxidants that seem to limit the crippling pains of arthritis in hands.
- I have more confidence in myself and can understand my problems and how to set goals.
- A positive attitude about my health and setting goals for myself.

Question 15: What is one thing if any, about your health that you have changed or altered since being on the CarePlus programme?

As a result of being on CarePlus, patients stated they had made some changes in the following key areas:

• **Diet,50% of patients surveyed said they had made some changes in their diet. Examples of comments made include;**

- Healthier diet, drink more water.
- Changed my eating habits and now taking care with my diet and exercise.

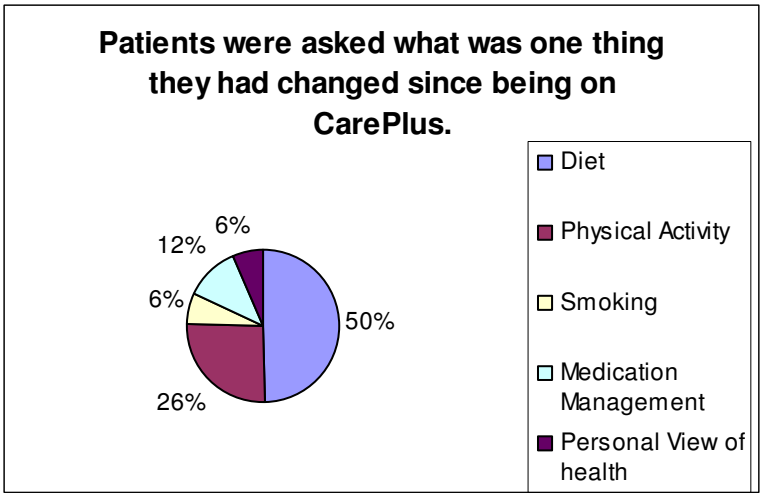
- Lose weight, eat healthier Iam totally aware of my own responsibility of my care.
- I turned 81 years of age in august and made the decision to stop dieting.
- reading ingredients on food labels when shopping

- **Physical Activity, 26% of patients surveyed said they had made some change in their physical activity. Examples of comments made include;**
- exercising more (this was mentioned by many respondents)
- get more activated in walking and modified Tai Chi classes.

- **Smoking, 6% of patients surveyed had stopped smoking. Examples of comments include;**
- Stopped smoking and listened to good advice.
- Given up smoking.

- **Medication Management, 12% of patients surveyed had made a change in their management of their medication. Examples of comments made include;**
- A greater knowledge of the intended effects of each one of my medicines.
- getting better at taking all my pills now

- **Personal view of health, 6% of patients surveyed had made changes in their personal view of health. Examples of comments made include;**
- sticking to the plan that has been given me by the specialist and understanding why.
- I have become physically independent and overcome frailties.
- putting time aside to deal with wellness as the single focus.
- Keeps me motivated to help improve health by exercise and type of food eaten.



Areas for improvement.

Some suggestions for improvement noted by patients included the following:

- Increase the knowledge and ability of the nurse so she can advise on a wider range of medical topics.
- Cover more aliments, so more people can be included in programme.

From the perspective of the PHO one area requiring some further work is to ensure that CarePlus visits are uninterrupted. The CarePlus Coordinator will address this in practices early in 2008.

Conclusion:

Overall patients are extremely satisfied with the CarePlus programme, with a number of people noting how satisfied they are and how CarePlus is totally committed to them and to helping make changes in their lifestyles. one patient commented that the "personal approach was working well." A comment was made by a grateful wife of a patient on CarePlus which said "my husband is being looked after with CarePlus, from my point of view I have found that the CarePlus has been very helpful for me, taking some of the worry and stress away from me"
The establishment of a partnership between patient and health care professional is a key success factor, which seems to have strengthened in practices.

There is an increasing body of knowledge that validates the difference that a patient centred approach makes to health and quality of life for both patients and their families/whanau that live with a chronic condition. Results from both this questionnaire and the questionnaire distributed in 2006 further reinforce the stance that CarePlus is continuing to make a positive impact on the health and wellbeing of individuals, whanau living in Manaia Health PHO Boundaries.

CarePlus questionnaire distributed Oct / Nov 2007; report prepared by Jayne Hill, CarePlus Coordinator Manaia Health PHO, December 2007

Appendix D

Email: Permission being given to reproduce the IHI Simple Data Collection Tool.

From: jaynecomplete@gmail.com
Sent: Wednesday, 22 September 2010 7:31 a.m.
To: Jayne Hill
Subject: Fwd: Permission to reproduce IHI.org content

---------- Forwarded message ----------
From: **Val Weber** <VWeber@ihi.org>
Date: 5 May 2010 10:08
Subject: Permission to reproduce IHI.org content
To: "jayne.hill@manaiapho.co.nz" <jayne.hill@manaiapho.co.nz>
Cc: Info <info@ihi.org>

Hello Jayne,

I received your inquiry below seeking permission to reproduce the Simple Data Collection Planning tool content from IHI's website in your Masters project paper.

http://www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Tools/Simple+Data+Collection+Planning.htm

We are pleased that you find this material useful in your work, and we give you permission to reproduce the specified content in your project paper. Please include the following credit line with the material:

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Best wishes,

--Val

Valerie Weber
Institute for Healthcare Improvement
20 University Road, 7th Floor
Cambridge, MA 02138
Tel (617) 301-4811, Fax (617) 301-4848
www.ihi.org

Please consider the environment before printing this email.

-----Original Message-----

From: webmaster@ihi.org [mailto:webmaster@ihi.org]

Sent: Sunday, May 02, 2010 8:27 PM

To: Improvementmethods

Subject: A message from an IHI.org user

An IHI.org user has sent the following feedback from the Contact Us form:

User's Name: Jayne Hill

User's Email Address: jayne.hill@manaiapho.co.nz

Category: Improvement Methods

Subject: Improvement Methods-simple data collection

Message:

Hi,

Would it be possible for me to reproduce your Simple Data Collection Planning steps in a write up Iam doing for my practice project as part of my Masters in Health Science I am doing at AUT University in Auckland New Zealand? Please let me know if you would like any further information.

Kind Regards

Jayne Hill

This e-mail message has been scanned for Viruses and Content and cleared by **MailMarshal**

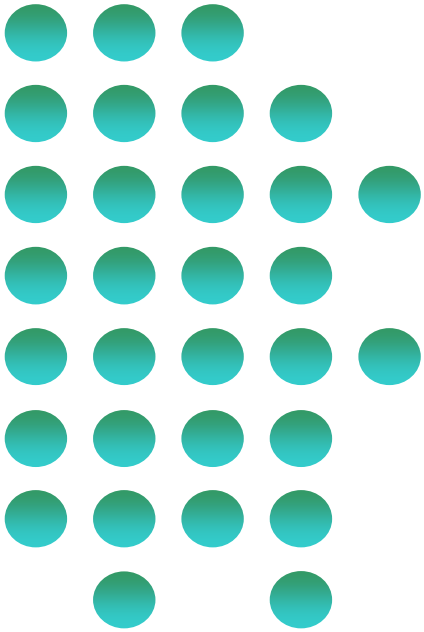
Appendix E

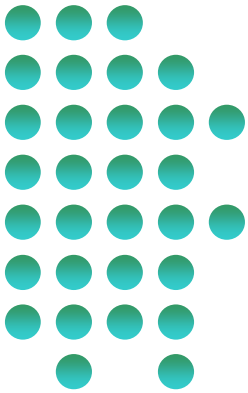
2006 Annual CarePlus Report

Asking the question "Is CarePlus making a difference"

Manaia Health Primary Health Organisation

CarePlus Annual Report June 2006





CarePlus Annual Report

Background

CarePlus is a government initiative which was introduced nationally through PHO's from 1 July 2004. The service is targeted towards people who need to visit their General Practitioner or nurse often because of significant chronic illnesses such as diabetes or heart disease, have acute medical or mental health needs, or a terminal illness. It was envisaged that people using CarePlus will get effective management of chronic health conditions, better understanding of their conditions and support to make lifestyle changes.

As described on the Ministry of Health (MOH) website (2004), a person is eligible for CarePlus if they are enrolled in a PHO and who:

- Is assessed by a doctor or nurse at their general practice and who could benefit from "intensive clinical management in primary care"(at least two hours of care from one or more members of the primary health team) over the following six months; and either
- Has two or more chronic health conditions so long as each condition is one that: is a significant disability or has a significant burden of morbidity; and creates a significant cost to the health service; and has agreed and objective diagnostic criteria; and continuity of care and a primary care team approach has an important role in management; or
- Has a terminal illness (defined as someone who has advanced, progressive disease whose death is likely within 12 months) or;
- Has had two acute medical or mental health related admissions in the past 12 months (excluding surgical admissions); or
- Has had six first level service or similar primary care visits in the past six months (including emergency department visits); or
- Is on active review for elective services.

It was intended that CarePlus would:

- Fund and protect practice team time and resources to enable additional, planned time to be spent with CarePlus patients and would be directed at improved health outcomes. This would focus attention on the health status of patients and their personal health related goals
- Enable systematic attention to objective measures of health status of patients, defining carefully their health needs and risk factors (physical, social, lifestyle and behavioural), creating with patients a composite management plan, and re-measuring their health outcomes after set periods of time
- Provide an opportunity to implement interdisciplinary and clinical/cultural approaches to primary health care
- Provide an opportunity to improve or develop relevant tools, processes and guidelines to support this systematic approach to delivering and measuring health care services.

Local Implementation

CarePlus was introduced in Manaia Health PHO in October 2004, with the underlying premise that a carefully planned and supported rollout was essential.

Key principles which have guided the initial and on-going implementation of CarePlus within Manaia Health PHO include:

- Maintaining the integrity of the purpose of CarePlus through a well structured and carefully managed roll-out – the focus has always been on quality as opposed to meeting arbitrary enrolment targets.
- Being clear that the central focus is on the patient and his/her family/whanau
- Encouraging and supporting a team approach to CarePlus implementation, both at the general practice level, and across the primary/secondary interface.
- Ensuring the general practice team is well supported ~ this includes multiple strategies to support IT and administrative functions, as well as the General Practitioner and Practice Nurse roles
- Ensuring that tools, resources and education provided to support CarePlus are based upon best practice guidelines

Key Strategies:

A focus on specific chronic conditions

In the initial stages of implementation the decision was made to focus primarily on four main chronic diseases – this enabled a clear and focussed framework for subsequent development. Eligibility for enrolling patients into CarePlus was therefore restricted to patients who had two chronic conditions, one of which must be either diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) or cardio vascular disease (CVD). These conditions are clearly recognised as leading causes of mortality and morbidity in our population. A parallel development occurring at the time was the decision made by Northland DHB to introduce the Counties Manukau chronic care management (CCM) system across Northland's primary care providers. This programme provides a generic approach and a common set of tools for care planning and management for people with diabetes, COPD, CHF and CVD. This model was seen as complimenting and enhancing CarePlus, as it is based upon similar elements, namely: self-management support, clinical information systems, delivery system redesign, provider decision support, healthcare organisation (structure, goals and values) and linkages with community resources. Clinical information is recorded on self-populating disease templates within the GP's existing Patient Management System (PMS). An agreed clinical data set is sent via Health link to an integrated care server (ICS), which applies a set of guideline rules to the data and then automatically sends alerts, reminders and other suggested advice to the provider to support clinical decision making.

IT support

Manaia Health PHO has developed a robust I.T infrastructure, which carries out regular update instalments of the Counties Manukau Templates. The I.T team also assists and supports the practices with any CarePlus issues related to their practice management system, and responds to all queries. IT support with the template interface management system is also provided from Counties Manukau.
A stream-lined and effective invoicing system has also been established ~ a fax reminder is sent out at the end of each month to remind practices to invoice the PHO for the CarePlus patients they have seen that month, and the Practice Managers send the invoice via e-mail at month's end. This system also enables the CarePlus Co-ordinator to track progress regarding numbers of new enrolments into the programme.

Clinical oversight

A CarePlus sub–committee was established to provide clinical guidance and support during the initial roll-out phase ~ this comprised members of Manaia Health's clinical committee, PHO staff, and representation from a Maori health provider. As the programme has become more embedded in practices, it was decided this sub-committee was no longer required – CarePlus reports are now submitted to Manaia Health PHO's clinical committee, with issues concerning CarePlus now been addressed in this forum.

Incentivising participation

To encourage the initial participation of practices into CarePlus, the GP's were offered an additional incentive through a memorandum of understanding (MOU). The MOU set negotiated, realistic and achievable enrolment targets that the practice was expected to meet within a clearly defined time-frame. The majority of practices within Manaia Health participated in this process, with the incentive payment being primarily used to establish CarePlus clinics and to ensure sufficient and protected nursing time was available. This process was also an important opportunity to discuss the concept of CarePlus with the GP's, to explain the systematic approach been taken by the PHO, and to ensure there was a shared understanding of the programme.

Support for the general practice team

From the outset it was recognised that a key success factor for CarePlus implementation was to ensure that Practice Nurses were well supported in terms of knowledge and skill development. While CarePlus is undeniably based on the premise of a team approach to care delivery, in the majority of Manaia practices, it is the Practice Nurse who undertakes the patient consultations. Education strategies have focussed on both enhancing knowledge of the specific disease states, as well as strategies to support the patient focussed, self management approach which is inherent within CarePlus. Previous work undertaken by the PHO's nursing leader and diabetes nurse established a strong foundation from which to build the vision for CarePlus, and assisted in gaining 'buy-in' to a process that for many nurses was a significant change to their role within the practice team.

Prior to implementation of CarePlus most of the Practice Nurse's were funded to attend brief opportunistic intervention training. This course was facilitated through the Auckland University, General Practice and Primary Health care Unit, and included the concept of motivational interviewing. It was recognised at this time that CarePlus was a new approach to managing chronic disease in the general practice setting, and that many Practice Nurses needed support in working with patients to develop wellness plans and identify patient-centred goals. Education was also provided for GP's and Practice Nurses at scheduled Continuing Medical Education (CME) sessions on the management of chronic conditions, and utilisation of the Counties Manukau best practice templates. The 'launch' of CarePlus was marked by a symposium for nurses – nurses were provided with a 'snap-shot' of the four key chronic conditions, and community agencies were present to talk about their services.

On-going education

Over the past 12 months this focus on education has been maintained. The PHO has provided regular CarePlus education to all Practice Nurses involved with CarePlus. All

four chronic conditions have been covered in depth and a variety of speakers including medical and nursing specialists from both the primary and secondary sector, as well as pharmacists and PHO staff, have ensured that the education provided is of a consistently high standard. These sessions have been important in raising the nurses' confidence and knowledge base, as well as strengthening relationships and understanding between primary and secondary care. Shared learning, networking and support have certainly impacted positively in reducing some of the primary/secondary interface issues, while continuing to include input from various community groups (e.g. Diabetes Northland, Age Concern) has been successful in broadening the inter-sectoral approach to health care delivery.

The formal CME programme facilitated by Manaia Health has also included sessions on the four chronic conditions (i.e. diabetes, COPD, CHF, and CVD). These sessions have a focus on continuing education for GP's, but other practitioners such as pharmacists, Practice Nurses and Maori health provider nurses also attend these monthly sessions. A recent addition to the educational support provided for CarePlus has been the introduction of bi-monthly CarePlus nursing support groups. These are facilitated by Manaia Health PHO's CarePlus Co-ordinator, and arose from a need expressed by nurses for a forum where general issues around CarePlus implementation can be discussed, informal learning can occur, and relationships can be strengthened across the practice nursing workforce. The forums are also excellent opportunities for other clinical staff employed by the PHO (e.g. mental health practitioner, dietician, diabetes resource nurse) to discuss their roles and the support and resources they can provide for patients enrolled within CarePlus.

CarePlus Co-ordinator

From the inception of CarePlus, Manaia Health PHO has employed a CarePlus Coordinator – this position has played a pivotal role in the successful implementation and on-going commitment to CarePlus within Manaia Health practices. It is doubtful whether the gains made would have been possible without this dedicated position.

Key Activities of the CarePlus Coordinator's role include:

- Providing practical advice and support for the general practice team – some examples include assisting in CarePlus clinics, troubleshooting issues that arise
- The development of a range of resources to support CarePlus implementation within the practices – these have included:
  - development of a poster and leaflets to inform patients about CarePlus and its potential benefits – as a result of seeing these resources in the practice waiting room, patients have often then enquired about their eligibility for the programme
  - development of patient held wellness plans and folders, and regular updating as required
  - resource packs to support education undertaken
  - a list of community groups available to support referral processes
  - a list of nurses involved in CarePlus to encourage peer support
- Preparation of monthly reports for the clinical committee and PHO board to demonstrate trends and highlight any issues arising
- Facilitating the utilisation of best practice guidelines into practice by ensuring that clear guidelines are given to all CarePlus nurses, and supporting nurses in using flowcharts and other appropriate resources in their daily practice.
- Working with the IT team to ensure the Counties Manukau templates are installed and functioning correctly in all practices.

- Organisation and implementation of on going education/training for Practice Nurses
- Speaking to community groups about CarePlus to raise community awareness and understanding – some examples include Age concern, diabetes Northland, and nursing students.
- Obtaining feedback from patients, doctors and nurses regarding the benefits, as well as any issues, with CarePlus implementation. Presently such feedback has been informal in nature, with a patient questionnaire currently being developed to formalise the feedback process in an objective manner. Similar processes will also be undertaken to gain feedback from the general practice staff.

Challenges faced

The implementation of CarePlus has been a significant change management process, and many challenges have been recognised and addressed (where possible) over time. Some of these have included:

- embedding a different model of care delivery within general practice, one where the role of the Practice Nurse has been extended, where a team approach is integral to success and where there is an increased emphasis on preventing ill-health and patient self-management
- maintaining the integrity of the focus on steady progress, rather than enrolling patients without any identifiable change in the mode of care delivery – the stepwise funding model for CarePlus has served to disadvantage PHO's who have been committed to building and maintaining a solid foundation for CarePlus and this continues to pose financial risk for the PHO. Financial penalties associated with not attaining numbers have had, and continue to have, the potential to threaten both the integrity and viability of the programme
- time and space constraints have often impeded the ability of some practices to embrace CarePlus to its fullest extent
- IT issues have been challenging and frustrating at times, due to the regular upgrades from Counties Manukau which flow through from Counties Manukau to Manaia PHO, and then on to the user – this process all takes time and places additional demands on the IT team, CarePlus Co-ordinator and general practice staff.

Each of these challenges has been addressed through a combination of the strategies described earlier, i.e. education, support from the CarePlus co-ordinator, and commitment to the key principles underpinning the programme from the PHO board and PHO staff

Current Statistics

Figure 1

Number of patients enrolled in CarePlus across Manaia Health PHO general practices

Non M/PI	M/PI	% of M/PI	Total Numbers In Practice	C+ (5.1 %)	Rolling Total Feb-05	Rolling Total Jul-05	Rolling Total Oct-05	Rolling Total **Jan-06**	Rolling Total **Apr-06**
2073	614	23%	2687	137	3	39	53	59	68
9000	1667	16%	10667	544	85	249	289	320	320
5919	1021	15%	6920	353			15	90	112
1006	455	31%	1461	75			0	0	4
1412	282	17%	1694	86			16	45	65
792	168	18%	960	49	2	11	23	24	19
1278	159	11%	1437	73			8	25	50
746	174	19%	920	47			0	0	0
5964	1474	20%	7438	379	78	114	120	130	134
5000	2052	29%	7052	360		46	139	183	225
4905	891	15%	5796	296	18	49	141	175	275
3878	2019	34%	5897	301		0	16	72	71
790	347	31%	1137	58	8	11	16	22	27
961	450	32%	1411	72		0	1	1	1
1174	498	30%	1672	85	2	24	36	36	37
1414	376	20%	1845	94		0	0	0	0
1440	1425	48%	2945	150	2	4	35	51	61
70	1033	94%	1103	56		16	51	51	57
1551	176	10%	1727	88	10	11	13	5	9
2219	366	14%	2585	132		0	43	47	47
1936	609	24%	2545	130			71	148	115
873	99	10%	972	50		3	12	30	33
2616	716	21%	3332	170		33	58	69	84
2543	332	12%	2875	160		12	38	49	59
59560	17403	23%	77078	3944	208	622	1194	1632	1873
					6% C+(4.2%)	17% C+(4.7%)	32% C+(4.9%)	41% C+(5.1%)	47% C+(5.1%)

Figure 2
Number of Maori patients enrolled in CarePlus across Manaia Health PHO general practices

PRACTICE	% Maori Enroled in Care +	Rolling Total Maori	Rolling Total
Bream Bay	21%	14	68
Bush Road	13%	43	320
Central	17%	19	112
Hikurangi	100%	4	4
James Street	15%	10	65
Maunu Road	37%	7	19
Ngunguru	4%	2	50
N.Environmental	#DIV/0!		0
Onerahi	25%	34	134
Paramount	16%	35	225
Prime Care	17%	46	275
Raumanga	42%	30	71
Ruakaka	30%	8	27
Rust Ave: Reti	0%		1
Whitton	30%	11	37
Testa	#DIV/0!		0
Te Aroha Noa	49%	30	61
Te Puawaitanga	88%	50	57
Town Basin	22%	2	9
Tui	19%	9	47
Waiarohia	27%	31	115
Waipu	12%	4	33
West End	21%	18	84
W/S	17%	10	59
	22%	417	1873

Figure 3
Total number of patients enrolled in CarePlus within Manaia Health PHO

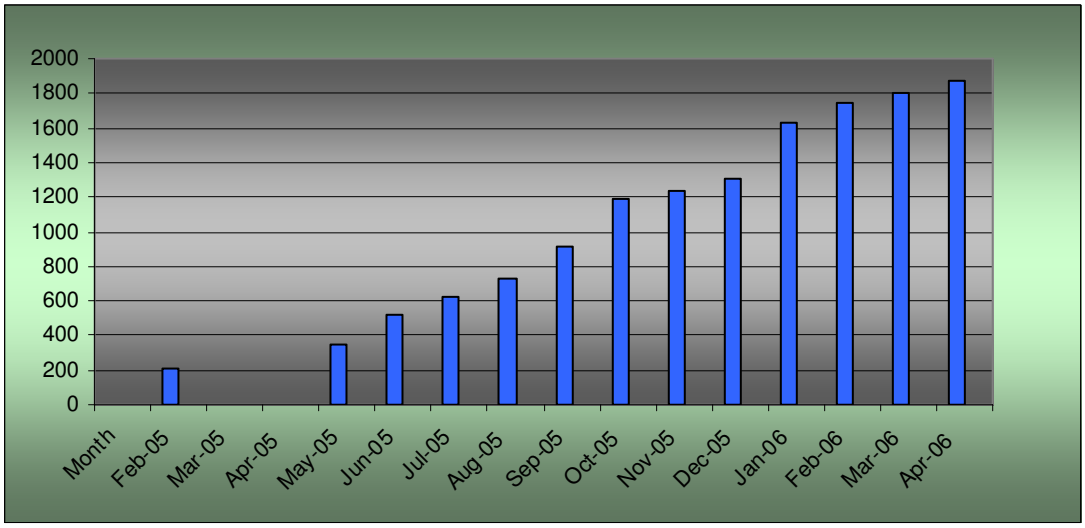


Figure 4(a)
Percentage of Maori enrolled in CarePlus by age group.

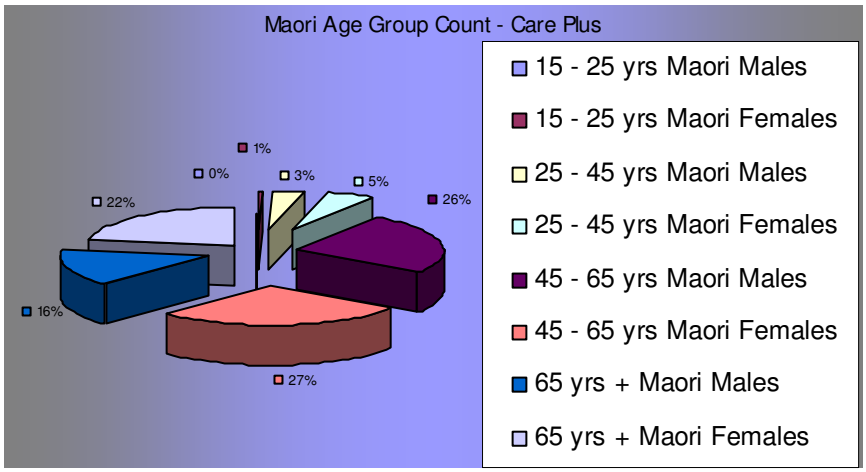


Figure 4(b)
Percentage of Non Maori enrolled in CarePlus by age group.

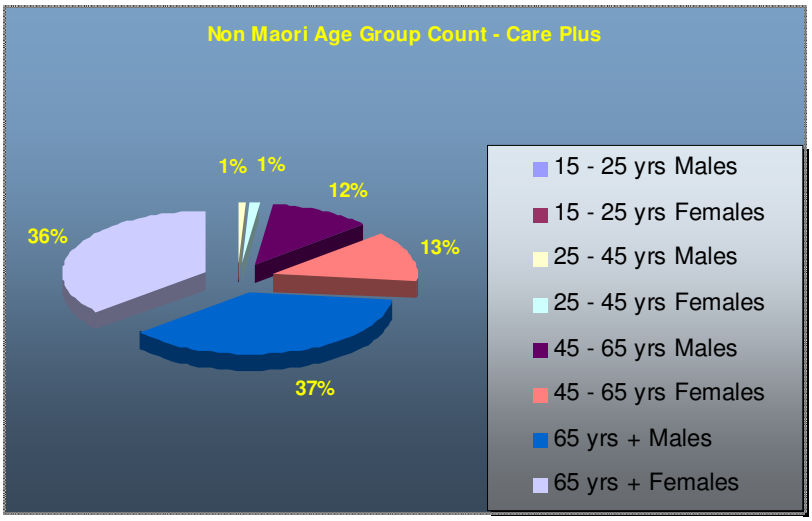
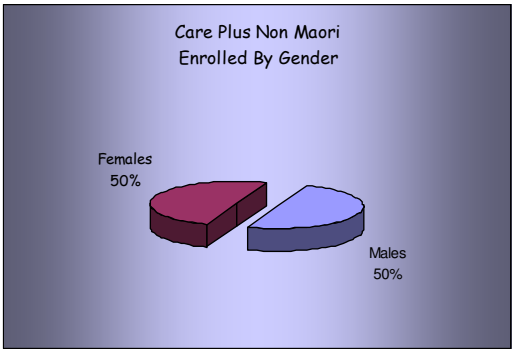


Figure 5
Percentage of Maori and non-Maori enrolled in CarePlus according to gender



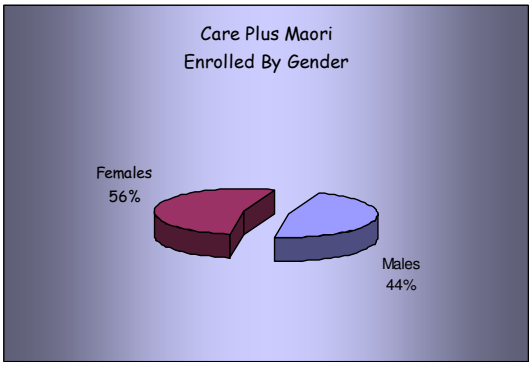
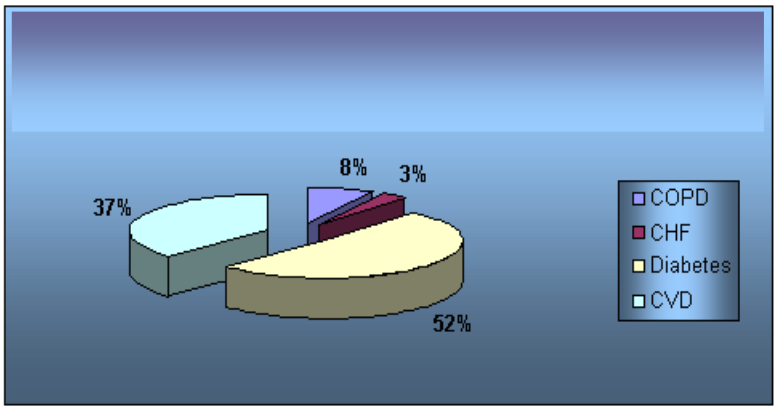


Figure 6
Percentage of patients enrolled in CarePlus according to chronic condition (this information is taken from CCM reports provided by Counties Manukau)



So … Has CarePlus Made A Difference?

The above graphs demonstrate that enrolments into CarePlus have steadily increased. 1873 people living with chronic conditions within Manaia Health PHO boundaries, 400 (21%) of whom are Maori, now receive four free consultations per year with the GP and/or Practice Nurse. Anecdotal feedback from patients indicates that the additional time available to discuss their condition and medication regime and to set some achievable goals has indeed impacted positively on their ability to manage their condition, and has given support to make some lifestyle changes. However, it is recognized that such feedback must be formalised, and we are currently in the process of developing a patient questionnaire that will provide feedback on a range of CarePlus related issues – for example, timing of visits, value (or otherwise) of the wellness plan, perception of the patient/practitioner interaction, and any behavioral changes that have occurred.

In addition to 'real-time' decision support and feedback on individual patients when the template is submitted to Counties Manukau, Counties Manukau also provides aggregated PHO and practice level monthly reports on a range of clinical indicators. For example, the diabetes report covers aspects such as HbA1c, BMI, BP, % on statins, % smokers etc. To date, enrolled numbers per condition per practice, and the length of time patients have been enrolled in the programme, have not been sufficient to provide meaningful aggregated data in terms of trends, but it is anticipated this will improve. Counties Manukau are also in the process of re-designing the reporting format to ensure the data is presented in a more meaningful and user-friendly manner. However, the feedback provided on individual patients which is based on best practice guidelines is providing useful information to the general practice team to guide clinical decision making and care planning, as well as promoting a sense of collaborative teamwork and shared decision making between the GP and Practice Nurse.

As with the patient feedback, anecdotal feedback on CarePlus from the perspective of the general practice team has generally been positive, but this also needs to be collected in a more objective manner. Practice Nurses describe how their contribution to the team has been increasingly recognised, that more discussion occurs with their GP colleagues regarding patient management, and that their skills are been utilised in more appropriate ways. Many certainly believe their care is making a more positive impact on their enrolled population living with a chronic condition. GP's do often raise the question of the cost of implementing CarePlus, but many have recognized the

benefits of supporting a broader scope of practice for their Practice Nurse colleagues. Some GP's who did not initially embrace the concept have become more positive when they see that the CarePlus visits with the Practice Nurse do not negatively impact on the GP's relationships with patients, that patient involvement and understanding of their care improves, and that the GP's workload is often reduced. The following is one GP's perspective of the impact Care Plus has made to his practice.

"To put it simply, I think Care Plus is fantastic. It has been embraced enthusiastically by my patients and from a selfish point of view has decreased my stress levels and workload. At Bush Road we are incredibly fortunate to have Cathryn Henty working full time as our Care Plus practitioner. Cathryn has taken 300 of our most time consuming, unwell and difficult to manage patients and using the CCM guidelines has fine tuned their clinical management. In doing so she's relieved me of hours of frustrating and difficult consultations in which I always felt I was missing things or not giving my patients enough time. I'm still getting to see my CCM patients to discuss and implement the CCM guideline advice but all the hard work has been done.

I*'ve never had a problem "selling" Care Plus to patients. I tell them that after the CCM process their management will be as good as it can get. It's hard to decline that offer. Cathryn has greatly improved the patients understanding of their problems and in doing so improved their compliance and satisfaction. The feedback information returned from the CCM system can at times seem a bit daunting but I've only been doing one or two things at each subsequent visit as often there isn't any rush to get things all done at once.*

Care Plus has clearly demonstrated to me that we are underutilizing our nurse's skills. If nurses are able to manage and improve the health of our most fragile and unwell patients then we need to extend their range of practice to as many other clinical areas as we can. Around the country there are numerous nurse led initiatives using standing orders and guidelines that we can hopefully adopt locally. This type of team approach can only make my job easier and more enjoyable. I'm all in favor of that".

Dr Andrew Miller—GP

Future Direction

The integration of CarePlus into general practice remains a key focus for Manaia Health PHO and the programme will continue to be supported and proactively encouraged by the CarePlus Co-ordinator. In addition to continuing to build on the strong framework already in place through on-going education and IT support, specific areas of focus for the 2006-2007 year include the following:

- A request has been made from some practices for the inclusion of additional chronic conditions as the key criteria for enrolment into CarePlus i.e., expanding beyond diabetes, CHF, COPD and CVD. Discussions with general practice staff and members of the clinical committee have indicated that osteoporotic bone disease and asthma would be useful and a project plan is currently been developed to progress this. Although CCM templates are not available for these specific conditions, we will be adhering to the underlying premise that templates based on best practice guidelines must be developed prior to implementation, and that focussed education, including knowledge of available community resources must also occur in a timely manner.
  Currently, a depression template is being piloted in Counties Manukau, and this will provide another potential option for inclusion.

- In order to further embed the concept of patient self management into CarePlus we are currently exploring the possibility of incorporating the The "Flinders Model" of Chronic Condition Self-Management (CCSM), developed by the Human Behaviour & Health Research Unit of Flinders University, into the programme. This model provides a set of generic tools and processes enabling patients and clinicians to undertake a structured process that allows for assessment of self-management behaviours, collaborative identification of problems, and goal setting leading to the development of individualised care plans. These care plans are considered important cornerstones in enhancing self-management in people with chronic medical conditions. It is anticipated that Manaia Health's CarePlus Co-ordinator will undertake the 'training for trainers' to enable her to provide training in the Flinders model to general practice staff.
- As mentioned previously a range of questionnaires will be developed, distributed and collated to evaluate various aspects of CarePlus from the perspective of patients, General Practitioners and Practice Nurses. This information will assist in guiding and fine-tuning the future direction of the programme.
- Some patients have now been enrolled in CarePlus for a year, and it is anticipated that the clinical indicator data reporting from Counties Manukau will be able to provide more meaningful data for general practices and the PHO as a whole – this has the potential to support and guide future clinical projects, quality initiatives and educational planning.
- It was envisaged from the outset that CarePlus would provide a framework to support a more integrated and collaborative approach to caring for patients with chronic conditions between general practices and Maori health providers within Manaia Health boundaries. There are significant potential benefits for patients, especially those living in isolated rural areas and /or those for whom access to general practice is difficult for a variety of reasons. This will be a key area of work for the coming year.

Conclusion

With the ageing of our population and the increased rates of chronic conditions, our primary health care services have a growing and imperative need to better manage chronic disease ~ if not, the burden on secondary services and the health and disability community sector will be overwhelming. CarePlus provides a framework for more effective and efficient management of chronic conditions within the primary care environment. Within Manaia Health PHO the programme has enabled and supported the embedding of some key elements of effective chronic disease management within general practice. This has included but is not limited to aspects such as the value of a collaborative team approach, personalised care plans, self-management education, support for patients to adhere to treatment regimes, and provision of regular follow up and monitoring. There is an increasing body of knowledge that validates the difference that a patient centred approach makes to health outcomes and quality of life for both patients and their familes/whanau who live with a chronic condition. Manaia Health PHO certainly acknowledges the challenges inherent in supporting a significant paradigm shift in the model of care delivery which is inherent in the CarePlus framework. We do however remain committed to an approach that we believe does indeed make a difference to the health and well-being of individuals, families, whanau and our community as a whole.

CarePlus report prepared by Leonie Gallaher, Clinical Manager & Jayne Hill, CarePlus Co-ordinator, Manaia Health PHO.
June 2006.

Appendix F

Example of the Excel spread sheet used for data collection.

CarePlus Questionnaire Results

				Q1			Q2			Q3			Q4				Q5				Q6				Q8			Q9			Q10				Q11		Q12				
code	Practice	Total No distributed	Total No received	Doctor	Nurse	Both	Too much	Not enough	just right	too long	too short	just right	improved a lot	improved slightly	stayed same	decreased	improved a lot	improved slightly	stayed same	decreased	very useful	somewhat useful	not useful	neither useful or useless	Yes	No	if not, why not?	Fully listened to	felt listened too some of time	not listened to	Discussed everything wanted to	discussed a lot of what I wanted	discussed some issues	did not discuss any issues	Yes	No	Very satisfied	somewhat satisfied	satisfied	somewhat dissatisfied	dissatisfied
1	Bream Bay	13	2	0	2	0	0	0	1	0	0	2	2	0	0	0	2	0	0	0	2	0	0	0	0	2	0	2	0	0	1	1	0	0	2	0	2	0	0	0	0
2	Bush Road	64	37	0	29	8	2	0	35	1	1	35	17	10	10	0	15	12	10	0	23	13	0	1	28	7	0	33	3	0	31	3	2	0	25	10	30	1	5	0	0
3	Central Family	22	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4	Hikurangi	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5	James St	13	8	0	6	2	0	0	8	0	0	8	6	1	1	0	5	2	1	0	6	2	0	0	3	5	0	7	0	0	7	0	0	0	6	2	8	0	0	0	0
6	Ngunguru	10	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
7	Onerahi	26	1	0	0	1	0	0	1	0	0	1	1	0	0	0	1	0	0	0	1	0	0	0	0	0	0	1	0	0	1	0	0	0	1	0	1	0	0	0	0
8	Primecare	55	6	0	4	2	1	0	5	0	0	6	4	0	2	0	4	1	1	0	5	0	0	1	3	2	0	6	0	0	6	0	0	0	5	1	5	0	1	0	0
9	Paramount	45	37	1	34	2	0	1	36	3	0	34	20	7	8	0	17	11	8	0	24	12	1	0	25	12	0	37	1	0	31	3	2	0	23	13	34	1	2	0	0
10	Raumanga	14	8	0	6	2	0	1	7	0	1	7	4	3	1	0	4	3	1	0	2	4	1	1	4	4	0	8	0	0	5	2	1	0	4	4	5	0	3	0	0
11	Ruakaka	6	10	0	3	7	1	0	9	0	0	10	7	2	1	0	6	3	1	0	8	2	0	0	8	2	0	9	1	0	7	2	1	0	5	5	8	1	1	0	0
12	Rust Ave	7	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
13	Te Aroha Noa	13	5	0	4	1	0	0	5	0	0	5	4	1	0	0	4	1	0	0	3	2	0	0	3	2	0	4	1	0	3	2	0	0	1	4	4	0	1	0	0
14	Otangarei	11	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
15	Tui Medical	9	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
16	Waiarohia	22	2	0	2	0	0	0	2	0	0	2	1	1	0	0	2	0	0	0	2	0	0	0	2	0	0	2	0	0	2	0	0	0	1	1	2	0	0	0	0
17	Waipu	7	1	0	1	0	0	0	1	0	0	1	0	1	0	0	0	0	1	0	1	0	0	0	1	0	0	1	0	0	1	0	0	0	1	0	1	0	0	0	0
18	Westend	15	4	0	4	0	0	0	4	1	0	3	3	0	1	0	3	0	1	0	4	0	0	0	1	2	0	4	0	0	4	0	0	0	4	0	4	0	0	0	0
19	W & S	11	4	0	3	1	0	0	4	0	0	4	2	1	1	0	2	1	1	0	2	2	0	0	2	2	0	4	0	0	2	2	0	0	2	2	4	0	0	0	0
		364	**125**																																						

Comments

Q.7 Suggestions re improvement of wellness plan
None. The CarePlus plan is very good where I am
None yet!
Allow nurse to do minor medical work now done by doctor
Maybe to look at alternative medicine and how this could improve our own well-being
I get excellent attention and feel the nurse really cares about my well-being
Any written recording in CarePlus personal folder be dated
Can't be improved
All is o.k
Maintain a healthy diet and lifestyle within my capabilities
Nothing
This plan is the best that has happened from the feedback that I have got from the Whg hospital A&E staff & ward staff
Nothing at this stage
I think it is fine the way it is
For me, nothing needs to be improved
I just want to do the best I can when my nurse tells me what I should be doing at each visit.
Eat & drink the right foods & exercise
No suggestions
None at this stage
It is working well for me
Focussing on looking after myself in my retirement years
I can't think of any
None. I am quite happy with the plan as it is.
None.
None yet as I have only been twice
None - I am very pleased with my progress
This is Dads 1st visit, but our overall comments are very favourable so far. We can see the benefits that will come
Pleased with present plans
None
Being able to discuss any problems and new concerns re health, which crop up at any time between visits
Full info on results of any hospital visits for any reason
Think it's great as it is
photos of what can happen to skin from not looking after feet, diet etc
I access the internet for information as well as reading material from diabetes clinic & careplus nurse. It's just another folder.

What has been the most useful part of Careplus for you?
The understanding and the way my Nurse explains things (plain english)
Discussion on diet. Arranged to see Primary Health Care Dietitian
The opportunity to discuss things at length where the Doctor is too rushed
Being able to spend the time to discuss minor health problems rather than take up the Doctors time
More Information on medical problems
Talking through issues
Availability of nurse
Being able to express feelings much more comfortably
To have someone respond sincerely to your needs
Blood test results, blood pressure & general health monitored

The fact that someone really cares and doesn't rush you
Satisfaction of knowing my health is being cared for by Dr & Nurse
Nurses have talked with me and not at me, eg. Explanations in simple lay-person's language for understanding
Interest shown as a patient
Good support and checks
updated state of health, and medical advise forthcoming and clearly explained
To be cared for
Knowing I am being checked up on regularly
Peace of mind in that I fully understand my medication
I am now aware of what my various counts mean and what they should be - also my weight
Having regular visits
Having regular check ups. Discussing other symptoms that may occur etc
More time spent on medical condition & medication
Most useful has been able to visit every 3 months to catch up with medications, treatments etc, general discussions about one's self & knowing that there is some progress
Advice
Learning about my health issues & improving on my wellness
I understand more about my condition
Discussing with the Nurse things perhaps you would not with the Doctor
Keeping a record of how my body is responding to treatment
A nurse who listens and talks things through with me. I take my care plan with me if I go on holiday etc
All aspects
The information given by my nurse
Health improvement
Finding out about the acu check batteries and the sugar record book and info re foods
Knowing about my condition and talking about how I feel and what can be done, or what I can do for myself and just have someone to listen
Talking things over
Getting regular checkups and peace of mind
Being able to talk to the nurse and the doctor also when he is not busy
I feel I can discuss my health condition with the nurse quite freely
Having a medical person with the time to listen & answer my questions; and not feel I am holding up the waiting room.
Knowing somebody cares
Diet & health management of diabetic condition
I am learning to find time to look at myself, alter daily things eg walking, drinking more water & exercise
Exercises. Good to have follow-up on progress
Setting goals for progress, understanding my diabetes
Questions answered
The understanding that someone is not only prepared to listen to elderly aches & pains but also has an intimate knowledge of one's medical situation. I feel most comfortable with these visits
To be able to talk and get advice from the nurse
Being able to discuss your difficulties and finding out what you can do
The fact that it is there
Getting questions answered
Super Nurses, easy to talk too
Not sure yet - too early to tell as I have appts with other health professionals in the future via CarePlus
To keep a check on the Diabetes
The encouragement and good advice
Seeing my blood sugars stat at an ideal range. My cholesterol become normal, blood pressure excellent and loosing weight. All monitored & keeping me on line
Being made aware of services available to help Dads overall care and wellbeing. The nurse made necessary arrangements to have some of the services put into action. Joan (nurse) was very patient & helpful
I can take control of my health and make goals that help to improve myself
Setting goals to achieve
Not feeling hurried
Monitoring weight etc & encouragement re exercise

Blood sugar awareness
Being able to discuss my medical condition fully
Being able to discuss any problems and new concerns re health, which crop up at any time between visits
Being weighed regularly - regular blood count tests as well as some good tips or advice from nurse
Having an understanding, knowledgeable & unjudgemental listener
Regular care available
Having all medications listed for ease of taking. Talking about side effects etc
Clear explanations - to the point & honest
Learning about diabetes
Giving you peace of mind that I'm doing o.k
Centralising all the needs of a diabetic
People caring & help received
To get an understanding of my health
Prompt help
Discussing my health problem & speaking out openly
Learning more about diabetes
Everything
Happy with everything
Seen myself getting well
Personal service received
Personal attention
Having someone interested in me
Discussing what is wrong with me
Time to talk with the nurse about my condition
Learning
Learning more about my condition
Listening to my nurse I'm interested to hear about my condition & intend to make changes but not disciplined enough
The full explanations that I have been given regarding my condition
Knowing someone who cares
What is one thing if any, about your health that you have changed or altered since being on the Careplus programme?
My eating habits and exercise
Changed eating pattern as had weight loss, now putting weight on
Change of time taking some medication
Eating habits, more exercise, understanding the terminology
Much more concerned about health physically & mentally
The process on how I have been perceiving my health
None
More awareness of little details and trying harder to stay fit and well
A change and better understanding of a balanced diet
Drink more water. Exercise
Diet & exercise
Nil
Taken notice of what medication I'm on
Nothing really
It is good being able to check my blood pressure count by referring to previous counts
Stopped smoking
I now know a lot more about my health

Have improved with my diet & my weight. Looks as though will have to work at my cholesterol
Exercise
Regular exercise, making goals, change in diet
Leant not to stress over things I can't change
Drinking at least a litre of water each day. What are the best foods to eat and how much. Quit smoking
Eating & drinking the right foods and plenty of exercise
Try to keep sugar down
Taken more care of myself health wise. Thinking more positively about my condition and where I'd like to be 3 years from now
I feel happier about things generally
Exercised more
No changes
I now have confidence in my unusual medical problem that help is always available
I'm more positive
Exercise more
Lifestyle changes. Joined weight watchers. Regular exercise and no longer require medication
Too short a time in which I have been involved to make any observations of this nature. I suspect that nothing momentous will result
I have my blood sugar well under control, and I am more aware of what I am eating
Sleeping patterns
Trying to drink more water
Watching my diet better
Nothing yet - although have made enquiries about gyms etc
None yet as only been twice
Getting better at taking all my pills
Gym exercise, healthy eating, resting more and am more aware of dangers
Just started
Going for longer walks more often
Keeping to the goals
Nothing
More careful with diet
Nil
To eat healthier food, drink at least 1 ltr of water a day & read the ingredients on food labels when shopping
Taken medication at different times ie Lypex after my meal at night and not after breakfast
Not sure
Eating healthier
Be more focussed on my health
Diet
Diagnosed with bowel cancer, have had surgery and radiotherapy
Become more aware of a personal programme & diet and the importance of following it
watching my diet more closely
help me in my endeavours
Eating the right food, exercise more often
I would like to loose weight
My diet
Diet
Have tried to diet & exercise more
Nothing. It just reinforces what I am already doing
I now use Podiatrist
Diet & exercise
Diet - eating more healthier
Cut down on smoking with the hope of giving up altogether
Reduced my alcohol intake

Are there any areas we could improve on?
I don’t know about anyone else, but I am very satisfied with the CarePlus I have
Think in most cases 1/2 hr should be ample time per visit
Just perfect
Allow nurse to do minor medical work now done by doctor
Quite happy with what's happening
Workshops on how we could better maintain our well-being and quality of life
No
I am quite satisfied
No
I don't think so
No, it works well for me
No
No, I appreciate the service
No, it is excellent
None
Not at the moment
No
I am completely satisfied with CarePlus
No
Not at this stage
For me - none
Not that I can think of
Not that I'm aware of
No
No
No
No
Cover more ailments for the public
No - CarePlus is totally committed for me, in my changing lifestyle
No
I can't think of any
No
No
Not that I can think of
Not really - it is up to us the clients to want to get fitter/better etc. I feel my nurse has made all the suggestions she can - the rest is up to me. You can lead a horse to water but you can't force it to drink
You could prescribe for me a bottle of Navy Rum once a month!!
Not at all. I am so pleased with the plan
Just started. Very happy thus far
No not yet
Not at this stage
No
I appreciate the time given to me
No
Not really
Would like to see it stay as it is
No
Less paper work
At this time, no

No
Start a body measuring service when exercise and diet programme is followed - it is encouraging to each participant
no, well satsified with the care received
No, happy with the way things are
All well
None
No
I think they have it well covered
Can't see any
Not sure
Suggest that letter sent reminding people to make appointment should include reminder about folder
Not for me
A lot of doubling up on what diabetic clinic nurses & Drs surgery nurses say.
No
Probably but I can't think of everything
Other comments
"My husband is being looked after with CarePlus. From my point of view I have found that the CarePlus has been very helpful for me, taking some of the worry and stress away from me" - a grateful wife