# Primary Care Reimbursement Service

## Medical Card Process Review

August 2014

PROSPECTUS
Experienced Insights, Real Impact

Deloitte.

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## Executive Summary

This review was commissioned and conducted at a time of extensive change and reform within our health service. Many of the health related initiatives outlined in the Programme for Government 2011 and '*Future Health*: *A Strategic Framework for Reform of the Health Service 2012-2015'* are well underway, including specifc changes in the way Primary Care services are delivered and administered throughout the State.

This exercise is one of a number of interlinked reviews aimed at addressing challenges and questions around the administration of the medical card application process in Ireland. The primary objective of this review was to examine how the Primary Care Reimbursement Service currently administers the medical card application process and recommend ways in which the process could be made more efficient, simple and user-friendly in the future.

As part of the review process, the Prospectus/Deloitte team reviewed a wide range of information and material, and conducted an extensive consultation process in order to obtain the views and opinions of a wide number of stakeholders around lessons to be learned and improvements that could be made. This consultation and engagement was conducted over a three-week period using qualitative research methods.

It is important to note at the outset a number of key operating statistics and achievements of the PCRS:

- The vast majority of people that engage with the PCRS obtain a positive outcome (approximately 90%).
- The vast majority of medical card applications that are received with complete information and subsequently approved are processed within the stated deadline of 15 days or less (97.8% compliance rate in 2013).
- Approximately 1.5 million assessments have been completed since 2012 at a time of reducing staff numbers and staff re-deployment.
- PCRS are responsible for administering 18% of the overall health budget, and doing so with significantly reduced resources.
- PCRS' centralisation of the medical card application process has saved the exchequer in the order of €80 million over the past three years and made the administration of the process more equitable, transparent and consistent

As part of the consultation process a number of issues under the following key themes emerged: Policy, Planning, Structure, Process, Capability, Technology, and Communications. Having analysed these themes, it was determined that if reoccurrence of many of the issues highlighted during the consultation process, and in particular frustration and dissatisfaction with the medical card application process, is to be halted then there is an urgent need to:

**Connect policy, processes, resources and stakeholder communications in a more systemic and longer-term manner**

In order to do this we have developed a series of recommendations, envisaged as the 'Future State'. These recommendations, compared to the "As is" situation or 'Current State' are outlined below:

| No | Current State | Future State |
|---|---|---|
| **1** | Public, media and political attention on the Medical Card process has resulted in PCRS acting as a "lightning rod" for criticism and complaints relating to the process. | The media, political system and general public are aware of the roles and responsibilities of all those involved in the Medical Card application process. There is clarity that the political system decides and sets policy, including eligibility limits, which is then implemented by the PCRS assessment team. All stakeholders groups, in particular Local Health Offices (LHOs), are fully discharging their duties in line with legislative and policy guidelines. |
| **2** | PCRS is subject to a wide range of external decisions and policy shifts which means that the current processes continually have to react to environmental and operational challenges. The reactive nature of the business places significant pressures on the staff and PCRS operations and often leads to backlogs and unintended outcomes. | PCRS future role and strategic direction is clearly defined and appropriate governance structures are in place to facilitate and monitor its implementation. External policy shifts are minimised and are fully evaluated and tested before implementation. |
| **3** | While management review a wide range of performance metrics, there is a lack of Organisational "Key Performance Indicators" (KPIs). This has limited PCRS' ability to measure, monitor and manage its organisational performance. | An agreed list of organisational KPIs is in place and is supporting the delivery of PCRS's strategy. |
| **4** | The Medical Card processing team has limited resources and is a very "flat" organisation with a small number of Deciding and Medical Officers. These resource pressures and structural issues have militated against PCRS's success | PCRS is appropriately resourced and properly organised to allow it fulfil its role. PCRS has access to an appropriate number of Deciding Officers, supervisory staff and Medical Officers to prevent bottlenecks and delays in the system. |
| **5** | The extended remit of the PCRS over time, in particular assignment of the responsibility for the processing of medical card applications and review in 2011, has diluted people's understanding of the role, functions and effectiveness of the PCRS. This extension of PCRS' remit has resulted in the PCRS receiving a large amount of negative public and media attention, albeit very often misinformed, labelling all of PCRS | The two core functions of the PCRS i.e. medical card assessment and reimbursement of medical services, both have a clear vision, structure and appropriate customer service ethos focused on their respective duties that is easily communicated and understood by all internal and external stakeholders. |

| No | Current State | Future State |
|---|---|---|
| | processes as inefficient and non user-friendly. | |
| **6** | The application and review process is largely paper-based and heavily reliant on manual workflows and the transfer of paper files throughout much of the assessment process. | All medical schemes can be fully applied for and administered electronically. The evaluation process is supported by an electronic workflow system, which allows all relevant information to be accessed at each point in the assessment process. |
| **7** | There are limited end-to-end process maps and flow charts detailing the medical card application and review process. This leads to a level of inconsistency and ambiguity in administering the current process. | Clearly defined and documented operating policies and procedures are agreed and made available to all relevant stakeholders. The availability of these documents should ensure the consistent administration of applications. |
| **8** | The HSE currently administers a number of medical support schemes. These schemes are administered independently and largely follow separate application and evaluation processes. This lack of integration can lead to duplication of effort and access to secondary benefits, which may not be strictly necessary. | Applicants receive appropriate supports and the application process is simplified so that there is a single application process for medical supports, e.g. Medical Card, GP Visit Card, Long Term Illness Scheme and Drugs Payment Scheme. |
| **9** | Limited opportunities for formal training has resulted in process inconsistencies and reduced levels of knowledge around the end-to-end process. | Staff have the necessary skills and appropriate understanding of all stages in the process to properly discharge their duties and responsibilities. |
| **10** | There is an opportunity to enhance and further develop the level of functionality and visibility available through the Medical Card application and assessment system. In particular all staff involved in the assessment or query processes should be provided access to underlying and supporting documentation.<br><br>In addition, the application does not interface with other Government systems. This results in requests for duplicate information leading to errors and frustration. | The Medical Card application system is available to all staff (in an appropriate manner i.e. read only) and fully integrated with other Government systems. Requests for duplicate information are minimised and automated interfaces reduce the risk of error. |
| **11** | The level of information captured by staff in the observations screen is inconsistent. This leads to difficulties and inefficiencies when responding to applicant queries or conducting reviews at later points in the process. | Staff are trained to provide clear and specific observations in relation to each application. |
| **12** | A significant amount of information is necessarily required to assess and process Medical Card applications. Many applicants perceive the requested level of information to be excessively onerous, | Ready access to personal and financial information held by other Government departments and agencies (e.g. Revenue, DSP) minimises the level of information requested from applicants. Where |

| No | Current State | Future State |
|---|---|---|
| | leading to high percentage of incomplete applications and in turn highly labour intensive processing requirements. | additional information is required, this is proactively followed up by the PCRS team with an enhanced level of tailored and customised requests sent to the applicant |
| **13** | GPs, Dentists, pharmacists, other service providers, and existing medical cardholders are not fully aware of the full range of functionality available to them in relation to the medical card scheme. In particular, some GPs seem unaware of their authority to extend medical card entitlements. Despite the best efforts of the PCRS team, some Medical Card holders can first learn that they are no longer covered when they arrive at the GP or pharmacy. | There is a high degree of interaction and communication between PCRS, Service Providers and Medical Card holders. Service Providers and applicants are fully aware of the authorities of Service Providers in relation to the extension of Medical Card eligibility and GPs are capable of advising individuals that they are no longer covered. |
| **14** | Public discourse around Medical Card eligibility and entitlement is shaped by media coverage, which typically focuses on complex medical needs rather than permitted financial means. There are many positives associated with the current process however this message is not effectively communicated. | The general public have an appropriate level of understanding around Medical Card schemes and financially based eligibility criteria. Where members of the public require additional information, suitable and easily available channels are available. Multiple channels to check the processing status of an application are available. |
| **15** | There are limited opportunities for communications, feedback and information sharing across the wider PCRS team. This has contributed to a sense of disconnect between internal PCRS teams and between PCRS and the LHOs. It has also given rise to a level of ambiguity and misunderstanding around certain key stages in the Medical Card process, for example the issuing of Emergency Medical Cards. | There are defined and agreed mechanisms for communications, upward and downward feedback and information sharing. This takes the form of periodic team meetings and knowledge sharing events, collaboration workspaces and informal information sharing mechanisms. |

For these recommendations to be implemented successfully and for the transition from the Current State to the Future State to be achievable, a number of implementation Key Success Factors must be considered:

- Proper resourcing and supports need to be put in place immediately
- The development and commitment to a detailed implementation plan with a clear reporting framework
- The development and roll-out of a comprehensive communications, engagement and customer service ethos plan
- Emphasis on Change Management, underpinned by dedicated resources focusing on managing the programme of change
- The development and ownership of a Risk Management and Mitigation Plan

Successful implementation of the proposed recommendations cannot rest solely with PCRS management and staff, it is critical that other key stakeholders recognise and assume appropriate levels of implementation and change responsibility, in particular the Department of Health, HSE Senior Management, Primary Care Division, Local Health Offices and other health sector personnel.

# 1. Introduction

## 1.1 Report Context

The Programme for Government (2011) commits to fundamental reform and restructuring of the health service to ensure equal access to healthcare based on need. *Future Health*: *A Strategic Framework for Reform of the Health Service 2012-2015*, is a detailed framework containing 48 actions. The programme comprises a series of inter-related and interdependent projects and portfolios.

Government policy aims to deliver a total transformation of healthcare in Ireland through the implementation of Structural Reform (Healthcare Commissioning Agency and Pricing Office, Hospital Groups/Trusts, re-organisation of primary and community care delivery structures); new funding arrangements (HSE Vote returning to Department of Health, Money Follows the Patient etc); and a new framework for Health and Wellbeing. The proposed changes of immediate relevance to the PCRS and its service users are:

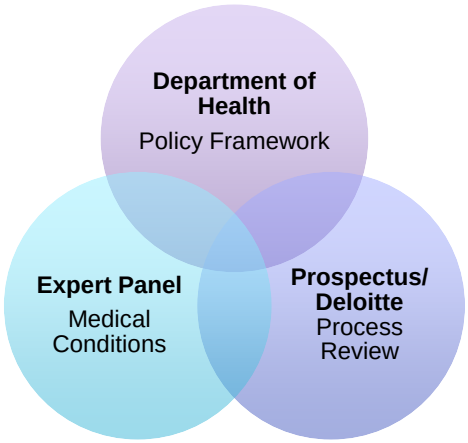
- Changes in the acute/primary care interface and greater integration around service delivery
- The recent Integrated Service Area review, with indications that there will be a move from 17 ISAs towards nine Community Healthcare Organisations
- The move towards a policy of universal health care, which will be largely underpinned by a money-follow-the-patient financing mechanism
- Ongoing GP contract negotiations
- The creation of a new Healthcare Commissioning Agency
- The establishment of a new Patient Safety Agency
- The establishment of a National Information & Pricing Office
- The proposed rollout of free GP care for children under the age of six
- A restructuring of the National Clinical Programmes into seven aggregate groups with a specific category relating to the provision of Primary Care.

Given many of the above on-going and proposed healthcare reforms directly impact on how primary care services are delivered and funded, it is incumbent upon PCRS to consider how any such policy changes might impact on the administrative process and the organisation itself.

Some recent policy decisions have led to an increased workload for the PCRS, which has endeavoured to respond to the heightened demand accordingly.

## 1.2 Recent Developments

Following extensive political and public discussion around eligibility criteria to obtain public health supports the Government initiated a number of distinct reviews tasked with examining different aspects of the "medical card issue".




### *1.2.1 Department of Health – Policy Framework*

The Department are examining the policy context and considering the implications for the administration of medical card processes should policy or legislative changes be deemed necessary.

### *1.2.2 Expert Panel – Medical Conditions*

The role of the Expert Panel is to examine how medical needs should be taken into account in the context of medical card eligibility. The Expert Panel will examine the range of medical conditions that could be considered when determining medical card eligibility.

### *1.2.3 Prospectus Management Consultants & Deloitte – Review of Processes & Communications*

The HSE has commissioned Prospectus Management Consultants and Deloitte to review the administrative and logistical arrangements by which new applications and reviews of Medical Card and GP Visit Card eligibility are processed by the Primary Care Reimbursement Service (PCRS).

These projects are independent and distinct in their own right, but there is a degree of interconnectedness between the projects to ensure joined-up thinking and a collaborative approach to the progression of health services.

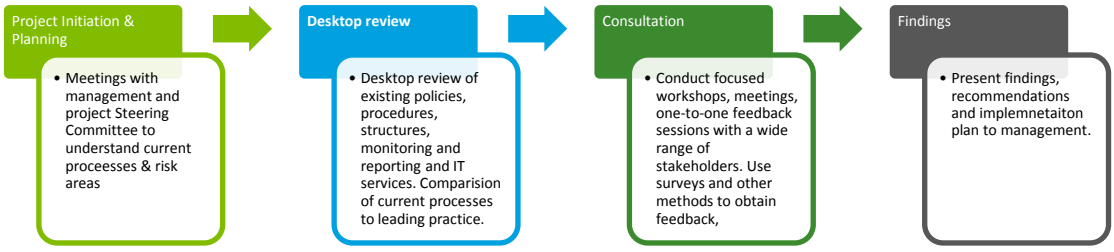
## 1.3 Aims of this Project

The specific aims of this project as per the agreed Terms of Reference were to:

1) Provide an account of the key learnings from the recent review of medical card eligibility undertaken by PCRS;
2) Present recommendations on how the learning from this process can be used to simplify and/or make the application processes more user-friendly;
3) Outline any potential changes in legislation that may be required to make the process changes envisaged;
4) Examine how 'Communications' was managed during the previous review process and then outline how this can be improved in the future.

## 1.4 Review Approach

One of the key aims of this project was to understand and review the current processes and develop a series of lessons learned from the existing processes which can be applied to future activities. The approach adopted is outlined in the graphic below:




The information obtained and work performed as part of our review consisted of the following key steps:

- Detailed discussions with key personnel to develop an understanding of the current assessment process and identify any gaps or inefficiencies;
- Review of relevant documentation and procedures;
- Conduct workshops with PCRS staff and relevant stakeholders to identify process issues or opportunities for improvement; and
- Validate observations and items noted with PCRS staff and management.

It is important to note the timing of this review (July - August 2014) took place against a backdrop of extensive public, media and political discussion in regard to medical card eligibility and calls to broaden the definition of "undue hardship" (as currently set out in the Health Act,1970) to include medical conditions and not just financial means. This issue is being considered by the Expert Panel outlined above and is outside the remit of this exercise.

## 1.5 Report Structure

The sections in this report are as follows:

In **Section 2** of this report we set out our current state assessment or "**PCRS As is**". This firstly involves outlining the policy context and an assessment of the legal framework within which PCRS operates. This is then followed by the findings from a broad consultation process and the identification of key issues that need to be addressed.

**Section 3** of this report sets out the **Future Requirements** for the development of PCRS services and sets out a number of outcomes that need to be achieved. These are supported by the identification of short (2014), medium (2015), and long term actions (2016). We also identify those responsible for the delivery of these outcomes and the key dependencies to their acheivement.

Finally in **Section 4** we provide a high level **Implementation Plan** and idenify some of the critical success factors that need to be considered if these outcomes are to be delivered.

# 2. PCRS 'As is' review

## 2.1 Overview of the Primary Care Reimbursement Service (PCRS)

The HSE's Primary Care Reimbursement Service (PCRS) supports the delivery of a wide range of primary care services to the general public, through over 6,600 primary care contractors i.e. General Practitioners, Dentists, Pharmacists and Optometrists across a range of community health schemes. These schemes form the infrastructure through which the Irish Health system delivers a significant proportion of primary care to the public.

PCRS was originally established as a reimbursement service for primary care service providers and currently handles almost 78 million transactions annually. These represent services provided to 3.4 million people in their community at a total cost of *c.* €2.5bn, which equates to approximately 18% of the HSE's overall budget. Over time and due to their success, other responsibilities have been added to PCRS including, a supporting role for the Medicines Management Programme; the provision of statistics and trend analyses on primary care spend to state bodies; and most recently responsibility for administering the introduction of the Individual Health Identifier.

However, of most relevance to this review was the decision in 2011 to move the processing of medical cards from local services i.e. LHOs, into a single centralised national service, located in the Health Service Executive (HSE) Central Processing Centre in Dublin. The rationale for decision was to ensure medical card applications were assessed in a single uniform and consistent manner regardless of their geographic location; and to make sure the same rule set was applied to every applicant, including the application of discretion. The PCRS was assigned responsibility for the newly centralised process and service.

In recent years, the challenging budgetary position has required the HSE to review eligibility for medical cards in order to ensure that scarce resources are targeted at those in greatest need. This has resulted in explicit public concerns and intense media and political discussions around access to primary care health services. This has placed a significant spotlight on the PCRS and the way it discharges it functions. However, it is once again important to highlight the fact that PCRS operates the medical card application process in strict adherence to Government policy and it has no authority to deviate from agreed policy objectives and/or political direction.

Notwithstanding these challenges it is important to note a number of key operating statistics and achievements of the PCRS:

- The vast majority of people that engage with the PCRS obtain a positive outcome (approximately 90%).
- The vast majority of medical card applications that are received with complete information and subsequently approved are processed within the stated deadline of 15 days or less (97.8% compliance rate in 2013).

- Approximately 1.5 million assessments have been completed since 2012 at a time of reducing staff numbers and staff re-deployment.
- PCRS are responsible for administering 18% of the overall health budget, and doing so with significantly reduced resources.
- PCRS' centralisation of the medical card application process has saved the exchequer in the order of €80 million over the past three years and made the administration of the process more equitable, transparent and consistent

## 2.2 Current Legal Framework

As part of this review we examinied the relevant legislation to determine any key areas which may need to be reviewed or amended in order to support the more efficient processing of medical card applications. In particular we have focused on the Health Act 1970 (as amended) (the "Health Act"), the Health (Alteration of Criteria for Eligibility)(no.2) Act 2013 and No.1 Act. In addition, we also considered the "HSE Medical Card/ GP visit Card Guidelines" (the "Guidelines").

In summary, the legislation, at its most basic provides for:

a) The awarding of medical cards to an individual where the individuals income is below a certain threshold (certain exceptions exist, which are mentioned below).
b) The awarding of a medical card where an individual's income is above the relevant threshold but where it would cause undue hardship to the individual not to award the medical card. This discretion is exercised by the HSE within the parameters set in the Guidelines.

If after such consideration the applicant fails to qualify for a Medical Card the deciding officer may consider the applicant for a GP Visit Card:

a) The awarding of GP Visit Card to an individual where the individuals income is within the threshold.
b) The awarding of a GP Visit Card where an individual's income is above the relevant threshold but where it would be unduly burdensome for the applicant to provide GP medical and surgical services for themselves and their dependents. This discretion is exercised by the HSE within the Guidelines.

Following a review of the legislation we considered a number of key areas in relation to Medical Card processing. These are set out below:

**Firstly, we considered if there are any provisions allowing the sharing of information with other state bodies?**

We noted that section 8 of The Health (Alteration of Criteria for Eligibility) Act 2013 provides for the furnishing of personal data to and by the HSE in certain circumstances. The HSE may request personal data to assess eligibility, the Minister for Social Protection may request personal data to assess entitlement to social welfare and the Revenue Commissioners can access personal data to assess

collection of taxes. Section 8(5) provides for a data exchange agreement to be entered into between the three parties which will cover the procedures for requesting and furnishing personal data in this regard.

**Secondly, we examined particular challenges, constraints or issues that might impact on streamlining the processes e.g. automatically awarding cards to anyone claiming social welfare payments etc.**

Overall the process is organised on a case by case basis so even if the thresholds are not met, there is discretion under the undue hardship process that will apply. There are also a number of exceptions such as people from other EU member states, retention for Government Schemes etc that may make it difficult to develop a streamlined process.

Other considerations that might apply include:

- Data protection- adherence to Data Protection Act 1988 and 2003 in respect of sensitive personal information. The recent announcement to understake a public consultation process as part of the Data-sharing and Governance Bill process will allow further discussion on the use of information across Government bodies.
- IT Systems/ Process and connectivity both within the PCRS and with other bodies.

## 2.3 Consultation Feedback

An extensive consultation process was undertaken with a number of key stakeholder groups, including senior HSE and PCRS personnel, PCRS staff members, representatives from the Expert Group, Department of Health, Irish Medical Organisation, Irish College of General Practitioners, patient groups, Local Health Officers and Integrated Service Areas. A number of different methods were used, including: face-to-face interviews, focus groups, telephone consultations, and a staff survey.

The table below is a summation of the recurring themes and their defintion emerging from the consultation process.

| Theme | Definition |
|---|---|
| **Policy** | Comments and observation in relation to the wider policy environment regarding medical cards. This includes comments relating to operational decisions and positions taken within PCRS and external policy directives which impact on the current medical card application and review process. |
| **Planning** | Comments relating to organisational planning that have significant strategic implications for the PCRS. |

| | |
|---|---|
| **Structure** | Structural or strategic observations and areas for improvement that pose a risk of operational disruption or represent a clear opportunity for service improvement. |
| **Process** | Operational type observations or areas for improvement that may result in inefficiency, operational disruption or present an opportunity for service improvements. |
| **Capability** | Findings and observations which relate to the capability of current staff and resources available to support the timely and successful processing of medical card applications and reviews. Observations relating to learning, development, training and work-practices. |
| **Technology** | Technology related observations and areas for improvement that present an opportunity for greater use of ICT to support improved medical card processing. |
| **Communications** | Observations relating to the communication and awareness of medical card processing across a range of stakeholders. These observations relate to opportunities to improve awareness and understanding of the medical card, eligibility criteria, application and processing procedures. |

It is important to stress the nature of these engagements centred on identifying issues or perceived weaknesses within the medical card application process and as such the focus of many of the comments below relate to specific areas for improvement. However, it would be remiss not to recognise the many positive comments received about the PCRS since the centralisation of the application process in 2011. In particular the increased objectivity in the application process over the past three years and the reduction in inconsistent interpretations of the eligibility criteria across different Local Health Offices. In addition, it is also acknowledged that the PCRS is not immune from the many challenges being experienced across the health sector including significant system change at a time of considerable resource constraints.

It is equally important to note that many of the findings outlined below are based on the direct comments received from the stakeholders received during the consultation process. Whilst we are confident they accurately reflect their respective opinions and experiences it has not been possible to independently verify every comment received given the timeframe and Terms of Reference of this project.

### *2.3.1 Policies*

As stated above under this heading a number of issues regarding the broader policy agenda affecting medical eligibility and the future role of the PCRS, including:

- It was suggested there is a need to redefine “undue hardship” and reexamine the legislative basis underpinning medical card eligibility if future eligibility is to be assessed on criteria other than financial means. The Expert Panel have been tasked with looking into this area.
- In particular all patient/advocacy groups consulted with argued that the current eligibility criteria and process is too blunt and that all circumstances must be considered when defining and determining future eligibility and not just financial hardship.
- Many of those consulted thought the linking of other non-health related benefits to the possession of the medical card placed an undue importance and emphasis on the medical card application process and in turn the PCRS.
- The centralisation of the medical card assessment process had allowed other health and public sector bodies to delegate their responsibilities to the PCRS.
- It was strongly suggested by a number of those consulted that Government needs to decouple the various health and non-health benefits attached to a medical card to allow for the future granting of customised supports to applicants.
- It was suggested if the most common health related supports i.e. Medical Card, DPS, LTI, GP Visit Card, PCRS could then oversee the consolidation of the respective application process into one form and in turn the identification of appropriate supports.
- The future role and functions of the medical card process and the PCRS was raised given proposed policy objectives.

### *2.3.2 Planning*

The need for clear strategic thinking and detailed operational planning is central to the success of any organisation, this was considered by a number of those consulted who raised the following points:

- It is suggested that as a priority the HSE should define and agree the PCRS’ future role within the broader health system in line with the objectives of the Primary Care Division. It was thought this would then allow the PCRS to develop a clear plan for the future implementation of policy initiatives and national and local operational plans.
- It is widely agreed that a dedicated project management office within the HSE specifically aimed at implementing strategic change in PCRS will be required if it is to deliver on the changes required.
- Despite detailed operational performance indicators e.g. processing deadlines, staff application quotas, query-handling deadlines etc. it was thought the absence of broader organisational performance indicators reduced the PCRS’ capability to properly plan and monitor organisational performance.

### *2.3.3 Structure*

Under this heading issues relating to both internal and external structural relationships and design were raised.

- A key issue raised under this heading related to the appropriateness of PCRS having responsibility for discharging two distinct functions i.e. service provider

reimbursement and medical card application assessment under the same structure given the differing demands.

- It was widely thought that since centralisation the operational and administrative links between the PCRS and LHOs have become completely separated and this has had many detrimental implications for applicants, LHOs and the PCRS.
- It would seem the PCRS lacks significant supervisory/middle management numbers and capability. It was said this has limited the level of supervisory oversight that can be achieved and this in turn has led to inconsistencies in procedures.
- A number of bottlenecks in the application process were identified. Specific problems were mentioned in regard to access to two key players in the application process i.e. Deciding Officers and Medical Officers.
    - It was thought that the role of the Deciding Officer was centralised in too few individuals and this caused unnecessary backlogs.
    - Limited and ad-hoc access to Medical Officers was also cited by many as being a significant and critical problem for the application process.

### *2.3.4 Process*

This heading is divided into two distinct categories given the range of comments received i.e. those relating to the process from an external perspective and those relating to internal process issues.

**External**

- It was said on a number of occasions that the form and application process was too burdensome with many finding it quite off-putting.
- Many external stakeholders said they were dissatisfied with the ambiguity surrounding eligibility criteria and the apparent lack of transparency in the decision making process
- A number of people raised the lack of personal interaction or individual accountability within the application process since the centralisation of the application process and it was thought this has resulted in trust issues being raised about the current system.
- It was thought there is a requirement for a more integrated process, with closer links to the Local Health Offices, Service Providers, and other Healthcare Professionals. There is a degree of ambiguity around roles and responsibilities due to the absence of integrated pathways and communication channels, however, it is acknowledged that appropriate consideration would need to be given to avoiding potential conflicts of interest arising
- Issues regarding the appeals process and the level of consistency applied by appeals personnel (non-PCRS personnel) were raised. However, it was acknowledged the PCRS have recently instigated changes to the appeals process to ensure sharing of all information and rationale for previous decisions. Given the early stages of this change, sufficient empirical data does not yet exist to assess the success or impact of this change.

**Internal**

- It is thought that the limited information sharing and data transfer between PCRS and other Governmental bodies has led to unnecessary duplication of effort and data collection.
- It was suggested that the absence of clear process maps for each stage in the process has resulted in some inconsistencies in approach, outputs and outcomes within the PCRS.
- It was also thought the query handling process is overly time consuming and unnecessarily labour intensive. It is felt that it currently gives rise to duplicate queries from multiple sources and these can in turn slow down other parts of the process.
- Concerns were expressed that the apparent absence of a formal mechanism to link and prioritise queries resulted in urgent or sensitive cases not being dealt with as quickly as they should.

### *2.3.5 Capability*

This relates to PCRS' staff and its service providers ability to deliver on their respective duties and responsibilities, amongst the issues raised under this heading were:

- Resource constraints and processing pressures had meant that staff had received minimal amounts of training and development supports since centralisation despite the high number of new entrants to PCRS processes with no background, skills, capability or experience in this domain
- It was suggested the limited opportunity for staff to rotate across different sections within the PCRS has resulted in many staff not being fully aware of the full end-to-end process and hence the implications of their decisions.
- Concerns were expressed that external service providers are not properly trained or fully aware of their role in the medical card process e.g. there is no specific training or awareness program for GPs or Local Health Offices to highlight the options and facilities available to them.

### *2.3.6 Technology*

The use of technology to improve processing efficiencies and the client experience was central to this review, and whilst it is acknowledged that several technology projects are currently well advanced, a number of issues were highlighted during the consultation process, including:

- The number of manual checks required given access limitations to various information systems in particular the Department of Social Protection's Infosys database- makes the application process more labour intensive and less efficient than it could be.
- Requirements that people submit signed application forms and supporting photocopied documents means that the online application form and process is not delivering any real benefits both from the applicant and staff's perspectives.
- Full technological integration between different components of the PCRS and other key bodies such as LHOs etc. was regarded by many as inadequate. It

was suggested there is a need for greater sharing of real-time application information.

### *2.3.7 Communications*

Many issues were raised about stakeholders' interaction with the PCRS, but some of the recurring points were:

- It was suggested that the heavy public/media focus on PCRS as the body regarded as responsible for *all* medical card related decisions has resulted in some negative perceptions around the PCRS' "brand".
- It was thought customer satisfaction with PCRS was lessened by the fact there is no automatic link or communication of alternative or other services available to the client – such as access to the Long Term Illness (LTI) Scheme, Drug Payment Scheme (DPS) or other support services.
- Most people agreed that 4,000 calls and queries received by the PCRS per day are symptomatic of wider structural and procedural issues and concerns.
- Staff and applicants alike voiced frustrations with procedural constraints around direct phone communication between PCRS query handling staff and applicants to discuss, explain or resolve issues or queries.

## 2.4 Analysis - Key issues emerging

In summary, the main issues emerging from the consultation process are as follows:

- The current medical card application and review process is not as efficient, consistent or simplified as it should be. There are a number of manual transactions and paper-based activities that need to be redesigned. There are wide variances in how some processes are carried out and a lack of standardisation for some tasks

- There is a requirement for a more integrated medical care application process, with closer links to the Local Health Offices, Service Providers, and other Healthcare Professionals. There is a degree of ambiguity around roles and responsibilities due to the absence of integrated pathways and communication channels

- The organic growth of the PCRS has resulted in the organisation assuming responsibility for diverse functions, this has caused confusion amongst some of its stakeholders in regard to what the organisation should and should not be held responsible for.

- There is a lack of IT systems integration between various departments, both internally - between the PCRS back office and call centre, and externally - between the PCRS and the Local Health Offices and other Government Departments (Revenue, Department of Social Protection etc.)

- Communication, interaction and engagement between the PCRS and the public could be improved on a number of levels. Similarly, communication

with applicants at some stages in the past was regarded as being unclear, ambiguous, delayed, inaccurate and incomplete.

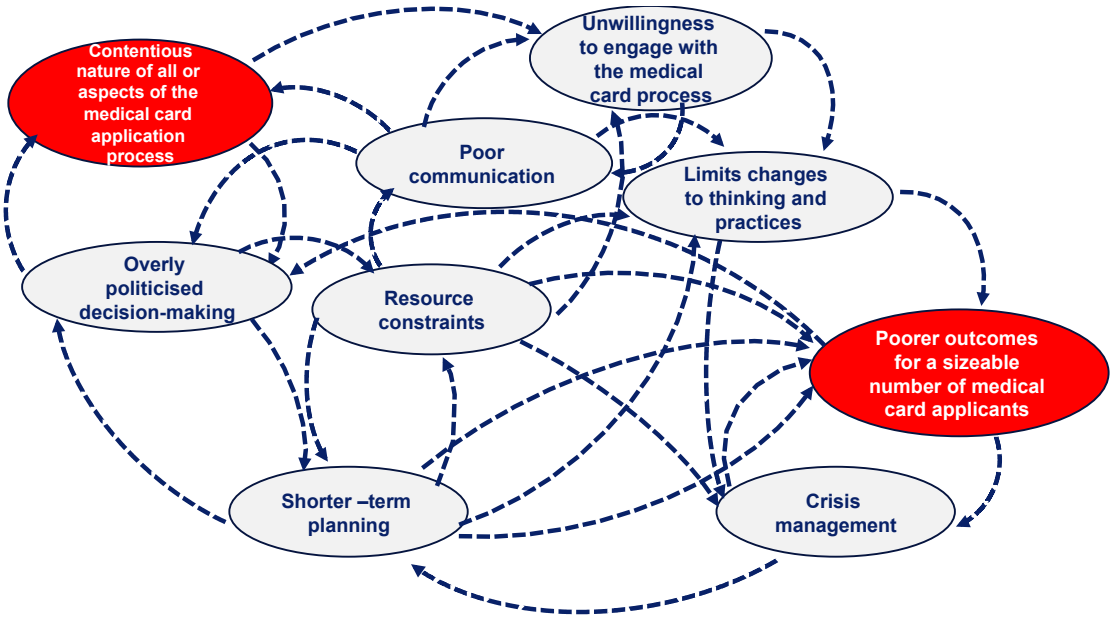
- There are training and development gaps in the PCRS. Other than a formal induction process and on-the-job training there are no formal training and development plans in place for staff. The absence of consistent training initiatives has added to inconsistencies in the understanding and application of SOPs, policies, guidelines and eligibility criteria

- There is a large resource gap in the PCRS at present, both in terms of absolute numbers, and also in relation to skillsets/grade. PCRS staff members are under a great deal of pressure on a daily basis. There is a lack of supervisory-type Middle Management, which again leads back to the issue of Senior Management being overwhelmed by operational detail. The resource gap issue is most obvious in relation to the lack of Medical Officers and the limited number of Deciding Officers, which is causing an acute bottleneck in the process.

- Whilst PCRS is a key component of the National Service Plan and the Primary Care Division Plan, there is no formal long-term strategic plan or vision for the PCRS. This lack of long-term strategic planning and associated resource management has invariably resulted in senior management being almost entirely subsumed in day-to-day operational detail, trouble-shooting and crisis management rather than higher-level strategic thinking and planning.

## 2.5 Conclusions

Having considered all of the findings from the consultation process and reviewed relevant PCRS documentation it was concluded that a series of inter-related "cause and effect" issues currently combine to result in poor outcomes for some medical card applicants. The diagram below provides an overview of these interdependencies followed by an explanation of the various relationships and ultimately a single definition of what needs to be done to improve the long-term administration of the medical card application process.




### *2.5.1 Cause & Effect Analysis*

**The** contentious nature of aspects, or all, of the medical card application process **has led to a sense of** poorer outcomes for a sizeable number of medical card applicants **been achieved. An explanation of the analysis that underpins this assumption is provided below:**

- The contentious nature of the process and on-going resource constraints across a number of relevant state bodies has resulted in their apparent **unwillingness to engage with the medical card process**
- Dissatisfaction amongst members of the public with the process has led to a sense of frustration with the application process, and for a number of people it has even resulted in them deciding not to pursue applications or engage in a constructive manner with the application process
    - This problem has also been compounded by poor communications between the PCRS and already frustrated applicants
- Legacy structures, poor engagement, resource constraints and communication issues have combined to **limit changes to thinking and practice.**
    - It is important to note that despite numerous challenges management and staff have displayed an on-going willingness to implement improvements to PCRS systems and processes, including many of the changes identified in this report. However, as it has not always been possible to implement and adequately communicate these changes in line with all applicants expectations, there is a perception that **poorer outcomes for a sizeable number of medical card applicants** are being experienced

- The combination of **resource constraints, limits to changes in thinking and practices** and high volumes of activity has typically resulted in continual reactive **crisis management**.
- Where there is constant crises it is difficult for managers and policy makers to look beyond the immediate problem and as a result **shorter-term planning** becomes the norm.
- Given public pressures and the high profile, such as in the case of medical card application processes, it is inevitable and almost incumbent upon policy makers and public representatives to involve themselves in identifying solutions.
- As political terms of office do not always facilitate longer-term planning given pressure to address immediate issues is high and as such this can lead to **overly politicised decision-making**.
- It is the combination of all of the elements listed above that invariably leads to a sense of **poorer outcomes for a sizeable number of medical card applicants**.

### *2.5.2 Summary and future requirements*

It is critically important to recognise that no single element of the process, or any distinct group of individual(s); or one organisational body is solely responsible for the poor outcomes a number of people experience during the medical card application process.

However, if reoccurrence of many of the issues highlighted during the consultation process, and in particular frustration and dissatisfaction with the medical card application process, is to be halted then there is an urgent need to:

**Connect policy, processes, resources and stakeholder communications in a more systemic and longer-term manner**

# 3. Future Requirements

The processing and review of medical card applications has developed in response to external policy decisions and organisational needs and as a response to changes and developments within the PCRS' operating environment rather than as a result of a detailed and planned strategy. This has resulted in a medical card processing system that tends to be reactive rather than proactive and sometimes lacks the support structures and frameworks that would allow for the delivery of best in class service.

In this section we set out what the "Future State" should look like for the PCRS under each of the headings outlined in the previous section and what needs to be done in the short (2014), medium (2015) and long (2016) term. Within each recommendation the key bodies responsible for ensuring the delivery of the actions is identified. Finally the Dependencies section sets out what needs to be in place for the Future State to be successfully achieved.

## 3.1 Policies

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| **1. Current State** | Public, media and political attention on the Medical Card process has resulted in PCRS acting as a "lightning rod" for criticism and complaints relating to the process. |
| **Future State** | The media, political system and general public are aware of the roles and responsibilities of all those involved in the medical card application process. There is clarity that the political system decide and set policy, including eligibility limits which is then implemented by the PCRS assessment team. All stakeholders groups, in particular LHOs, are fully discharging their duties in line with legislative and policy guidelines |
| **Actions** | **Short-term (2014)**<br>• The relationship between PCRS and LHOs and their respective roles and responsibilities are clearly defined and agreed<br>• The agreed communications plans include mechanisms to outline the PCRS role in medical card processing.<br>**Medium-term (2015)**<br>• Processes and mechanisms to increase LHOs "front of house" responsibilities and capabilities are designed and implemented<br>**Long-term (2016)**<br>• LHOs have appropriately integrated with PCRS systems and processes and front, PCRS back office and contact centre are functioning properly |
| **Responsibility** | Primary Care Division, PCRS, Department of Health |
| **Expected Dependencies** | • Cooperation from LHO staff<br>• Additional resources may be required |

## 3.2 Planning

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| **2. Current State** | PCRS is subject to a wide range of external decisions and policy shifts which means that the current processes continually have to react to environmental and operational challenges. The reactive nature of the business places significant pressures on the staff and PCRS operations and often leads to backlogs and unintended outcomes. |
| **Future State** | PCRS future role and strategic direction is clearly defined and appropriate governance structures are in place to facilitate and monitor its implementation. External policy shifts are minimised and are fully evaluated and tested before implementation. |
| **Actions** | **Short-term (2014)**<br>• Develop a three-year strategic plan for PCRS as part of a broader Primary Care strategy<br>• Confirm reporting relationships and mechanisms to monitor Primary Care strategy implementation<br>• Communicate and share Primary Care strategic plan with all relevant stakeholders<br>• Consider renaming the PCRS to reflect the breadth of the roles and responsibilities of the Business Unit<br>**Medium-term (2015)**<br>• Commence implementation of the Primary Care strategic objectives<br>• Review the Primary Care strategic direction at the end of 2015 and revise as required<br>• Department of Health fully evaluates and assess any policy changes before implementation<br>• Policy changes are assessed to determine strategic impacts before implementation by Primary Care Division<br>**Long-term (2016)**<br>• Continue implementation |
| **Responsibility** | Primary Care Division, PCRS & the Department of Health |
| **Expected Dependencies** | • Cooperation from Department of Health<br>• The development of an agreed change and governance process to prevent knee-jerk or overly reactive decision being implemented. |

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| **3. Current State** | While management review a wide range of performance metrics, there is a lack of Organisational "Key Performance Indicators" (KPIs). This has limited PCRS' ability to measure, monitor and manage its organisational performance |
| **Future State** | An agreed list of organisational KPIs are in place and are supporting the delivery of PCRS's strategy |

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| **Actions** | **Short-term (2014)**<br>• Identify appropriate KPIs as part of the strategy development process using a Balanced Scorecard Approach<br>• Develop a monthly reporting pack which is distributed to key stakeholders and outlines performance against KPIs<br>**Medium-term (2015)**<br>• Continuous improvement and monitoring of additional statistics aligned to KPIs |
| **Responsibility** | Primary Care Division, PCRS |
| **Expected Dependencies** | • Available performance data |

## 3.3 Structure

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| **4. Current State** | The Medical Card processing team has limited resource and is a very "flat" organisation with a small number of deciding and medical officers. These resource pressures and structural issues have militated against PCRS's success |
| **Future State** | PCRS is appropriately resourced and properly organised to allow it fulfil its role. PCRS have access to an appropriate number of deciding officers, supervisory staff and medical officers to prevent bottlenecks and delays in the system. |
| **Actions** | **Short-term (2014)**<br>• Carry out an audit and assessment of required PCRS staff resources and proposed organisation structure. Analyse what is required to staff the organisation adequately. Particularly focus on the areas of access to Medical Officers, Deciding Officers, and Middle Management.<br>• Develop the above analysis into a Business Case for additional human resources<br>**Medium-term (2015)**<br>• Define and agree an appropriate organisational structure, operating model, workforce planning model and span of control.<br>• Examine opportunities to increase the number of Deciding Officers through recruiting additional supervisory grades and/or lowering Deciding Officer grades for less complex cases<br>• Identify and recruit/reallocate/promote potential candidates to fill the vacant key roles identified.<br>• Full time access to at least three - four Medical Officers every day. Consideration should be given to securing this resource outside of the existing HSE cohort e.g. a panel of GPs, outsourcing to private service providers or assigned to |

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| | other healthcare professionals, such as nurse or other clinicians, to lessen the burden on existing Medical Officers.<br>**Long-term (2016)**<br>• Develop and implement a Performance Management & Development System to ensure all resources are being properly utilised and their development needs addressed |
| **Responsibility** | Primary Care Division & PCRS |
| **Expected Dependencies** | • Resources to conduct and design appropriate organisational and operating models<br>• Sanction to recruit additional staff, if necessary |

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| **5. Current State** | The extended remit of the PCRS over time, in particular assignment of the responsibility for the processing of medical card applications and review in 2011, has diluted people's understanding of the role, functions and effectiveness of the PCRS. This extension of PCRS' remit has resulted in the PCRS receiving a large amount of negative public and media attention, albeit very often misinformed, labelling all of PCRS processes as inefficient and non user-friendly. |
| **Future State** | The two core functions of the PCRS i.e. medical card assessment and reimbursement of medical services, both have a clear vision, structure and appropriate customer service ethos focused on their respective duties that is easily communicated and understood by all internal and external stakeholders. |
| **Actions** | **Short-term (2014)**<br>• Review the existing organisational chart for the PCRS, highlighting specific responsibilities and clear reporting lines<br>• Review the existing management structures and consider if a revised structure would better support the assessment and delivery of medical cards.<br>• Develop a transformation programme and structure designed to implement any recommendations arising from this review and monitor progress.<br>**Medium-term (2015)**<br>• Appoint a member of the HSE Directorate to act as a programme sponsor to guide and direct transformation within the medical card application process.<br>• Review and agree governance structures designed to deliver best in class customer service and remove a perceived perception linking eligibility to cost savings.<br>• Appoint a dedicated senior manager tasked with implementing the agreed transformation programme.<br>**Long-term (2016)**<br>• Implement a mechanism to regularly review governance structures to ensure a focus on customer service and delivery. |
| **Responsibility** | HSE Directorate, Primary Care Division & PCRS |

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| **Expected Dependencies** | • Support and buy-in from staff to respond to governance changes<br>• Support from HSE Directorate to act as programme sponsor for the transformation programme. |

## 3.4 Process

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| **6. Current State** | The application and review process is largely paper-based and heavily reliant on manual workflows and the transfer of paper files throughout much of the assessment process |
| **Future State** | All medical schemes can be fully applied for and administered electronically. The evaluation process is supported by an electronic workflow system, which allows all relevant information to be accessed at each point in the assessment process. |
| **Actions** | **Short-term (2014)**<br>• Roll out the necessary hardware and software i.e. Scanning facilities, to move from hardcopy to softcopy applications and supporting documentation<br>**Medium-term (2015)**<br>• Policy & SOPs amended to accept online applications<br>• Provide local options for non-online applications i.e. LHO, Primary care centre support and assistance<br>**Long-term (2016)**<br>• Launch and receive full online applications which will ensure a more streamlined and efficient service<br>• Implement a fully automated workflow system which integrates online applications and all stages of the assessment process |
| **Responsibility** | Primary Care Division & PCRS |
| **Expected Dependencies** | • Necessary capital and current resources to support the roll out of online services will be required<br>• GPs and other stakeholders agree to cooperate with the process |

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| **7. Current State** | There are limited end-to-end process maps and flow charts detailing the Medical Card application and review process. This leads to a level of inconsistency and ambiguity in administering current process. |
| **Future State** | Clearly defined and documented operating policies and procedures are agreed and made available to all relevant stakeholders. The availability of these documents should ensure the consistent administration of applications. |

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| **Actions** | **Short-term (2014)**<br>• Develop comprehensive Process Maps and Flow Charts outlining each step and decision point in all application process<br>**Medium-term (2015)**<br>• Review and update as required, incorporating changes, improvements and staff feedback to ensure a current and consistent administration of applications<br>**Long-term (2016)**<br>• Continuous review and refinement of policies and procedures<br>• Consideration should be given to opportunities to automate and provide self service options for some elements of the assessment process |
| **Responsibility** | PCRS |
| **Expected Dependencies** | • Necessary resources to support the development of relevant documentation |

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| **8. Current State** | The HSE currently administers a number of medical support schemes. These schemes are administered independently and largely follow separate application and evaluation processes. This lack of integration can lead to duplication of effort and access to secondary benefits, which may not be strictly necessary. |
| **Future State** | Applicants receive appropriate supports and the application process is simplified so that there is a single application process for medical supports, e.g. Medical Card, GP Visit Card, Long Term Illness Scheme and Drugs Payment Scheme. |
| **Actions** | **Short-term (2014)**<br>• Communicate the specific eligibility criteria for each of the medical schemes to all relevant stakeholders. This will support a clear, definitive understanding of each scheme.<br>• Implement a mechanism to pro-actively alert clients who are unsuccessful for a particular application, to other supports that may be available.<br>**Medium-term (2015)**<br>• Begin the process of decoupling the historical secondary benefits associated with the medical card scheme. Initiate and develop the process for assessing the medical support schemes through one application process<br>• Develop a single, combined application process for each of the medical schemes<br>• Consider the possibility of changing the current LTI scheme to include prescription charges for drugs dispensed under the LTI scheme. This will help reduce the desire of some applicants to apply for both schemes. |

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| | **Long-term (2016)**<br>• Rollout of the single application process and agreed eligibility criteria and entitlements. This will lead to a system which is appropriate to a persons medical need and financial means |
| **Responsibility** | HSE, Primary Care Division, PCRS, other Government Departments |
| **Expected Dependencies** | • Policy decisions are required to combine schemes into a common application and assessment process<br>• Input from other Government Departments will be required to fully decouple the medical card from secondary benefits<br>• Decisions will need to be subject to relevant control measures and data protection measures |

## 3.5 Capability

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| **9. Current State** | Limited opportunities for formal training has resulted in process inconsistencies and reduced levels of knowledge around the end-to-end process. |
| **Future State** | Staff have the necessary skills and appropriate understanding of all stages in the process to allow properly discharge their duties and responsibilities |
| **Actions** | **Short-term (2014)**<br>• Undertake a detailed "Training Needs Analysis" involving staff focus groups and feedback sessions to assess training and development requirements in line with PCRS' objectives. Develop training material. This will lead to a full list of training and development requirements, plus training syllabus and material by year end 2014<br>**Medium-term (2015)**<br>• Rollout agreed training to all staff to ensure that staff are fully trained in the application process and understand the end-to-end process<br>**Long-term (2016)**<br>• Review training needs based on any revisions to PCRS policy and practice and develop revised training plan if required |
| **Responsibility** | PCRS and HSE HR unit |
| **Expected Dependencies** | • Staff availability for training<br>• Resources and cooperation form the HSE HR unit to implement the necessary training |

## 3.6 Technology

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| **10. Current State** | There is an opportunity to enhance and further develop the level of functionality and visibility available through the Medical Card application and assessment system. In particular all staff involved in the assessment or query processes should be provided access to underlying and supporting documentation.<br><br>In addition, the application does not interface with other Government systems. This results in requests for duplicate information leading to errors and frustration. |
| **Future State** | The Medical Card application system is available to all staff (in an appropriate manner i.e. read only) and fully integrated with other Government systems. Requests for duplicate information are minimised and automated interfaces reduce the risk of error. |
| **Actions** | **Short-term (2014)**<br>• Meet with LHO and Call Centre staff to assess their information requirements<br>**Medium-term (2015)**<br>• System integration, software updates and development of SOPs to ensure that call centre and LHOs have access to full information suite<br>**Long-term (2016)**<br>• Full system integration with other Government Departments leading to complete ICT integration, data sharing and audit trail |
| **Responsibility** | Primary Care Division & PCRS |
| **Expected Dependencies** | • Cooperation from other Government Departments to provide information exchange<br>• Funding and resources to further develop and enhance the current systems |

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| **11. Current State** | The level of information captured by staff in the observations screen is inconsistent. This leads to difficulties and inefficiencies when responding to applicant queries or conducting reviews at later points in the process. |
| **Future State** | Staff are trained to provide clear and specific observations in relation to each application. |
| **Actions** | **Short-term (2014)**<br>• Hold a staff focus group to discuss, agree and define standards around the correspondence audit trail that is available on screen. Identify the level of information that is required, what decisions need to be recorded and the level |

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| | of detail to be captured<br>**Medium-term (2015)**<br>• Implement new standards, include standards in staff SOPs<br>• Implement staff training schedule if required<br>**Long-term (2016)**<br>• Monitor the implementation of new audit trail requirements and refine if necessary |
| **Responsibility** | PCRS |
| **Expected Dependencies** | • None identified |

## 3.7 Communications

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| **12. Current State** | A significant amount of information is necessarily required to assess and process Medical Card applications. Many applicants perceive the requested level of information to be excessively onerous, leading to high percentage of incomplete applications and in turn highly labour intensive processing requirements. |
| **Future State** | Ready access to personal and financial information held by other Government departments and agencies e.g. Revenue, DSP minimises the level of information requested from applicants. Where additional information is required, this is proactively followed up by the PCRS team with an enhanced level of tailored and customised requests sent to the applicant |
| **Actions** | **Short-term (2014)**<br>• Engage with staff to develop a complete list of most common Additional Information (AI) requirements and establish recurring issues.<br>• Investigate possible mechanisms to provide the maximum amount of detail possible when requesting additional information, e.g. time frame for bank statements and payslips.<br>• Work with LHOs to establish appropriate "Front of House" access to applicants looking for eligibility information or advice on AI requests<br>**Medium-term (2015)**<br>• Enhance the current communication process to deliver a fully implemented communications protocol for AI request:<br>1. Specific and tailored letter to request additional information (currently in place)<br>2. Text message sent out to confirm receipt of application and/or request any specific additional information required. Contact details for call centre for any clarifications or queries (partially in place at present)<br>3. Follow-up phone call from PCRS to ensure AI request is being actioned by the applicant (partially in place at |

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| | present)<br>4. Final reminder letter issued to applicant (currently in place)<br>• Examine alternative access points for collating and supporting application and any additional information requirements<br>**Long-term (2016)**<br>• Engineer processes and procedures to increase the numbers applying and submitting online and thereby reducing levels of written contact |
| **Responsibility** | PCRS and PCRS Call Centre |
| **Expected Dependencies** | • Cooperation from other Government Departments and Agencies in order to make information available<br>• Necessary resources to enhance existing systems and provide staff training |

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| **13. Current State** | GPs, Dentists, pharmacists, other service providers, and existing Medical Card holders are not fully aware of the full range of functionality available to them in relation to the Medical Card scheme. In particular, some GPs seem unaware of their authority to extend Medical Card entitlements. Despite the best efforts of the PCRS team, some Medical Card holders can first learn that they are no longer covered when they arrive at the GP or pharmacy |
| **Future State** | There is a high degree of interaction and communication between PCRS, Service Providers and Medical Card holders. Service providers and applicants are fully aware of the authorities of Service Providers in relation to the extension of Medical Card eligibility and GPs are capable of advising individuals that they are no longer covered. |
| **Actions** | **Short-term (2014)**<br>• Meet a representative group from each service provider profession to obtain their views on how communication and interaction can be improved.<br>• Work out a communication plan/template between PCRS and service providers, and any training that may be needed on systems/eligibility criteria.<br>• Prepare and distribute a high-level summary document to outline key steps in the medical card process<br>**Medium-term (2015)**<br>• Implementation and rollout of improvement initiatives i.e. Establishment of direct contact liaison point/dedicated query line for GPs, Dentists etc. Ensure service providers are trained on how systems work/eligibility criteria.<br>• Ensure that GPs and Service Providers have direct access to dedicated personnel in the PCRS which allows for real-time information sharing of medical card status<br>• Offer additional training and system demonstrations to |

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| | service providers to be rolled out through the cooperation of professional bodies.<br>**Long-term (2016)**<br>• Continuous review and monitor communication channels to ensure that Service Providers and Card holders are fully aware of the services provided |
| **Responsibility** | PCRS & Service providers |
| **Expected Dependencies** | • Cooperation from service providers<br>• Resources and staff willingness to support closer engagement with service providers |

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| **14. Current State** | Public discourse around Medical Card eligibility and entitlement is shaped by media coverage, which typically focuses on complex medical needs rather than permitted financial means. There are many positives associated with the current process however this message is not effectively communicated. |
| **Future State** | The general public have an appropriate level of understanding around Medical Card schemes and financially based eligibility criteria. Where members of the public require additional information suitable and easily available channels are available. Multiple channels to check the processing status of an application are available. |
| **Actions** | **Short-term (2014)**<br>• Plan a new public awareness campaign utilising various media forms to highlight the purpose and eligibility criteria of the medical card scheme<br>• Raise the profile and awareness of the medicalcard.ie website and as a point of information on all matters relating to medical card<br>• Increase the numbers of communication channels e.g. social media sites<br>• Simplify and shorten user guides to support the application process, where possible<br>• Highlight current features, such as the online application tracker in order to help reduce the need for phone calls<br>**Medium-term (2015)**<br>• Rollout public awareness campaign throughout 2015<br>• Measure and compile public awareness statistics on a quarterly basis<br>• Improve the level of information available via the online tracker to provide more granular detail in relation to the application status. At present the “in progress” status covers a number of stages and provides limited information to the applicant.<br>**Long-term (2016)**<br>• Refine and renew public awareness campaign based on feedback |

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| **Responsibility** | PCRS/HSE Communications Unit |
| **Expected Dependencies** | • Communications Unit availability and resources |

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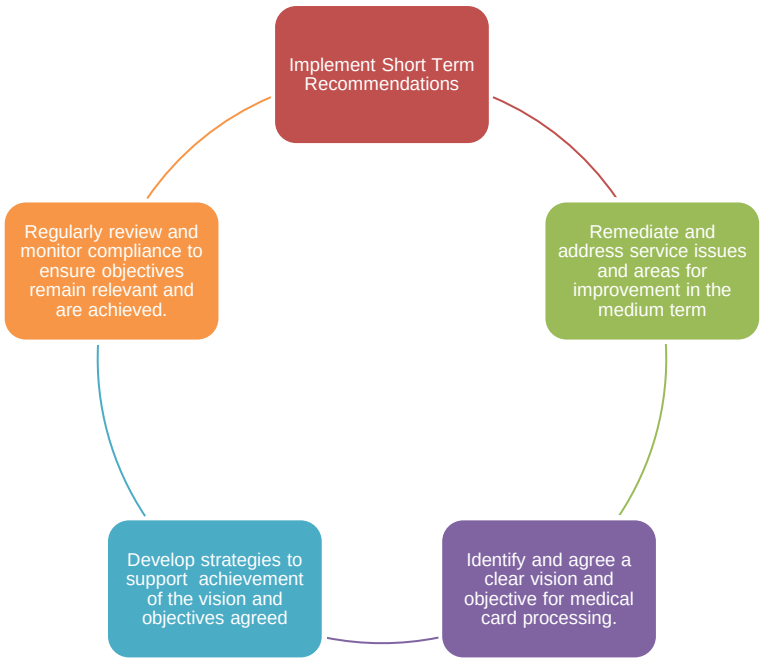
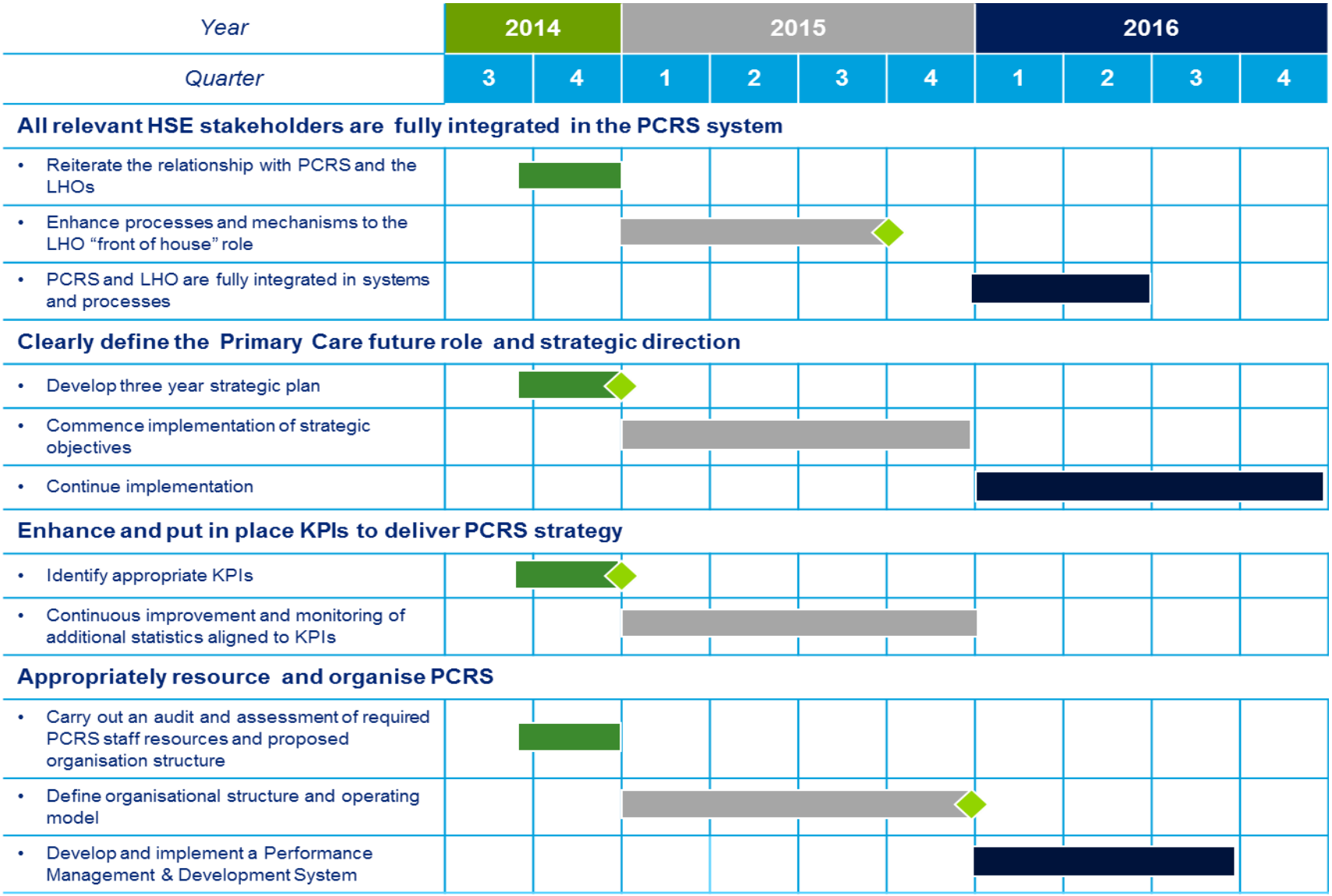
| **15. Current State** | There are limited opportunities for communications, feedback and information sharing across the wider Primary Care Team team. This has contributed to a sense of disconnect between internal PCRS teams and between PCRS and the LHOs. It has also given rise to a level of ambiguity and misunderstanding around certain key stages in the Medical Card process, for example the issuing of Emergency Medical Cards. |
| **Future State** | There are defined and agreed mechanisms for communications, upward and downward feedback and information sharing. This takes the form of periodic team meetings and knowledge sharing events, collaboration workspaces and informal information sharing mechanisms. |
| **Actions** | **Short-term (2014)**<br>• Recommence the staff engagement process to identify best ways to develop improved information sharing mechanisms.<br>• Involve staff from all areas of PCRS and the LHOs in the design of an internal communications strategy to address current information deficits<br>• Liaise with PCRS, GPs and LHOs to identify short term measures to address immediate term issues, such as the "End of Life" card<br>**Medium-term (2015)**<br>• Execute the internal communications strategy |
| **Responsibility** | Primary Care Division, PCRS and Local Health Offices |
| **Expected Dependencies** | • Cooperation of LHOs and external service providers |

# 4. Implementation

## 4.1 High level plan

It is recommended that PCRS consider the following high level road map in order to respond to the observations noted and position PCRS operations to be able to respond and react to on-going pressures during a period of change and uncertainty in the sector.

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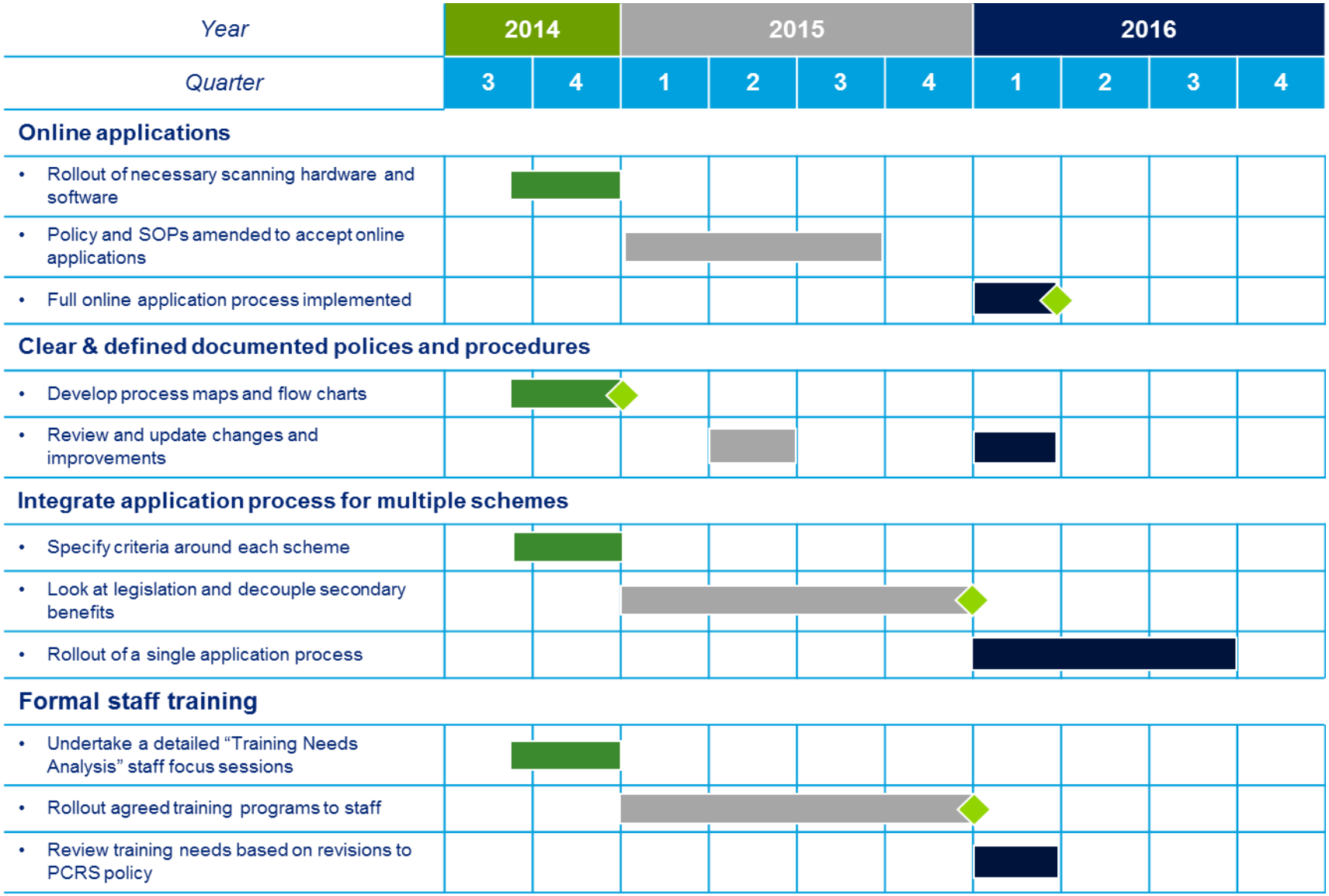
All relevant HSE stakeholders are fully integrated in the PCRS system
• Reiterate the relationship with PCRS and the LHOs
• Enhance processes and mechanisms to the LHO "front of house" role
• PCRS and LHO are fully integrated in systems and processes
Clearly define the Primary Care future role and strategic direction
• Develop three year strategic plan
• Commence implementation of strategic objectives
• Continue implementation
Enhance and put in place KPIs to deliver PCRS strategy
• Identify appropriate KPIs
• Continuous improvement and monitoring of additional statistics aligned to KPIs
Appropriately resource and organise PCRS
• Carry out an audit and assessment of required PCRS staff resources and proposed organisation structure
• Define organisational structure and operating model
• Develop and implement a Performance Management & Development System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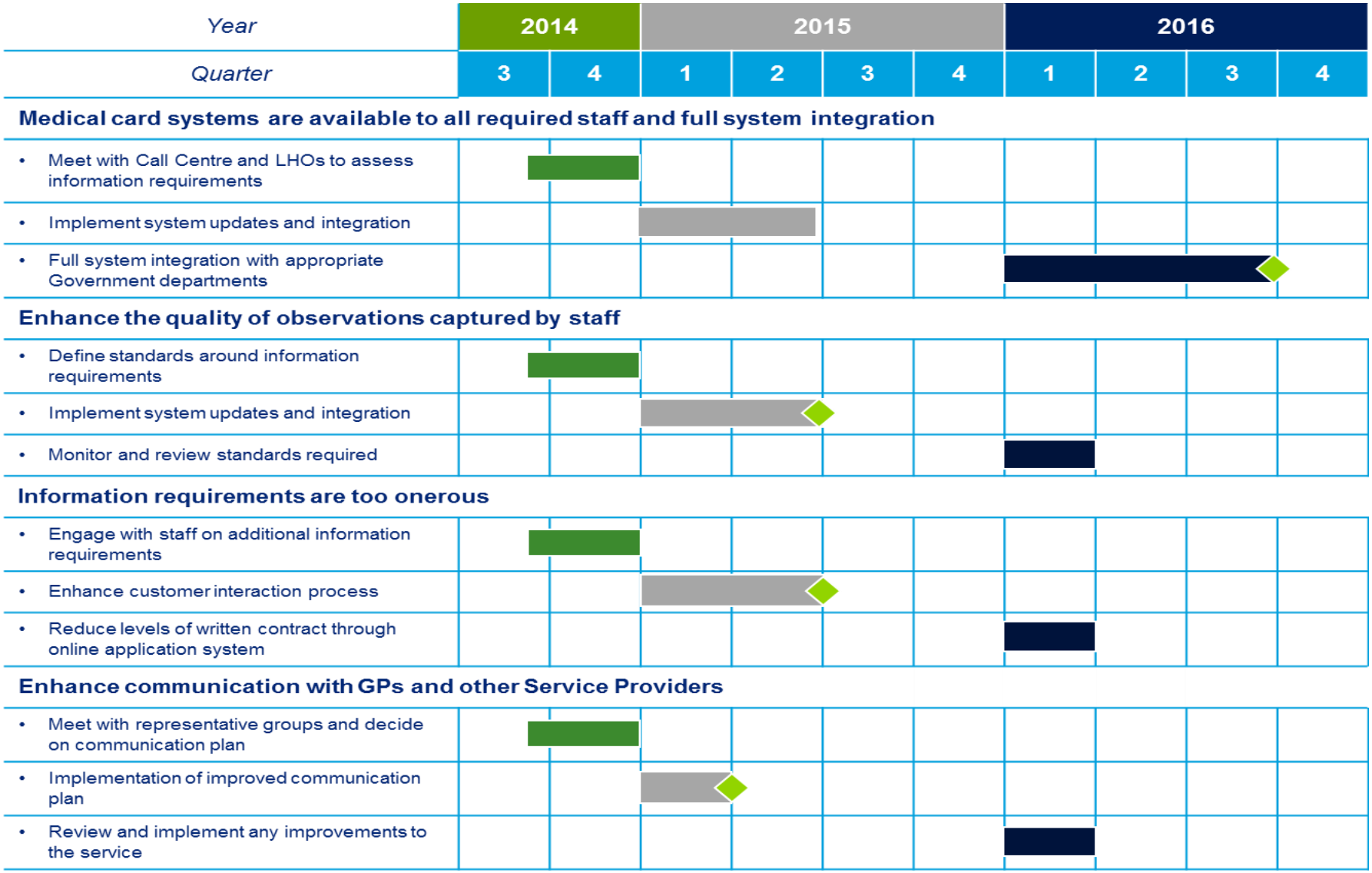
Online applications
• Rollout of necessary scanning hardware and software
• Policy and SOPs amended to accept online applications
• Full online application process implemented
Clear & defined documented polices and procedures
• Develop process maps and flow charts
• Review and update changes and improvements
Integrate application process for multiple schemes
• Specify criteria around each scheme
• Look at legislation and decouple secondary benefits
• Rollout of a single application process
Formal staff training
• Undertake a detailed "Training Needs Analysis" staff focus sessions
• Rollout agreed training programs to staff
• Review training needs based on revisions to PCRS policy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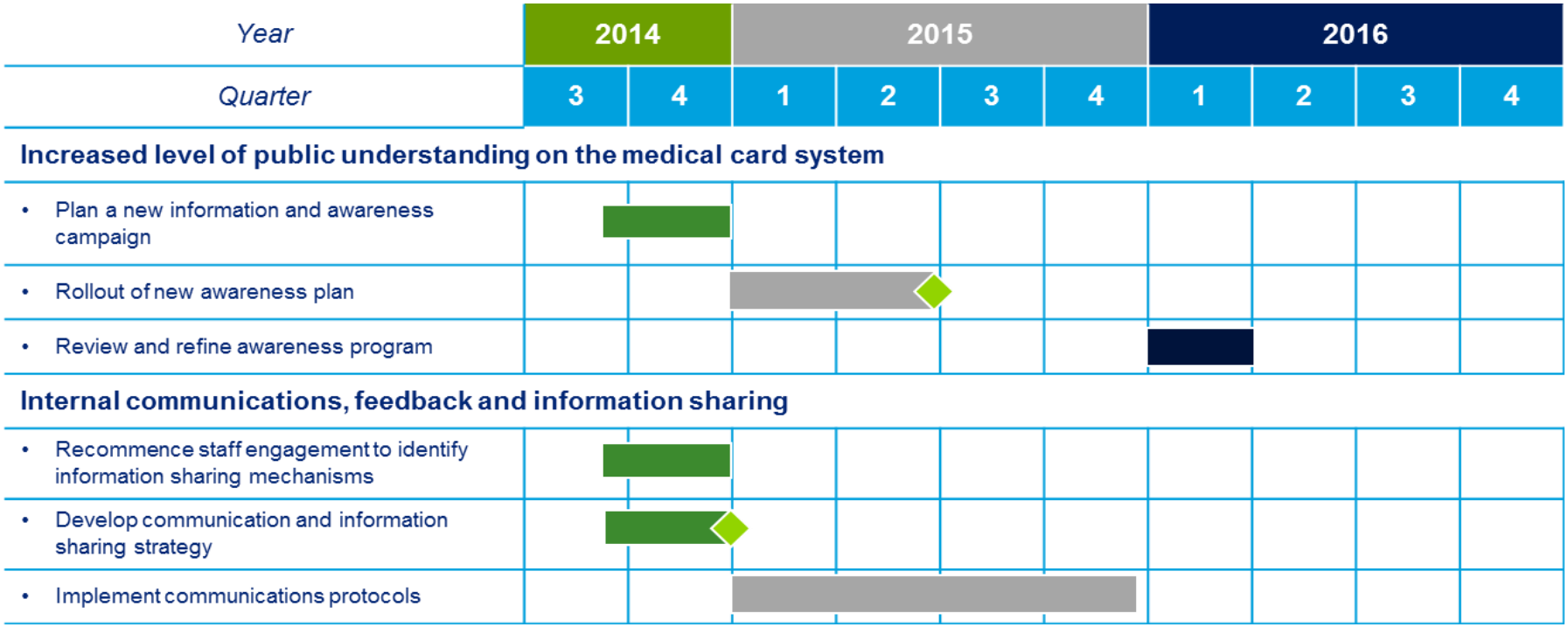
Medical card systems are available to all required staff and full system integration
• Meet with Call Centre and LHOs to assess information requirements
• Implement system updates and integration
• Full system integration with appropriate Government departments
Enhance the quality of observations captured by staff
• Define standards around information requirements
• Implement system updates and integration
• Monitor and review standards required
Information requirements are too onerous
• Engage with staff on additional information requirements
• Enhance customer interaction process
• Reduce levels of written contract through online application system
Enhance communication with GPs and other Service Providers
• Meet with representative groups and decide on communication plan
• Implementation of improved communication plan
• Review and implement any improvements to the service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Increased level of public understanding on the medical card system
• Plan a new information and awareness campaign
• Rollout of new awareness plan
• Review and refine awareness program
Internal communications, feedback and information sharing
• Recommence staff engagement to identify information sharing mechanisms
• Develop communication and information sharing strategy
• Implement communications protocols

## 4.2 Communications

Many of the issues faced by the medical card processing service were compounded by challenges in relation to communications and the difficulties faced by the HSE in adequately addressing external criticism and comment, while always needing to respect and protect applicant confidentiality.

A high level communications plan was developed to help guide and manage overall communications, however additional work is required to ensure that key messages are delivered to the relevant audiences. Based on our very high level review and observations obtained from discussions with a wide range of stakeholders we have noted the following, opportunities for improvement;

- There is a lack of opportunities for communications with PCRS and LHO staff, and where communication does occur this tends to be one way, with limited opportunities for feedback.
- There are a number of technology solutions available to the HSE and PCRS to support employee engagement and communications however these are not fully utilised. For example, we understand that the HSE has access to technologies such as Microsoft Lync which could be utilised for videoconferencing, information sharing and communications.
- Significant effort has been invested in developing “how to” guides and videos however these have not been promoted or awareness raised among the general public.
- The HSE Communications Unit is not always involved as a key stakeholder in support of PCRS communication strategies and responses.

In an area related to the need for improved communications we also noted the need to develop a customer service ethos for all staff working in the medical card processing area. While it is noted that a draft Customer Charter for PCRS has been developed, and it is clear that there is a desire to support and assist applicants to obtain all services they are eligible for, this desire is not communicated to the outside world and may not be consistently applied within the PCRS and LHO systems due to the lack of a clear set of customer service principles and ethos.

In developing this customer service plan, PCRS should consider the following elements:

- Customer Service Principles
- Customer Service Ethos
- Customer Service Vision
- Customer Service Goal

In order to address these areas for improvement PCRS should develop a comprehensive communications, engagement and customer service ethos plan in conjunction with other key players such as the Primary Care Division and LHOs. The plan should be developed with support from other Business Units within the HSE, including the Communications Unit, HR and the Learning and Development team.

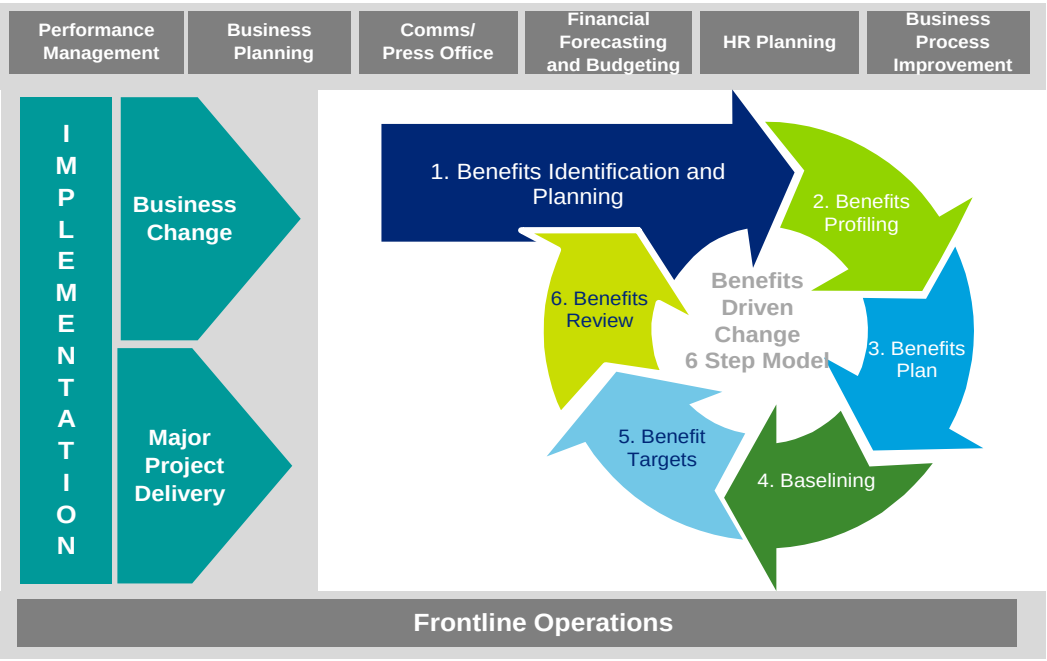
The development of the plan should include a detailed assessment of the current communication activities, a definition of strategic communication priorities and a clear implementation plan to implement key actions identified.

As part of our review we have provided an approach and templates that can be used to support the development of a comprehensive communication and engagement plan. This is available as a separate information pack.

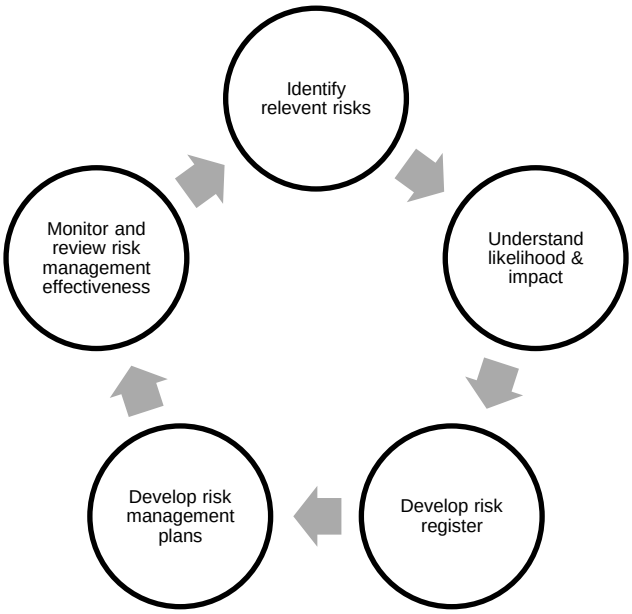
### 4.3 Change Management

Notwithstanding the signifcant level of change that has already taken place in the administration of the medical card system, it is expected that the current focus on Health Sector reform and reaction to the current medical card processing issues will result in significant additional change across PCRS. This will invariably necessitate the development of a more integrated approach to benefits realisation, ensuring maximum synergy and minimising any duplication. An integration change management approach should be followed to ensure that there is a benefits-driven change approach bringing together project delivery, change management, operational performance management and financial management to focus on realising the benefits of health sector reform.

A suggested approach which integrates the key activities across the organisation into a common approach to benefits realisation, is set out below:



## 4.4 Risk Assessment




Given the level of change that needs to occur within PCRS, it is vital that risks are carefully managed and assessed as part of the change and governance process. In addition risk management should be embedded into business as usual operations within PCRS to ensure that risks are appropriately managed and monitored. A high level approach to risk management is summarised in the diagram above. The key elements of the approach include:

- Enhancing the PCRS' existing risk register to identify and record all relevant risks. Risks captured on the risk register should also include budget or cost risks, delivery and timing risk as well as stakeholder interaction and communication;
- Identify relevant risks and prompt all staff to consider risks at all stages of the application and review process. Risk domains such as Governance, Operations, Strategy and Reporting should all be considered.
- Reviewing progress to ensure deliverables and outcomes are being delivered;
- Developing a quality plan that identifies the quality review points in the assignment.

In order to manage risks fully PCRS should aim to include input from a range of risk, control and internal audit specialists who can provide input into various steps of the risk management process and ensure the risk management demands are fully considered.

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