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This report is part of the final evaluation report on Care Net Illawarra, one of the Australian Coordinated Care Trials based in the Illawarra. Each of the national trials addressed the same primary hypothesis:

Coordination of care of people with multiple service needs, where care is accessed through individual care plans, and funds pooled from existing Commonwealth, State and joint programs, will result in improved client health and well being within existing resources.

A summary of the key elements of the Care Net Trial is contained in Appendix 1 of this report.

There are 10 reports in this evaluation series:

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| Report Number 8 | The Care Net Trial – Impact on the Wider System |
| Report Number 9 | The Care Net Trial – Value for Money? |
| Report Number 10 | The Care Net Trial – The Evaluators Conclusions (this report) |

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Report Number 10

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The Care Net Trial – The Evaluators Conclusions

10.1 The primary conclusion

10.1.1 The primary hypothesis

The primary hypothesis was not supported by the evidence, namely that:

Coordination of care of people with multiple service needs, where care is accessed through individual care plans, and funds pooled from existing Commonwealth, State and joint programs, will result in improved client health and well being within existing resources.

- Outcomes for intervention clients were no better than for the control group; and
- Care Net did not develop a financing model that was sustainable. The trial ended with a deficit of \$1.8 million or 13.2%.

10.1.2 Care Net clients

Clients in the intervention group were overwhelmingly positive about their Care Net experience.

They were particularly pleased to have a care coordinator because:

- They felt they could talk to, and trust, their care coordinator and thus felt less of a 'burden' on their family; and/or
- They received new and improved services; and/or
- They saw care coordination as an "insurance" against future health and related problems.

But only about 13% of the clients had high needs which is the group in the literature thought to benefit from coordinated care.

10.1.3 Financial results

Care Net ended about 13% in deficit. Close to 17% of the Care Net fund pool was spent in Care Coordination.

If the primary hypothesis was to be supported, Care Net had to make efficiency savings of about 17% over mainstream services. Put another way, in order to break even Care Net had to identify 17 cents in each dollar in mainstream services which could be better spent.

Instead, Care Net spent about 13 cents in every dollar more.

10.2 The broader evaluation of Care Net

Care Net undertook a very complex task that was under planned and not well managed. It addressed a series of challenges facing mainstream services and attempted to pursue multiple objectives at once, with limited expertise and a short planning period.

We identified 8 main interventions in the trial and have drawn the following conclusions:

10.2.1 The formal assessment of clients

A broad range of client evaluation data was collected but they were not put to best use. While information was part of the intuitive background for care planning, we could not find a systematic link between assessment results and the services purchased for the client. There was no central record of a medical assessment and GPs were not linked closely into the interpretation and use of data from functional assessments.

10.2.2 The use of care coordinators

Everybody we questioned was positive about the care coordinators and their work. They were thought to work hard and responsively. They might have been better used if there had been a higher proportion of clients with high needs within the intervention group. As it was, many clients did not require a care plan.

10.2.3 The use of care plans

We could find little evidence of systematic blending of the medical and social elements of the care plan. The impact of care plans was hard to measure since every intervention was unique and there was no classification of clients linked to intervention types. Purchasing was not systematic. The key substitution seemed to be private services in place of services from the public sector contributors to the funds pool.

10.2.4 GPs as case managers

GPs felt that the trial was worthwhile. They welcomed the broader perspective on their patients which was given by the care coordinator's assessment. The new MBS items introduced toward the end of the trial provide a useful opportunity for GPs to continue some of the practices developed in the trial. The trial provided a useful opportunity to develop key themes of the Illawarra Division of General Practice (IDGP) agenda such as shared care and IT developments. There was some evidence of strengthening communication links between private GPs and public hospital service providers.

10.2.5 The use of IT

GPs were very strong supporters of the medical director software system provided them by the trial. The information systems designed to permit better communication developed slowly throughout the trial. But, despite initial plans, these systems were never rolled out beyond Care Net itself and the participating GPs.

The management of information was a continuing problem in the trial. While data were collected efficiently, data quality management was poor, and therefore there was little evidence that management action was timely or based on good data. The potential of the data collected for both management and clinical purposes was not realised.

10.2.6 The use of a funds pool

The method of funds pooling proved to be feasible and broadly acceptable. But the absolute level of funds provided to any particular trial depended on the relative 'wealth' of the region in which it was located and the relative efficiency of its public hospital system as demonstrated by the cost of

its inpatient care. Since, in the case of the Illawarra, this was low, the absolute sums of money potentially available for release for community services was also low.

Care Net did achieve some savings relative to the MBS, PBS, IAHS and DVA contributions to the fund pool. But these savings were not sufficient to fund expenditure on community services which exceeded income by between \$1,260 and \$1,991 per intervention client.

The original intention was to shift funds within the pool. But most of Care Net's substitution involved shifting funds from pool contributors to (predominantly private for profit) non-contributors.

10.2.7 Changes in clinical practice and substitution

Although we identified a number of programs that attempted the substitution of services, there was no evidence of systematic changes in services that could be assessed against client outcomes.

The preventive strategies adopted by the trial often meant the use of private services that could act immediately and provide services far earlier than would be usual in mainstream services.

There were also examples where Care Net changed the responsiveness and the ability to participate in care planning of smaller providers.

10.2.8 The creation of a new organisation, namely Care Net

The new organisation was created very quickly but it faced a series of complex and demanding challenges that mainstream services, with their considerable specialist resources, have generally been unable to meet. Care Net fared no better. It had insufficient time and managerial capacity to meet such challenges.

10.3 The wider system

The Illawarra provided a good context for the trial having a history of cooperative projects and significant accumulated goodwill between the sponsors. In terms of the broader system, new links and new service types were introduced for the participants and the main shortfalls were in relationships with the smaller community care providers.

While the trial acted as a catalyst for a wide range of developments, the number of clients in the intervention group who required coordinated care was small and so the impact on mainstream services was correspondingly limited.

The level of resources available to the trial enabled a level of service to be provided to clients, usually without client financial contributions, which was superior to that of clients with similar needs receiving mainstream services. This created feelings of inequity among some mainstream services providers who felt that their clients had greater needs and should receive higher priority. This was an artefact of the clients recruited to the trial at its inception and their needs profile.

10.4 Broader issues

10.4.1 Unmet need

The trial results highlight difficult issues relating to the level of unmet need in the community. For example, one of the few significant differences in outcomes between the intervention and the control group was that *intervention* clients had twice the rate of admission to residential aged care. We interpret this finding to be due to the intervention group having had better access to assessment and advocacy services than the control group. No doubt the same level of need existed in the control group and, indeed, the broader community.

10.4.2 Equity

The trial also highlights difficult issues relating to equity of access to available health and community care resources. Despite the overall client group being of relatively low need, intervention clients received a wide range of services from public and private providers and they usually received them without the waiting period that would have been likely in over-stretched mainstream services. They received more services than people with equivalent or greater need already receiving services from over-stretched community health and community care providers and considerably more than those people sitting on waiting lists in the mainstream system.

10.4.3 Information sharing versus privacy

Nearly 2000 people gave their informed consent to participate in the Care Net trial. Not one person refused consent to their personal and health information being shared between the care providers (by electronic or other means). Despite initial concern over the privacy implications for sharing client data between health and community services professionals, Care Net clients saw the pooling of information as a positive step. It gave them the security of knowing that important health information was available in case of emergency. Quite clearly, the perceived benefits of continuity of care outweighed any potential concerns about privacy. This finding has significant implications for the future development of electronic medical records and common information systems across the health and community care sectors.

10.5 An environment for learning

Despite (or because of) the results reported above, the Illawarra region submitted a proposal in late 1999 to establish a second Coordinated Care Trial, to be known as 'Care Network'.

At one level, this decision may be seen to be surprising. Care Net's financial sponsor (the Illawarra Area Health Service - IAHS), was left with a considerable debt, Care Net had had little impact on the broader health and community care delivery systems and there was no evidence that client outcomes had improved.

At another level, the decision to seek a second trial represents an important outcome of the Care Net trial. The region had made a decision that the lessons of Care Net should not be lost. Important lessons were extracted from the collective experience of the trial (both positive and negative) and were used to design what the key stakeholders saw as a more sustainable model.

Importantly, the development of the new 'Care Network' model was supported not only by Care Net's initial sponsors and partners (the IAHS, the GPs and the Home Care Service) but also by community care agencies and other parties who had not participated in the initial Care Net trial.

Care Net achieved important outcomes. It strengthened the climate for learning. It further strengthened the regional network of health and community care providers. It provided an important platform to engage GPs in the broader system. It generated the ideas and the energy to enable the Illawarra region to learn from the past and develop more sustainable models for the future. In that sense, Care Net was a great success.

Appendix 1: An overview of the Illawarra Coordinated Care Trial

The Illawarra Coordinated Care Trial, or Care Net Illawarra, was established as part of a National series of demonstration projects that aimed to assess the benefits of coordinated care in the context of the Australian health care system. The primary hypothesis to be tested by the trials was that:

That coordination of care of people with multiple service needs, where care is accessed through individual care plans and funds pooled with existing Commonwealth, State and joint programs, will result in improved client health and well-being within existing resources.

Fund pooling was a key component of the coordinated care trials. The established, program-based organisation and funding of health care services was thought to be a principal factor in frustrating flexible service provision and service substitution. The way to overcome this issue was believed to be the pooling of funds from Commonwealth, State and joint Commonwealth-State programs. (Pekarsky, 1999) Trials would be allocated a budget from which they could purchase services for clients, with funds for the budget coming from the finances of existing service providers. But there would be no additional money. A key Commonwealth requirement was for trials to be cost-neutral.

The Illawarra trial encompassed three local government areas: Wollongong, Shellharbour and Kiama, the area being located south of Sydney, NSW. Its principal stakeholders were the Illawarra Area Health Service (IAHS), the Illawarra Division of General Practice (IDGP) and the NSW Home Care service.

The trial aimed to coordinate the care of people aged 65 years and over with either a risk of falling or who had complex medical or social problems that required multiple services from more than one health care service provider. During the 1997 planning phase of the trial, roughly 1800 eligible residents were referred to the trial by the 100 GPs participating. 1200 clients were allocated to an active group and would have their care coordinated by the trial, while the other 600 were allocated to a control group.

After the planning phase, the trial went live on 1 November 1997. It finished on 31 December 1999, a total period of 26 months over 3 financial years.

The coordination of care was undertaken by 15-16 care coordinators, in collaboration with the client's GP. The GP maintained control of the medical aspects of the client's treatment, while the care coordinator organised access to other services, purchasing services agreed to with the participant and GP. The care coordinators performed a systematic assessment of their clients initially every three months and subsequently in response to need. These assessments were intended to inform the creation of the clients' care plan that, among other things, included the goals of care for the client. Finally, a service plan was created that described the package of services to be bought by the trial in order to address the clients' goals was created.

Thus, the trial adopted a commissioning model of service provision. It secured services mainly from community care service providers, having access to both public services (those in the IAHS and the local HACC agencies) and private services. Medical (GP, specialist), pharmaceutical and hospital services were also within the funding pool, but these services were largely determined by GPs.

The trial used State and Commonwealth funds to develop an information system. Based on an intranet structure, the system supported email, client records, service utilisation, and financial data. This system did not support full communication between providers but significant steps included the increased use of computers by GPs.