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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:

Report Number 1	The Care Net Trial – What it was and How it was Managed
Report Number 2	The Care Net Intervention
Report Number 3	Care Coordination in the Care Net Trial
Report Number 4	The Use of IT in the Care Net Trial
Report Number 5	Client Experiences in the Care Net Trial
Report Number 6	The Care Net Trial – Impact on General Practitioners (this report)
Report Number 7	The Care Net Trial – Impact on Health and Community Care Providers
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

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Report Number 6

The Care Net Trial – Impact on General Practitioners

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6.1 Introduction

General Practitioners (GPs) were expected to play a full part in all of the Australian coordinated care trials and Care Net was no exception. This report discusses the role and the experiences of GPs in the Care Net trial. The trial itself is summarised in Appendix 1 and the hypotheses tested by the trial in Appendix 2.

6.2 Methods and Types of Data

This report is based on three main sources of data. Structured interviews were undertaken with the Chairman and Chief Executive Officer of the Illawarra Division of General Practice (IDGP) at the beginning of the trial. The interviews were designed to address the extent to which the Illawarra presented a receptive context for change drawing upon work by Pettigrew and his colleagues at the Warwick University Centre for Strategic Change (Pettigrew, 1992). Pettigrew argues that the context for organisational change can be more or less receptive and that complex change is particularly difficult in hostile environments.

These interviews were transcribed, returned to the interviewees for correction and amendment before analysis. A structured survey instrument was administered to all GPs in the trial in February 1999. The response rate was 55% after two reminders. The survey took the form of a series of statements based on the eight Care Net interventions identified in the Care Net mid-term evaluation. Statements were randomly worded in positive and negative form and a series of checks were inserted in the questionnaire to provide more than one question on key issues and try to ensure the best results were obtained from a questionnaire that GPs were likely to fill in quickly.

A series of four focus groups was undertaken in May 1999. All GPs in the trial were invited and the attendance was 37. The views of the groups are reported as G1, G2 and so on.

6.3 Findings

6.3.1 Introduction

6.3.1.1 *GP participation in the trial*

The role of GPs in the trial was to coordinate investigations, treatments, and the involvement of other health care disciplines in the care of his/her patients and liaise with institutions in the management of care. The GP was to manage the involvement of medical specialists, continue to provide care for chronic problems and act as a consultant and resource on personal, family, and social issues affecting the patient's care.

102 GPs participated in the trial. They ranged from having a single patient enrolled to having more than 40 patients in the trial. 70 GPs had between 5 and 20 patients in the trial (Eagar et al., 1998).

6.3.1.2 *GP access to IT in the trial*

A particular feature of the Care Net trial was the provision of an IT system designed to enable GPs to obtain information from personal computers (PCs) on their desks and to communicate electronically with Care Net and with other providers. These PCs were funded by a separate grant from NSW Health and were to be placed on GPs desks for their personal use, not as an administrative tool for secretaries and support staff. Some comment on GP use of the system will be made in this report but the main review of the IT system is in Report Number 4.

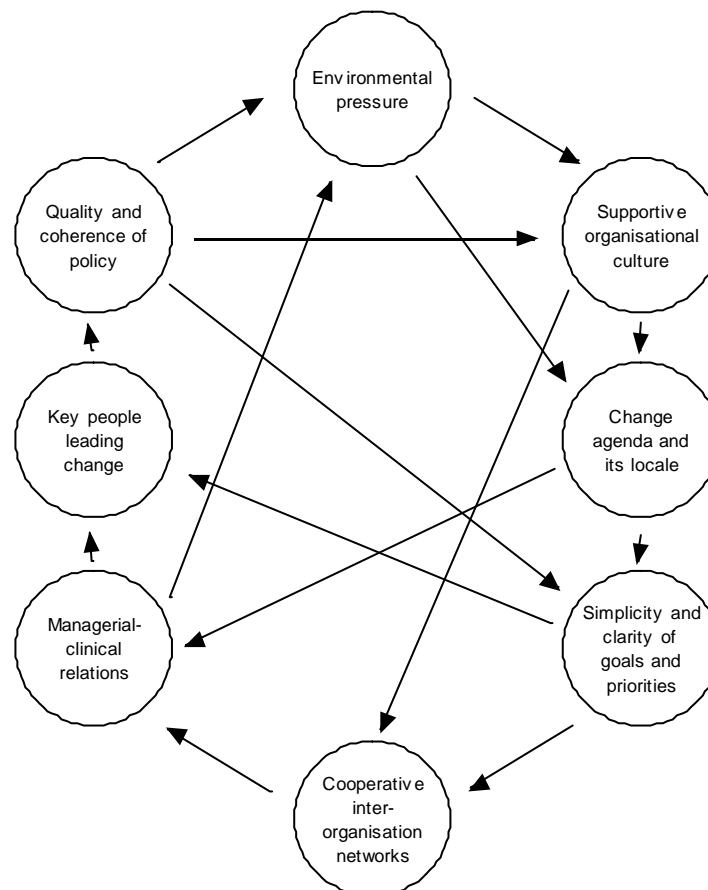
6.3.1.3 Incentives offered to participating GPs

Unlike other trials, GPs were not offered fees for the preparation of care plans. They received their normal MBS fees for patient appointments and the PC may be regarded as an additional incentive for participation in the trial. It is not inconceivable that some GPs may have lost out financially through seeing active trial patients less frequently that would have been the case without the trial. These data were not available to the evaluators.

6.3.2 A receptive context for change?

The purpose of initial interviews was to discover whether the Illawarra context promised a receptive context for change. The interviews were structured using a framework by Pettigrew, which is summarised in Figure 1. Interviews were held with the Chairman and the Chief Executive of the Illawarra Division of General Practice (IDGP) and are reported in this section. Broader contextual analysis can be found in Report Number 1.

Figure 1



6.3.2.1 The quality and coherence of policy

The policy underpinning the coordinated care trials was thought to represent an opportunity to move towards “a bigger picture approach to health problems” which would allow financial support for investments in prevention, screening, and risk assessment. Through the management of a funds pool:

“different sponsors would lose control of a budget segment, in exchange there is potential for strategic management, opportunities for changes to work practices, investment in new systems”.

This shift to an integrated approach to health problems would be supported by an IT system was expected to be:

“a unifying factor for GPs”. It made sense for the Home Care services to participate in the trial because “it fitted their broader policy directions”.

The trial was thus thought to fit well with the broader policy objectives of the partners but it was not seen as an answer to the most complex problems:

“Some patient care trajectories involving public and private agencies and ending in a nursing home bed might still prove very complex and it was not clear if such patients would benefit from the trial.”

One of the comments was reminiscent of a point made later by Leutz (Leutz, 1999) about the need to invest before savings could be realised – integration costs before it pays.

“The trial required organisational and other investments if it was to save resources later.”

Both interviewees saw benefits from the rational and strategic approach to problems that had previously been the responsibility of separate agencies.

6.3.2.2 The availability of key people leading change

Not surprisingly, both interviewees saw the IDGP role as crucial in establishing the partnership that allowed the trial to go ahead. The IDGP had spent considerable time and effort presenting the proposal to GPs and winning their support.

They also recognised the pivotal role of the Project Manager:

The trial manager had played a crucial role in leading change and the role of Illawarra Area Health Service Executive (IAHS), and Aged and Rehabilitation services had been important.

6.3.2.3 Long term environmental pressure – intensity and scale

The history of IDGP and its history of successful collaborative projects had acted to reduce the level of threat perceived by local GPs. This observation is important in a context where the Illawarra Area Health Service was thought by some to be a large and predatory organisation that might threaten the independence of other participants in the trial.

GPs generally thought themselves to be working under considerable pressure. They were interested in making their everyday clinical practice as efficient as possible and the trial, with the offer of Medical Director, promised to assist them in the management of chronic conditions.

There was a long history of cooperative arrangements amongst Illawarra GPs which had commenced with the after hours medical services and included a Division of General Practice within the IAHS structure.

6.3.2.4 A supportive organisational structure

The IDGP had strong relationships with the IAHS Executive who met together every two months to discuss developments of mutual interest. The chair of IAHS was a GP which also proved helpful.

There were however some frustrations with the trial which related to the (excessive) speed at which it had been set up that allowed insufficient time for resolving issues of detail about the trial, its information system, the incentives to GPs and specific goals of the intervention.

One interviewee commented:

“The unresolved issues are how to proceed in a way that keeps active involvement.”

6.3.2.4 Effective managerial-clinical relations

Not surprisingly the GPs did not perceive themselves to be operating in the context of a managerial-clinical relationship. One respondent interpreted this as relationships with the care coordinator and felt that the care coordinator produced independent and useful feedback to the GP on patients. There were some questions about the resource allocation decisions and guidelines used by coordinators. GP roles within the trial were:

to follow best practice protocols and plan interventions (for active clients) beyond what is normally available in mainstream services.

On the medical side the minimum expectation of the GPs in the trial was that they would use the computer system to generate prescriptions.

6.3.2.5 Cooperative inter-organisational networks

A number of projects demonstrated the IDGP intention to strengthen inter-organisational cooperation including investments in IT network systems between hospital and the GP's surgery, and a Medication in the Ethnic Elderly project designed to facilitate relationships with Non Governmental Organisations. The IDGP employed a community pharmacist as an initiative to improve the use of medications, over the counter drugs and particularly the use of drugs on discharge from hospital.

Other instances of cooperation included regular meetings with discharge planners and with the Community Health Executive of the IAHS.

6.3.2.6 Simplicity of goals and priorities

The goal of the trial was described in a straightforward fashion:

The basic idea is one of investment – spending money in order to save later on. This is the strategy at the level of the trial and at the level of the care coordinators.

But there were some caveats:

While the trial is an extra resource available to GPs, it can be more time-consuming for experienced practitioners who already have the networks – eg from work with community health and community care, DVA clients, nursing home/ACAT contacts.

The above comments suggest that there was good reason to believe that the context for change was positive. The Chairman and CEO of the IDGP clearly believed that the quality of relationships and the extent of cooperative experience meant that the trial would result in positive change for the benefits of patients and GPs. We interpret this as a positive context for change in which the GP's representatives believed that there was a reasonable chance of good outcomes from the trial. One interviewee concluded:

Care Net provides a catalyst for change, it presents opportunities to do more and better things for patients beyond what the current community health services can achieve.

6.3.3 GP views on the trial interventions

The GP survey was designed to collect general views about some of the interventions of the trial and about the outcomes for active patients. The interventions follow the structure of trial interventions set out in our mid term report. One or two items referred to details of trial arrangements where the evaluators required information. The results of the questionnaire are presented thematically alongside views from the focus groups.

6.3.3.1 Formal Assessment of clients (Intervention 1)

The first intervention identified in our mid term report was the formal assessment of clients. Just over half of the survey respondents felt that this formal assessment led to better clinical decisions. One quarter felt that such assessments did not improve clinical decisions. The question of assessments was raised in the focus groups and resulted in a variety of responses:

G1 *We have not seen the assessment data and so are unable to comment. If we were sent the assessment data we probably would not use it...the community nurses do the assessment again, the assessment data is not passed on.*

G2 *GPs and care coordinators assess different things.*

G3 *Assessment does complement our care. Documentation is important but I don't get to see the assessment.*

G4 *The assessment did not really provide new information.. the assessment gave a social insight into the patient's background.*

These comments need to be understood in the light of a sophisticated and extensive assessment that was repeated regularly (Eagar and Woods, 1999).

We conclude that the GP's views of formal assessment were mixed. It could be argued that the assessments used were functional rather than medical and that GP's training and experience did not usually help them to use these forms of data.

6.3.3.2 **The use and role of care coordinators (Intervention 2)**

GPs were very positive in respect of care coordinators both in their value to the GP and practice and also in their contribution to improved patient outcomes. Three-quarters of GPs believed that the care coordinator had saved them time and only 9% reported that their practice had not benefited from the involvement of the care coordinator. It should be remembered that some GPs had as few as one patient enrolled in the trial. They thought that it was important to communicate regularly with their care coordinator.

A very high proportion (86%) of GPs agreed with the statement that the care coordinator proposes effective care plans and only 20% felt that the care coordinator did not improve patient outcomes.

In summary, the data points to a **positive view of the role of care coordinators** which is supported by the focus group findings.

***G2** Generally care coordinators are seen as very helpful, and where there is appropriate background training also present, like OT, then this is very helpful.*

The additional time that the care coordinators could use for trial participants was thought to be important:

***G2** The time factor is an important issue – talking with relatives, becoming more familiar with the patient's circumstances – this all brings a broader outlook on care and makes the generalist approach broader still.*

***G3** helping us to do what we don't have time to do.*

The care coordinators were thought to be good at making things happen in a variety of ways:

***G1** They do practical type things, most useful to patients, they ensure things get done.*

***G2** (Patients') compliance with treatments has improved.*

***G4** (They) provide things for the patient – as they go into the home to unearth problems.. care coordinators have the facilities, the finances, to get services.*

The ability to bring time and other resources to bear on problems was clearly important in the view of the GPs who attended the focus groups and responded to the survey.

As a consequence they were popular with GPs, and GPs reported that the care coordinators were popular with patients.

***G1** Its great, patients love the care coordinator.*

***G2** GPs get feedback from patients on their care coordinator, GPs' estimate of patient satisfaction is 70% positive. There are a few instances where the Care coordinator is not available.*

An example was given in the focus groups where the role of the care coordinator resembled a provider role:

***G3** The care coordinator is there 3 times a day. Without the care coordinator talking to the family and supporting the family he would have been in hospital for a month. Palliative care – the family and the son manage as long as (the care coordinator) is there.*

While there was one mention of the usefulness of a particular clinical background, the general tenor of the reports is that of a practical person with time and other relevant resources who could act promptly and save time for the GP.

6.3.3.3 The use of Care Plans (Intervention 3)

The care plan was designed to be a flexible instrument that permitted a course of action to achieve client goals. The significance of client's own personal goals played an important role in the public discussion of the trials. We have already seen that the GPs felt that the coordinators proposed effective care plans. They were less clear that these plans matched patient goals with 49% opting for the undecided category and 36% for the affirmative. Respondents agreed that Care Net plans were always implemented and only 2% disagreed.

GPs at the focus group voiced a series of opinions about the care plans ranging from complementary to less positive views:

G4 I have seen a number of care plans, I get one for every patient, I check the recommendations and then file.

G2 The care coordinators are too busy and care plans are not so useful, with most planning being verbal. I don't refer to them.

G1 The coordinator rings with a suggestion, the GP agrees and then comes the paper.

G4 The care plan is an OK tool.

The question of whether the care plan was useful, and the planned actions eventuated, generated some discussion. GPs also identified cases where the care coordinator took a course of action, and the GP was not entirely happy:

G1 I have disagreed with the coordinator when the care coordinator suggested physiotherapy for a patient with back pain, we had tried it before and it had failed.

The context suggests a disagreement that resulted in an agreed cause of action. In another case:

G3 Referring patients to paramedics – they do it on their own. I think the GP should have an input. eg I had a diabetic with no complications and they referred to a dietician. Patient didn't need dietician. Should have communicated with me first.

Some GPs thought that their care coordinator should discuss their plans in more detail before committing them to paper or taking action:

G4 The care coordinator should discuss with the GP in the original planning stages. The care coordinator should visit the surgery and talk about the plan i.e. not just send a piece of paper.

6.3.3.4 GP as case manager/GP role (Intervention 4)

The survey touched on the GP role with respect to changes to the role, the use of IT and attempts to change clinical practice or substitute one kind of treatment for another.

80% of respondents reported that they had recruited patients to the trial on the basis of their need for community services. There was no agreement about better sharing of information between GPs and hospital over active patients with about one third in each camp. Only a quarter felt that Care Net only did for my active patients what I already do. The focus groups attempted to address these issues through a number of questions.

GPs still saw themselves playing the central role in caring for these patients.

G3 *GPs are responsible for patient care in Care Net, care coordinators do the hard yakka.*

G2 *The GP is part of a team and care management can only be done through the GP.*

G1 *care coordinators are no threat to the GP, they are only doing the things I used to do.*

The evaluators interpret the last comment to mean that GPs felt that time constraints prevent them from playing a wider role in respect to their frail elderly patients.

This theme of time saving was taken up by another GP:

G2 *Care management takes time and it saves time, and patients are better off, even though the savings in time means GPs spend less time on each patient.*

There was also a theme addressed by a minority of GPs that their role was diminished due to the activities of the care coordinator.

G4 *Minimal role, just to select the patient as they get Care Net after the event. See patients less often which takes away my caring role (and finances).*

There was no evidence that GPs saw their role as the patient's GP diminished by the activities of the care coordinator. They maintained their responsibility and primacy in medical treatment that was supported by the additional resources brought by the care coordinator.

6.3.3.5 The use of IT (Intervention 5)

The Care Net trial was unique in its IT investment and this issue is dealt with in greater depth in the Report 4. However questions were also asked in the GP survey and in the focus groups which represent views in May 1999.

The questions examined the value of the network communication opportunities, the Medical Director software in each GP's office, and the value of the computer as a tool in the GPs clinical practice.

Survey respondents suggested that the e-mail system assisted about half of the GPs to communicate about their active patients but another half were undecided or reported no benefit. The focus groups suggest some practical system problems had been experienced:

G2 *We hoped the e-mail would be more useful than it is. e-mail not working in one instance, not even one way!*

G1 *The E-mail has too many hiccups, we are not connected yet.*

The E-mail is useful.

The E-mail crashed yesterday with 15 messages.

I have been 35 days without e-mail.

The Medical Director software was thought to be easy to use (84%) and two thirds thought that it saved GP time. It assisted with prescribing for control (75%) and active (77%) patients. Together with the Care Net software less than half of the respondents (44%) felt that it improved their

access to diagnostic test reports for their active clients. This picture was supported in the focus groups:

G1 *Medical Director has a lot of potential. The time factor is important, especially training oneself to use it in a clinical context. I use MD for script writing, path reports – both generating and receiving. It is fabulous for writing referral letters. They cannot take it (MD) away from us, it is the biggest plus.*

G2 *The major benefit has not yet happened. There is no hospital pathology on line and feedback to the hospital from the GP would be useful. We can still use the access available at the hospital.*

Of the GPs who responded, 63% felt that the computer was an essential tool in their clinical practice but 23% felt it was not.

Again from the focus groups:

The computer system is the best thing. It has taught the majority of us how to use the computer. A lot of us were illiterate.

The picture from survey and focus groups was that the self-contained Medical Director software on the GP's computer made a bigger impact on their patterns of practice than the communications opportunities which were regarded as inconsistent and unreliable.

6.3.3.7 Changes in clinical practice and substitution (Intervention 7)

The Care Net trial was expected to have an impact on clinical activity in a number of ways. It was intended to permit innovative approaches to care, to enable the development and implementation of best practice guidelines, to influence prescribing practices, and to change patterns of clinical practice.

Three-quarters (72%) of GPs felt that Care Net permitted innovative and novel approaches to the care of active patients and only 9% dissented. Only 19% of GPs felt that Care Net duplicated their activities.

The best practice guidelines developed by Care Net were thought likely to assist in the care of active patients by 51% while 12% took the opposite view. A significant 37% were undecided about the value of the guidelines.

The Medical Director database was thought to assist GP prescribing for active and control patients with three quarters of GPs choosing the positive option in both cases.

In response to questions about whether Care Net had influenced their overall practice of medicine, 57% felt that Care Net had influenced their overall practice of medicine for active patients and 31% disagreed. Asked in a different way, 42% agreed with the statement that they had not made overall changes to their practice of medicine since Care Net and 46% disagreed.

GPs who attended the focus groups were less positive on the whole:

G1 *There has been no substitution of services. When we wanted different treatment eg fast track surgery, it was not available.*

In relation to the innovative treatments there was little sign of positive views of substitution:

G1 *Dressing gowns, there was no GP input, we have little faith in this activity. There have been some Mickey Mouse treatments for the active group.*

Others were less critical and sounded a note of caution:

G1 I would like to look at it over some years.

There were one or two positive exceptions:

G3 Asthma treatment has changed dramatically since the guidelines. Care Net has augmented treatment to all patients.

The question of substitution of services is covered in more detail in Reports 2 & 3 but it is clear that GPs surveyed and questioned at the focus groups were not convinced that evidence based substitution had taken place.

6.3.3.8 Questions of Funding (Intervention 6)

Questions were asked about the efficiency of Care Net expenditures and the principle of pooling Commonwealth and State monies. While half (51%) of the GPs were undecided, 42% felt that Care Net saved the Government money. Only 18% felt that Care Net monies could be better spent but 47% were undecided.

On the principle of fund pooling, only 4% responded that it was inappropriate and 46% were undecided. 50% supported the principle of fund pooling.

In the focus groups there were some interesting indicators of the range of GP attitudes:

G1 We do not think about money.

G3 We haven't got any of the money.

G2 The funds pooling mechanism operates completely in the background and does not make an immediate impact on medical decisions.

G3 Now I don't think what the HIC will say about it. If I think the patient needs it I just go ahead and do it.

6.3.3.9 Benefits for patients (Primary Hypothesis)

Patients in the active group were thought to benefit in a number of ways. In response to questions about health and quality of life, 71% felt that Care Net had improved the quality of life for active patients and 77% thought that it had improved the health of active patients.

In response to questions about better access to services, 91% agreed that, since Care Net, active patients had better access to a range of community and ancillary services. Half of the GPs who responded felt that active patients were less likely to be hospitalised as their peers in similar circumstances, but 48% were undecided about the statement, "Overall, active patients do not seem to stay in hospital for shorter periods than their peers in similar circumstances." Half of the respondents felt that Care Net had delayed institutionalisation for some of their active clients, but 20% felt that this was not the case.

In general half (49%) of the GPs felt that it was too early to tell what impact Care Net would have on patient care and 46% felt that patients in the control group had benefited from the GP's participation in Care Net.

From the focus groups there were some positive comments about patient benefits:

G1 *The health status of active's has improved, they are getting services quicker.*

G2 *Outcomes are more in terms of quality of life – it hasn't necessarily saved lives, although theoretically it could.*

6.3.3.10 General views about Care Net (Intervention 8)

In response to general questions about Care Net, 84% stated that they would recommend involvement in Care Net to other doctors and 60% stated that it should be expanded to other patient groups, for instance, to all elderly people. An indication of GPs' views of the reliability of Care Net came in the response to question 18 where 80% agreed that "Care Net plans, worked out by myself and the care coordinator, have always been implemented."

The focus groups identified some very positive comments about Care Net:

G1 *They do a fabulous job, they are there to save you time.*

Some GPs indicated that they incurred additional cost through Care Net:

G1 *The GP is doing a lot of work for the patient but is not able to charge for that work since the patient is not present.*

G4 *There is no reward for phone calls about the patient.*

This situation has changed since the introduction in late 1999 of the new MBS items for assessments, case conferences, and care planning.

6.4 Discussion – Implications for hypotheses and mainstream services

The GP evaluation data address hypotheses 2 to 6 (see Appendix 2) which are those processes the GP was best able to observe.

6.4.1 Hypothesis 2: the extent of substitution of services within the pool

Three sorts of substitution were identified by GPs - the introduction of the Medical Director system, the adoption of clinical protocols for Asthma and Congestive Cardiac Failure, and the development of protocols within the trial such as the provision of bathrobes for clients with Congestive Cardiac Failure.

GPs thought that Medical Director provided them with better information on drugs and that it permitted better use of drugs and some economies to be made. It should be remembered that the trial effectively introduced a form of patient enrolment, and that in the early stages of the trial a community pharmacist was employed to undertake reviews of drugs in the patient's homes permitting the removal of excess or unwanted drugs. GPs believed that their prescribing had improved and there is some evidence that pharmacy costs were reduced. We cannot identify a concomitant improvement in patient health or well being from this change.

The adoption of clinical protocols was thought by some GPs to have improved the treatment of relevant patients although it is not possible to prove this from the trial data. Similar protocols are part of the continuing IDGP research program and not wholly attributable to the trial. It should be noted that the clients were not selected according to clear diagnostic categories and so a care plan based on a clinical protocol was likely to be the exception rather than the rule.

Substitutions such as the decision to provide bathrobes and bathroom scales to clients with heart conditions are discussed in Report Number 2. The evidence in this report suggests that GPs were somewhat sceptical about the idea and that they played little part in its implementation.

From our interviews, discussions and focus groups with GPs there is no evidence of clear evidence based substitutions being systematically applied such that they could be properly evaluated.

6.4.2 Hypothesis 3: the range of services in the trial and the size of the pool

It is very clear that active patients received a wider range of services than would have been the case if they had not received the services of a care coordinator. This was due to the level of resources available to the trial, the breadth of client assessment and to deliberate attempts to innovate in the range of services provided for clients. This range of services was not available for a GP to prescribe under normal circumstances and the presence of the funds pool meant that patients received services immediately rather than referral to a waiting list or after assessment to determine clinical or social priority.

Evidence on the range and value of services provided to participants in the active group is provided in Report Number 5.

6.4.3 Hypothesis 4: characteristics of clients

GPs reported that clients were recruited to the trial on the basis of the GP's assessment of their need for community services. Further information on the health and functional status of trial participants can be found in Report Number 5.

6.4.4 Hypothesis 5: quality of protocols

A strict interpretation of this hypothesis would point to the absence of clear clinical and service delivery protocols at the beginning of the trial and a failure to implement the protocols that were developed or "adopted" during the trial. If we take this hypothesis to refer to care plans, we find that they were generally well regarded, although GPs reported different degrees of involvement in their preparation. Some GPs felt that they were presented as a *fait accompli*, while others reviewed proposed plans and made suggestions or exercised vetos. A significant number of GPs read the care plans but appear to have had a limited role in their implementation or review. This may not be surprising given the fact that there were few direct incentives to take an active role in care planning.

6.4.5 Hypothesis 6: characteristics of care coordination function

GPs were very positive about the role and performance of the care coordinators. The GPs were satisfied with the quality of the plans and the reliability of the care coordinators in implementing those plans. They felt that it was important to keep in touch with the care coordinator on a regular basis and that the patients were pleased with their care coordinators.

6.4.6 Hypothesis 1: the primary hypothesis

A number of points can be made with respect to the primary hypothesis:

A significant proportion of GPs were cautious about coming to any conclusions about the trial without access to evidence about its impact.

GPs felt that their active patients benefited from participation in the trial in terms of the enhanced range of services they received and its impact on their quality of life.

A small proportion felt that they could attribute improvements in patient health to the trial.

Some GPs felt that this improvement was achieved at a saving to government although a significant proportion felt that this could not be proved or that they did not have sufficient information to come to a conclusion.

6.5 Conclusions

It is clear from our research that a majority of the GPs who took part in the trial believed that it was worthwhile and that the opportunities given to the active patients should be extended more widely across the population of frail elderly persons.

While evidence of the value of formal client assessment is varied, many GPs welcomed the broader perspective provided by a multi-functional assessment conducted in the home and a care coordinator in touch with the patient able to bring resources to meet developing needs. The introduction of the new MBS items for care planning provide an opportunity to extend the practice of assessment but they do not provide the benefit of active care coordination or the resources to implement plans that were available in the trial.

Activities within the trial have reinforced some wider objectives of the IDGP such as the development of shared treatment protocols and the introduction of IT into general practice. These developments will require continued support but can be seen as trends that started before the trial and will continue into the future. The trial provided a significant boost for these activities.

It was not possible to provide GPs with access to an integrated communication/information service during the trial that would permit electronic communication between each of the agents involved in the care process. Useful steps were made in that direction and many GPs seek improved access to information that is not currently shared between different health and community care organisations.

As independent practitioners GPs are isolated from mainstream services, and yet an important part of those services, they have no direct access to clinical or community support staff and have welcomed the services of a care coordinator in the care of active patients. GPs would welcome better access to such skills and many believe that their patients would benefit.

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.

Appendix 2: Hypotheses

The National Evaluation Reference Group established a primary hypothesis and a series of secondary hypotheses that represented the likely influences on whether that statement could be supported. The Care Net trial adapted that framework into a local set of hypotheses. The national and local hypotheses that are relevant to this report are listed below.

NH1 The primary hypotheses:

Local Illawarra adaptation

<p>National Hypothesis 1:</p> <p>“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”.</p>	<p>Care Net Hypothesis 1:</p> <p>“if improved individual client health and well-being can be achieved within existing resources where an individual’s multiple service needs are met through an individual care coordinator, a single care plan and a single pool of funds”.</p>
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The extent to which this is achieved, will be influenced by:

NH2 The extent of substitution of services within the pool

<p>National Hypothesis 2: “The extent of substitution between services within a trial pool”</p>	<p>Care Net Hypothesis 4: “If improved health outcomes can be achieved with service substitution”</p>
	<p>Care Net Hypothesis 6: “If injury prevention can be achieved with service substitution”</p>
	<p>Care Net Hypothesis 9: “If care coordination and the purchasing of services from a central fund can reduce expected bed days in hospital. This will apply to both lengths of stay and re-admissions”.</p>

NH4 The characteristics of clients selected

<p>National Hypothesis 4: “The characteristics of the clients to whom services are provided”.</p>	<p>No corresponding local adaptation</p>
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NH6 The characteristics of the care coordination function

<p>National Hypothesis 6: “The characteristics of the care coordination function”</p>	<p>Care Net Hypothesis 2: “If the allocation of care coordinators to general practice surgeries improves communication between GPs and other services available to provide necessary services for their patients”.</p>
	<p>Care Net Hypothesis 3: “If the care coordinator in a role of patient/client advocate increase the patient’s involvement in care planning processes”.</p>

NH7 Particular Types of Admin Arrangements

National Hypothesis 7: “The characteristics of trial administrative arrangements”	Care Net Hypothesis 7: “If an information system communication network containing the care plan and relevant clinical information can improve the cost-effectiveness of care coordination processes and outcomes”
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NH8 Consumer Involvement

National Hypothesis 8: “The extent to which health consumers are partners in the planning of the coordinated care trial, the development of care plans and empowered through the coordination process”.	Care Net Hypothesis 5: “If consumer involvement in project management and policy development can improve the process and outcomes associated with care coordination”.
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NH9 Wider System

National Hypothesis 9: “That the primary results can be achieved without detriment to other key areas of government policy, particularly in regard to equity of access and privacy, including any impact on clients outside the trial”.	No corresponding local adaptation
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