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ISBN 0 86418 647 9

April 2000

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
Report Number 7	The Care Net Trial – Impact on Health and Community Care Providers (this report)
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

Suggested citation

Eagar K et al (2000) *The Care Net Trial – Impact on Health and Community Care Providers. Report 7 of the Final Evaluation of the Care Net Illawarra Coordinated Care Trial.* Centre for Health Service Development, University of Wollongong. ISBN Number 0 86418 647 9

Report Number 7

The Care Net trial – Impact on Health and Community Providers

7.1	<i>Introduction</i>	1
7.2	<i>Methods and Types of Data</i>	1
7.3	<i>Findings</i>	2
7.3.1	Expenditure on Services for Clients	2
7.3.2	Provider Views on Care Net Interventions	3
7.3.2.1	The formal assessment of clients (intervention 1).....	3
7.3.2.2	The use of care coordinators (intervention 2).....	3
7.2.3.3	The use of care plans (intervention 3).....	4
7.2.3.4	The General Practitioner as the case manager (intervention 4)	4
7.2.3.5	The introduction and use of information technology (intervention 5)	4
7.2.3.6	Care Net as an organisation (intervention 8).....	5
7.2.3.7	Client benefits (the primary hypothesis)	6
7.3.3	Provider Costs	7
7.4	<i>Discussion on Implications for Mainstream Services</i>	8
7.5	<i>Conclusion</i>	8
	<i>Appendix 1: An overview of the Illawarra Coordinated Care Trial</i>	9
	<i>References</i>	10

List of Tables

Table 1	Community Provider Types	1
Table 2	Fund Pool Performance November 1997 to December 1999.....	2

7.1 Introduction

Care Net was designed to address the primary hypothesis by assessing clients, creating care plans, and securing services from a range of providers. The purpose was to maximise health and wellbeing without increasing costs.

A decision was made early in the trial that clients should not be denied necessary services in a care plan only because the client was unable or unwilling to pay for those services. Where clients continued to receive a service which they had received before the trial then the same payment arrangements continued. Where a new service was received, that service was provided free of charge. Donations from clients were received by the trial and added to the funds pool.

Organisations that provided services can be placed in two broad categories: those that contributed to the funds pool and those that did not. There was a third category of organisation, namely Home Care, which negotiated a 100% buy-back arrangement such that Care Net was obliged to purchase services equal to the sum invested in the pool although those services might be of a different composition. It follows that some organisations (mainly public sector providers) risked making a contribution to the funds pool and finding that Care Net bought services elsewhere thereby resulting in a net outflow of funds for the duration of the trial. Other organisations such as Home Care bore no financial risk but risked that Care Net would purchase a different basket of services than those previously provided by the agency. Private sector providers made no contribution to the pool but were the beneficiaries when public funds were used to buy private sector services.

A simple classification of providers is made according to three factors: scale; specialist or broad range orientation; and location in the public sector. This framework is described in Table 1 below. The views of providers are obviously influenced to a greater or lesser extent by their structural and other interests and this broad classification is used to distinguish providers where this information is helpful in interpreting their views.

Table 1 Community Provider Types

	Small	Medium	Specialist	Large
Public	HACC (some)	HACC (some)	Rehabilitation and Aged Care	Community Health and Home Care
Private	Independent Therapists		Private Nursing Service	Retirement Services Agency

7.2 Methods and Types of Data

Data for this current report come from 3 sources: evidence from Care Net financial systems on the patterns of spending of the funds pool with respect to providers; a survey of all providers conducted in September 1999; and various interviews undertaken with managers of provider organisations. Questionnaire respondents were individuals within agencies who provided services to Care Net clients or managed those services.

Their experience illuminates each of the secondary hypotheses of the trial and so we discuss the implications of provider views for each hypothesis. The data are organised around the 8 interventions identified in our mid-term evaluation report (Eagar, Owen et al. 1998), and described in Report Number 2.

The questionnaire was designed to be easy to complete yet to provide opportunities for extended responses to open questions. Questions were randomly presented in positive and negative form to prevent bias due to leading questions. In an attempt to distinguish between different types of providers the following groupings are identified: independent private sector therapists (12) ; HACC Service Providers (9) ; Public Hospital Staff (10); Community Health (11) Specialist Aged Care Services(11); Large Private Sector Providers (2).

7.3 Findings

7.3.1 Expenditure on Services for Clients

Table 2 Fund Pool Performance November 1997 to December 1999

Income source	income	expenditure	difference
MBS	\$3,066,150	\$2,711,238	\$354,913
PBS	\$2,704,780	\$1,764,057	\$940,723
IAHS Outpatient	\$687,700	\$339,577	\$348,123
IAHS Inpatient	\$2,991,452	\$3,201,257	-\$209,805
Home Care	\$770,338	\$940,061	-\$169,723
HACC	\$0	\$278,218	-\$278,218
Private for profit	\$0	\$814,187	-\$814,187
Private non profit	\$0	\$166,068	-\$166,068
Care Coordination	\$0	\$1,602,550	-\$1,602,550
Contribution to administration costs	\$0	\$343,799	-\$343,799
Total	\$11,840,843	\$13,279,576	-\$1,438,733

The initial conception of the trial was that the partners would pool funds and that Care Net would purchase services using those funds from the contributing partners and others as required. It can be seen from the income column that the contributors to the pool included the Commonwealth through PBS and MBS, the Illawarra Area Health Service (IAHS) under inpatient and outpatient categories, the Department of Veterans Affairs (DVA), and Home Care. The responsibility for MBS and PBS expenditure was to a large extent outside the power of Care Net since these expenditures were committed by GPs and medical specialists. Care Net deliberately sought to reduce the number of inpatient days for the active participants. The IAHS outpatient category refers to the Community Health Service, Aged Care and Rehabilitation Services, and the IAHS Accident and Emergency Service. Home Care received its 100% buy back.

A number of types of provider organisation made no contribution to the pool but received monies from the pool to provide services to active trial participants. These include Home and Community Care (HACC) agencies (\$284,667), private “for profit” organisations providing community health and welfare services (\$813,224), and private “non profit” organisations (\$167,023). We might describe these organisations as net beneficiaries of Care Net pooled funds.

There was a net transfer of funds from the public to the private sector of almost \$1million. As Care Net had limited influence over the expenditures committed by doctors this is a significant component of the trial’s discretionary expenditure.

It is important to be clear about the structural and funding interests of particular providers when interpreting their views in the findings which follow.

7.3.2 Provider views on Care Net interventions

7.3.2.1 The formal assessment of clients (intervention 1)

It was thought that the formal assessment of clients would provide new information, save time in unnecessary reassessment, and be useful for a wide range of clients. While 42% of providers agreed that “the Care Net assessment would be useful for all clients” 35% were undecided. The strongest supporters were the independent therapists.

In response to the statement “the Care Net assessment does not save any of my time” providers were almost equally split. The majority of responses from community health and the specialist health care providers supported this view.

A third statement “I do not have enough information from the assessment of a Care Net client” was supported by most of the specialist providers but only a third of the independent therapists. 55% of providers felt that they had insufficient information. This could be interpreted to mean that the information was insufficient or that care coordinators did not pass it on to the provider.

An independent therapist wrote:

I feel that some of the care coordinators are not able to assess effectively at times due to their different career backgrounds.

7.3.2.2 The use of care coordinators (intervention 2)

Two questions relate to the clients who were referred by Care Net and the services ordered by care coordinators. Only 17% agreed that “Care Net refers clients with inappropriate needs to my service”. Those who agreed or strongly agreed were drawn disproportionately from specialist aged care services, HACC services and community health.

50% of providers agreed that “sometimes care coordinators order services which seem inappropriate for the client”. Those who agreed were disproportionately drawn from specialist aged care services and community health, although some independent therapists also shared this view.

One independent therapist wrote:

Inappropriate referrals for therapy – I don't feel this will – a) keep people out of hospital, b) keep them in their homes longer or c) give long term solutions to their musculo-skeletal/mobility problems.

This comment must also be seen in the context of professional and service rivalry, representing the views of different professional groups and generalist and specialist orientations.

43% of respondents agreed that “it is hard to understand how care coordinators select service providers”. The majority of community health providers held this view.

These findings can be interpreted in a number of ways. The decision to choose care coordinators who were not aged care specialists may have caused some differences in approaches to those normally adopted by specialist aged care staff. An independent therapist identified the need for coordinators to be allied health professionals by stating:

I don't feel that coordinators with nursing backgrounds are aware of allied health professions and what they have to offer.

One specialist provider wrote that:

I have found coordinators to have no understanding of assessment skills and the expectations of ... clients. They have no knowledge of the ... services or after hours services for those clients.

Mainstream public providers were likely to have compared Care Net referrals with their normal case loads and found differences of severity, for instance where Care Net objectives implied “preventive referrals” and mainstream services were used to clients with more severe impairments.

It could be also argued that the “innovative approach” adopted by Care Net was such that the reasons for referrals were not immediately clear to other providers.

There was strong support for the view that providers should communicate regularly with care coordinators and 40% agreed that “care coordinators need more information from service providers about the client’s progress”.

Almost all respondents felt that it was easy to communicate with care coordinators about client needs. There seems to have been a concern with some of the decisions and actions of care coordinators but there was no sense that they were aloof, difficult to communicate with, or difficult in any other way.

7.2.3.3 The use of care plans (intervention 3)

The providers who responded to the survey were cautious about the value of care plans. 33% agreed that “the care plan usually outlines the best mix of services for clients” but 43% were undecided. A third of the respondents agreed that “care plans do not always meet the clients’ needs” and another third were undecided. Half of the independent, private sector therapists felt that care plans did meet client needs.

It is not clear to the evaluators whether providers saw themselves as partners in implementing the care plan or as contractors providing services purchased by Care Net on behalf of the client.

7.2.3.4 The General Practitioner as the case manager (intervention 4)

The trial structure did not imply a direct relationship between health and community service providers and GPs and so only one question related to this issue. Only 14% of the providers agreed that “there is better communication with GPs since Care Net”. 39% disagreed while the rest were undecided.

There was no evidence of improved relationships between GPs and health and community service providers but this would be expected given that few mechanisms were actually implemented which would have caused such an improvement. It might be argued that the intervening role of the care coordinator reduced the need for GPs to contact agencies directly and that those agencies could contact the coordinator if the client’s condition changed, thus keeping GPs out of the loop in the first instance.

7.2.3.5 The introduction and use of information technology (intervention 5)

While the trial intended to extend its electronic communication system to community providers, this was never achieved and communications usually took place by phone and fax. Half of the respondents agreed that “communication between Care Net and my services could be improved with better information technology”. This view was strongly endorsed by specialist aged care and community health staff, but half of the independent therapists disagreed. It might be expected that

these small private businesses would have a limited investment in, and expectation of, IT when compared with the larger public providers.

Two-thirds of respondents believed that “..an e-mail system would be useful for referrals” but most of the independent therapists were not convinced.

7.2.3.6 Care Net as an organisation (intervention 8)

A number of the provider organisations found that their expectations of Care Net were not fulfilled. Almost half of the respondents agreed with the statement that “I expected that I would receive more referrals from Care Net”. This was particularly so for community health which was a “net contributor” to the trial. The view was also strongly supported by HACC service respondents.

In response to the statement “Care Net favours private service providers”, 53% chose the undecided category and there were no consistent patterns among respondents.

A group of questions focussed on the impact of Care Net on the provider organisations themselves. Only a third of the respondents felt that “my service is more flexible and responsive since Care Net”. This included all of the community health respondents and most of the specialist aged care providers. Three-quarters of respondents agreed with the statement “Care Net has not changed the way I deliver services”. This may point to the strength of the conservative dynamic in mainstream provider organisations or to the fact that Care Net clients were a very small proportion of the workload for all providers and therefore it would be surprising if significant change was occasioned as a result of their activities.

A singular exception to this view can be seen in the following case study.

Kiama Council Nursing Service was successful in obtaining a number of contracts to provide services for Care Net clients. An extended interview with the manager identified a very positive view of the organisation’s association with Care Net.

The trial has been an impetus for change to the way we work – allowing both a larger and more flexible role as a nursing service. This meant thinking “outside the box” and being clear about our role as a service provider.

The nursing service changed its style as a response to its relationship with Care Net.

We now operate more as business unit that can prove its performance, rather than a community service that tells clients what they can offer and when. We also cover the 3 LGAs of Kiama, Shellharbour and Wollongong

It had been able to increase the quality and complexity of its activities and as a consequence was able to tender for new work and additional contracts with other purchasers. In response to the question, “has service coordination improved?” the manager responded,

It has for our services. We are not a full-scale emergency service, but we are on-call 24 hours a day, and have the capacity to provide live-in services and overnight attendances. This has been a step-up from what was previously able to be offered, and as a result there is some pressure to go the next step to offering a full after hours service and the ability to be an emergency service.

Part of this success story might be attributed to the staffing structure of the service. It relies significantly on casual staff and has staff with a broad range of qualifications and skills.

The provider role in response to a number of brokerage services has changed in number of ways: requests for services can be very specific about the time of day a service is required; we have more staff on the ground; there are 45 casual staff that include RNs on a NSW Nurses Association award, plus AINs, ENs, PCAs, all on a Council-based award; staff are covered for insurances, travel time, training and are offered a good hourly rate; and we have better staff coordination through improved rosters and more attention to training and training needs.

This degree of flexibility proved much harder for the IAHS community health service since this flexible staffing structure was not possible within its industrial award arrangements.

The manager commented on the importance of the trial in establishing the importance of a single case manager.

Individual's care coordination has improved, and it is correct to say there have been changes to the local system, which wasn't flexible enough. The COPs model has worked well up to a point, but has not been as good as the trial because they were not able to be accepted as the only case manager. For example a person might be involved with four agencies and two of them would consider themselves as the case manager. The trial put the role clearly in one place and it was seen that way by the client.

In our data this is an interesting and exceptional example of change associated with the trial which is not reflected in the views of other providers. The majority of specialist aged care providers and community health respondents supported the statement that "Care Net only does what I was already doing". This might be interpreted to mean that care coordination and planning is not unknown within mainstream services and that staff from different agencies are able to work together in such a way that they do not duplicate each other's activities. Alternatively, the providers might be seen to be protecting their territory.

7.2.3.7 Client benefits (the primary hypothesis)

Among the local hypotheses for the trial was the view that active clients would require less frequent hospitalisation and their lengths of stay would be shorter than their peers in the control group. Only a quarter of respondents agreed that "overall, Care Net clients stay in hospital for shorter periods than their peers in similar circumstances". A similar proportion agreed that "overall, Care Net clients are not as likely to be hospitalised as their peers in similar circumstances". They believed that it was appropriate for Care Net clients to be cared for in the community as evidenced by the finding that only a quarter supported the statement "Care Net supports people at home when it is more appropriate that they are placed in an institution or hospital".

Not surprisingly, two-thirds of respondents believed that "Care Net clients had better access to a range of community and ancillary services" although a third withheld their judgement. One specialist aged care provider identified a positive aspect of the trial:

There has been a wide variety of services that the active clients can readily access.

But the negative side was,

Inequity of access for services for those who are not on the "active list". It is unfair for the majority of the elderly who have equal needs and equal rights to access...

A community health provider commented:

Inappropriate money being spent on a service that wasn't needed. Too much for some people – little or nothing for others.

A number of private sector independent therapists felt that the trial enabled public clients to have access to new therapies which were not available in mainstream services:

People who would not normally access my treatment have been seen.

I personally encourage the integration of natural therapies into the collective health care system as the norm rather than the exception. The trial has taken a positive step in this direction.

Care Net has provided access to my services for the elderly who may otherwise not have known of its beneficial effects to overall wellbeing, mind, body spirit. For some it was financially very difficult without Care Net, in times of great need.

It might be argued that some degree of inequity was essential in a trial that aimed to test interventions using a control group method. Perhaps this inequity would have been less apparent if the trial participants had resembled more closely the population receiving services from mainstream agencies. A specialist provider commented that the trial

“should be targeting clients who have high needs. They are the ones who need care coordination”.

Community health staff pointed to the duplication of existing activity and a lack of awareness of existing community services:

Duplication of services which are already in place. Client confusion. Care Net has made clients dependent on the service rather than independent within the community.

A quarter of the providers felt that it was too early to assess the impact of Care Net on client care but two-thirds thought that it had made a real difference to the quality of life of active clients in the trial.

7.3.3 Provider costs

A continuing concern throughout the trial was the different costs charged by providers and the reasons for such costs. Discussions at the Management Committee concerned whether low price providers provided low quality services or simply had more efficient practices and lower overheads to meet. As the Care Net Management Committee included representatives from community care agencies, they were seen by private providers as their ‘competitors’. After consideration at The Management Committee, it was agreed that specific contracts would not be reviewed by the Management Committee to assess the reasons for difference in price. Instead the Management Committee requested to the local evaluators to investigate the reasons for price variation. For instance, patient transport services varied in price from \$9.25 per hour to \$31.50. Domestic assistance varied from \$14 per hour to \$23.50, and personal care varied from \$19.25 per hour to \$30.50. There were bigger variations at night and at weekends.

There is no doubt that agencies varied in their employment practices, staff qualifications, status of employees (permanent or casual), investment in training and quality assurance activities, the level of investment in capital, and the costs of their administrative or bureaucratic overheads. It also appears that some agencies charged Care Net at marginal prices while others charged at full average prices. As contributors to the pool, both IAHS community and the HCS were required to contribute at full average prices and thus had no choice but to charge on the same basis. This was not the case for non-contributing providers who could make commercial decisions about their pricing policy. The playing field was thus not level, making “value for money” assessment difficult. It is an important lesson for any future trial.

A further problem was that those agencies who were net contributors to the pool suffered a budget reduction which may have marginally reduced their flexibility in responding to requests from Care Net to provide services.

7.4 Discussion on Implications for Mainstream Services

- Care Net did not provide the impetus for a significant change in the practices of mainstream service providers with the exception of Kiama Council. For most providers their Care Net clients represented a small proportion of their workload and such a proportion was not likely to significantly change their core work practices.
- Care Net clients were able to access a wider range of services more quickly than would have been the case if they had been served on the basis of the normal rules of clinical and social priority. The speed of response by provider agencies can be attributed to the funds pool and to the availability of excess private sector supply of health and community services that allowed almost instant response in some cases.
- Specialist aged care staff were more cautious in their appraisal of Care Net than the independent private sector agencies and staff. They were more likely to undertake further assessments and to be concerned about the skills and experience of care coordinators.

7.5 Conclusion

The overall impact on health and community service providers was small and consistent with the overall numbers in the trial. Where there was a strong synergy between Care Net's goals and provider interests and responsiveness (as in the Kiama Council example), significant change, albeit on a small scale, could occur.

The main determinants of the views of providers can be attributed to their position in the Care Net organisation's service system as created by its organisational model, superordinate goals and the purchase choices made by care coordinators.

Particular care needs to be taken in contracting for services to ensure that the reasons for price differences are understood and justified. Contracts for such services should permit an appropriate value for money audit to be undertaken.

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.

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