

The devil is in the detail: lessons for multi-disciplinary care teams from a local evaluation of coordinated care

ELIZABETH SHANNON

ELIZABETH SHANNON IS PROGRAM MANAGER, HEALTH QUALITY AND ACCESS, IN THE COMMONWEALTH DEPARTMENT OF HEALTH AND AGED CARE.

Abstract

The national evaluation report on the first round of Coordinated Care Trials focused on relationships of care coordination from two main perspectives: that of the General Practitioner (GP) as care coordinator; and the GP perception of non-GP care coordinators. As the majority of the Tasmanian care coordinators came from a nursing background and dealt with a wide range of health care providers, in addition to GPs, a more complex local analysis was required.

It was found that relations between care coordinators and other health providers varied considerably by profession and new strategies were required to ameliorate the resulting conflict.

This aspect of the local evaluation provides useful lessons for analysing and avoiding some sources of conflict in the formation and functioning of multi-disciplinary health care teams.

The role of the care coordinator

The Tasmanian Coordinated Care Trial, Careworks, was one of a series of trials across Australia testing a particular approach to the coordination of care. The trials were to develop innovative service delivery and funding arrangements in order to test the extent to which they contributed to improving client health and well-being outcomes; the development of services that would be more responsive to client need; and more efficient ways of funding and delivering services.

Care coordinators were employed to carry out client assessment; create, monitor, and review the client care plan; and to hold client case conferences with other health professionals about that client's care. Each trial would then compare health and well-being outcomes between an Intervention group who would receive care coordination, and a Control group, who would continue to receive the care available in the usual system (National Evaluation Team 2001).

The Tasmanian trial commenced with a 'tracking and development' stage between September 1996 and October 1997. This was followed by the 'live' stage, to December 1999. The final 'wind-down' stage was completed at the end of May 2000.

The Tasmanian trial had a model of care coordination that required an independent, dedicated care coordinator. Care coordinators were expected to hold some form of health qualification, but not be GPs; to be free of clinical

load; to form a multi-disciplinary team; and to be budget holders for their clients. Care coordinators worked with a cluster of geographically based GPs, ensuring GPs would interact with only one coordinator; and GPs were entirely responsible for the medical component of the care plan. Care coordinators were on a rostered, on-call arrangement available 24 hours per day, seven days per week, with an average caseload for each full-time coordinator of 50 clients (Dawson et al. 1999).

Most Tasmanian care coordinators came from community nursing, as this profession seemed to have a 'natural fit' with the types of skills desirable for the care coordination role. Of the sixteen care coordinators, only three came from non-nursing backgrounds: two occupational therapists and one ambulance officer (paramedic). The health professionals employed to fill these positions were, therefore, fairly typical of the non-GP coordinators described in the national evaluation report: having a community nursing background, some working part time, and most lacking experience with client care budgeting.

The national evaluation of the first round coordinated care trials focused on the relationships of care coordination largely from the perspective of the General Practitioner (GP) by focusing on the GP as the care coordinator, or on GP perceptions of non-GP coordinators. However, the local evaluation of non-GP care coordination needed to take into consideration their relationships with other health professionals, as well as with GPs. The local evaluation suggests that, without examining the interpersonal and organisational interactions involved, there is a danger that the real barriers to multi-disciplinary care will be overlooked (Shannon et al. 2000).

For example, the national evaluators reported 'role confusion and conflict' as parts of the national 'non-GP' care coordinator experience (National Evaluation Team 2001). Expecting that a certain amount of 'role confusion' would be associated with any new position, the Tasmanian trial had a stated expectation that care coordinators would participate in developing the care coordinator role as the trial progressed. Within a system of peer review, and with guidance from a Senior Advisor within the trial, this process was generally successful. It also resulted in two somewhat different approaches to the role.

The 'health provider' approach to care coordination saw this work as an addition to the usual tasks carried out by a community nurse. This approach to client assessment emphasised the use of their own professional judgement as a clinician; pre-disposed them to a more 'medical' approach to health and well-being, and led to an expressed preference for the use of clinical assessment tools. In contrast, the 'health administrator' approach to assessment was characterised by an emphasis on professional referral and compliance with the advice received from other health professionals.

The health provider approach to care planning selected care options and informed clients of best choices, whereas the health administrator approach offered information and alternatives in collaboration with client. The health provider/care coordinator implemented the care plan by acting as an advocate for their client - contacting service providers on their behalf, making appointments, and even providing some services themselves (eg counseling, transport, blood pressure check). The health administrator/care coordinator acted more as a 'health system navigator', providing service information only, and no actual health services.

Care plan monitoring and review by the health provider/care coordinator emphasised regular home visits based on clinical monitoring and case management of the client. There was a marked preference for a lower caseload for these coordinators. The health administrator approach placed an emphasis on phone contact with client and home visits at intervals required by the structured review schedule. These care coordinators could deal with a higher caseload.

These tendencies were not hard and fast dichotomies but were affected by a range of factors that varied over time. They included the following.

- The complexity of the clients in any one coordinator's caseload. A caseload of predominantly low-need clients made the health administrator approach more appropriate.
- The number of GPs with whom a care coordinator was working. The greater the number of GPs, the less face-to-face time available to the care coordinator and less likely a health provider approach would be taken.
- The geographic area to be covered. Travel time associated with covering rural areas reduces the amount of time available for contact and the likelihood of "just popping out" to see a client, making a health administrator approach more likely.

- The current status of a client. More intense contact will be required at particular times, during transition from the acute sector to the community, during significant decision points.
- The type of other health professionals the coordinator worked most closely with. Each time a care coordinator interacted with other health and community care providers, their reactions and responses to the care coordinator's behaviour reinforced or questioned that care coordinator's approach.

The 'role conflict' noted by the national evaluators emerged most often through this interaction with other health professionals. Care coordinators interacted with providers from a broad range of professional backgrounds, the most important being GPs, community nurses, and allied health providers. These groups had an equally broad range of expectations of the care coordinator role. Most significantly, they varied markedly in their degree of resistance or assistance to creating a team approach to care provision.

The local evaluation team needed an explanatory framework that could cope with these multiple relationships. Sabatier, Hunter and McLaughlin (1987) provided one that suggests the amount of conflict between stakeholders depended on the following:

- the degree to which the stakeholder group is experiencing a generalised sense of threat from other sources (ie, level of conflict in the system as a whole);
- the degree to which the stakeholders compete for the same specific professional activities, client group, etc;
- the distance from the 'policy core', impacting on effective communication with the stakeholder group; and
- the distance between the stakeholders' beliefs and those of their apparent opponents.

The greater the number of the above conditions that were fulfilled the more likely it was that conflict would occur. When most or all the conditions are fulfilled a 'devil shift' in perception occurs, creating a sense of distrust of the motives and behaviour of the other and, at the same time believing the other to have more influence on the outcomes of events than they do themselves. This typology was very useful in providing an explanation for the diverse responses of the major stakeholders in the provision of coordinated care.

The GP perspective

The local evaluation team used several methods to gauge the GP experience of coordinated care. They included a postal survey of all GPs in the southern Tasmania area in 1998; a follow-up postal survey of Intervention group GPs in 1999; face-to-face interviews with selected Intervention group GPs in 1999; and on-going contact with the Careworks GP Liaison Officer and Southern Tasmanian Division of General Practice (STDGP) representative on the Careworks Board of Management.

Congruent with the national evaluation report, overall GP approval of the trial in southern Tasmania was very high, with most Intervention group GPs finding it useful to have a care coordinator to work with in meeting their patients' needs. Early concerns about paperwork, remuneration and time management associated with coordinated care lessened over the course of the trial, and most Intervention group GP respondents believed that their patients had benefited from the experience.

The main concerns reported by Intervention group GPs related to a perception that 'the government' was interfering in GP practice; that unnecessary bureaucratic processes would add to their existing workloads; and that the care coordinator would interfere in the relationship between the GP and their patient. It is within this context that care coordination was implemented and, while these concerns were generally allayed over time, they were important to the way in which relationships with GPs were constructed.

Careworks went to considerable lengths to accommodate the central positioning of GPs in the health care system. Steps included ensuring that each GP would work with only one care coordinator; that clients could only participate in the trial if their GP was also involved; and appointing a GP Liaison Officer to the trial, partly funded by Careworks and partly by the STDGP. Any possible conflict between care coordinators and GPs was mediated by these structural conditions.

Professionally, GPs were not experiencing a strong 'sense of threat' from other sources during the time of the trial. If anything, the position of the GP became even more central to primary health care at this time through

the introduction of new Medical Benefits Schedule payments for GPs to undertake health assessments, care planning and case conferencing. In this policy environment, care coordinators were not likely to be perceived as a threat to the position of GPs.

This strong professional identity made interference in the doctor/patient relationship a sensitive issue. There were several instances where strategies instigated by trial management were perceived as 'crossing the line' in this matter. One example was when the trial wrote to participating GPs to remind them of the need to offer influenza vaccinations to their elderly clients before the winter season. This was interpreted by one GP as questioning his practice and the general impression trial management received from GP representatives was that this sort of initiative could jeopardise overall GP support for the trial. As a result, similar reminder notices were not sent out in the second year of the trial.

Communication, or distance from the policy core, was also mediated strongly by the professional position of the GP. Locally, the STDGP acted as a conduit for information while nationally, trade journals such as *Australian Doctor* kept GPs informed as to the broader policy context.

The Tasmanian GP experience reflected the national evaluators' findings in that there was a positive association between GP approval of care coordination with the number of patients the GP had in the trial, and the frequency of their contact with the care coordinator. Conversely, GP satisfaction had a negative association with the number of coordinators a GP worked with, and the number of GPs assigned to the care coordinator. (Although each GP was initially assigned one coordinator, and attempts to minimise disruption to this arrangements were made, the process of trial 'wind down' meant that there was some staff turnover.)

It was notable, however, that GP satisfaction with care coordination was also affected by the personal approach taken by their own particular care coordinator. Comparing subsequent survey results, those GPs whose care coordinators demonstrated a health provider approach were more likely than most to consistently say that care coordination did not take up an unacceptable amount time for the benefits received, and that it was useful having a care coordinator to work with in meeting their patients' needs. Those GPs whose care coordinators demonstrated a health administrator approach started with a largely 'neutral' stance on these issues to feel, over time, that coordinated care did generate an unacceptable amount of paperwork, did take up an unacceptable amount of their time relative to the benefits received, and also had a significant impact upon the workload of practice staff.

During follow-up interviews, both subgroups registered similar, positive responses when questioned about their relationship with their particular care coordinator, registering high levels of satisfaction with the adequacy of their communication, actions on their information, quality of their work, actions upon the GPs' information, and agreement with them about care. This suggests that GPs found the 'beliefs' of the health provider/care coordinators closer to their own approach, but that any tensions which arose from a contrasting approach were perceived to be associated with the management of the trial, rather than the actions of the individual coordinator.

In summary, the trial aimed to avoid conflict with the participating GPs and largely succeeded. While enjoying a high overall level of support from GPs, a number of specific initiatives met opposition. That a 'devil shift' did not occur is evidenced by the relatively positive assessment of the motives and behaviour of individual care coordinators while believing trial management to be more responsible for those aspects of the trial GPs found disagreeable.

Community Nurses' experiences

Community Nurses were one of the groups of non-GP service providers surveyed by the local evaluation team in 1998. There was also a follow-up postal survey of Intervention group service providers in 1999. Face-to-face individual and group interviews were held with selected Intervention group service providers in 1999; and there was on-going contact with the Tasmanian Department of Health and Human Services (DHHS) Senior Nursing Advisor and Community Nurse representatives on the Careworks Board of Management and Professional Advisory Group.

In contrast to the detailed consideration given to the role of GPs in the coordinated care trial, the role of the Community Nurse was not singled out for individual attention at a national level, at any stage: trial formulation, implementation or evaluation.

The local evaluation reported a sustained, poor relationship between many Community Nurses and care coordinators. Both in interview, and in repeated survey results, nurses consistently scored care coordinators lower than did all other professions did. In stark contrast to all other health providers surveyed, Community and Registered Nurse levels of satisfaction with the care coordinator role reduced over the course of the trial.

Care coordinators were introduced at a time when a number of threats, outside of the trial's responsibility or control, were affecting the nursing profession as a whole, as follows.

- The Tasmanian health system was experiencing budget cuts, reduced services, and service rationing through lengthy waiting lists for care. Changes in eligibility criteria and user pay principles also negatively affected State government and Home and Community Care (HACC)-funded services, including nursing services.
- The timing of the trial coincided with a lengthy industrial campaign undertaken by the Australian Nursing Federation and the Health and Community Services Union.
- One of the larger HACC-funded nursing services, the Hobart District Nursing Service (HDNS), became financially unviable, with resulting job loss fears through threats of closure.
- There were a number of changes to the way in which the Department of Veterans Affairs (DVA) purchased services for clients, directly affecting nursing services.
- A number of changes were made to the professional career structure for nurses working in the DHHS.

Many Community Nurses also perceived care coordinators to be a direct threat to their professional activities. In the 'usual care' system, where no individual or position is formally responsible for mainstream care coordination, the Community Nurse is the most likely person to undertake care coordination type functions. They are the usual contact for hospital ward staff during discharge planning; they are contracted to provide care for DVA clients; they work closely with palliative care teams, the Aged Care Assessment Team, and other allied health professionals. In rural areas, where there is a dearth of services, Community Nurses fulfil a range of care needs in a compensatory capacity.

Community Nurses also acted in opposition to particular trial strategies they perceived as interfering in their professional duties. For example, one of the strategic directions behind the trial was to reduce the number of assessments to which clients would be subjected by demonstrating the utility of a streamlined, comprehensive assessment process. From the beginning of the trial, negotiations commenced with nursing services on how this might be achieved. The opposition to this proposal was such that the trial quickly realised that the best it could hope for was to cease the regular assessments, by Community Nurses, of clients who received Home Help services only.

Although DHHS metropolitan Community Nurses agreed to this request in 1998, DHHS rural Community Nurses refused to agree. Negotiations with HDNS continued for the entire course of the trial, with little result. Community Nurses employed by HDNS felt so strongly that they continue to provide health assessments that they offered to continue to undertake the assessments but not to charge the trial - during the HDNS funding crisis, described above. This was not, in the end, taken up by the trial because although HDNS was not going to charge the trial, it was still intending to charge the client a HACC client contribution fee.

In contrast to the infrastructure that supports GPs, there are no Divisions of Nursing to support communication of new policy initiatives to the profession. In spite of representation in trial management structures, it proved very difficult to accurately communicate trial information and strategies to grass roots nursing services providers. Consequently, most Community Nurses involved in 'hands-on' care had little understanding of the aims of the trial or the role of the care coordinator. On an individual level, most care coordinators were aware of the need to spend time with Community Nurses. For care coordinators working across a large geographic region spanning rural and urban settings, it was difficult to allocate sufficient time to build on the relationship.

The importance of communication is underscored by the fact that managers of the community nursing services reported a gradual lessening of tensions between care coordinators and Community Nurses over the life of the trial. However, interviews with Community Nurses at service delivery level indicated quite the reverse: a 'hardening' of attitudes at grass-roots level.

One would not expect a great deal of distance between the belief systems of Community Nurses and care coordinators. Although there was a great deal of criticism of care coordinators by Community Nurses, no comments made directly to the local evaluators actually disparaged the care coordinators' personal motives, as such. What was expressed, very strongly, was a complaint against the reasonableness of providing this sort of new and, in their opinion, unnecessary intervention during a time of financial constraint. The most common perception articulated by Community Nurses was that care coordinators were simply a 'super nurse' equipped with cash, a car, a computer, a mobile phone and having the luxury of a small caseload.

Some community nursing services cited HACC funding guidelines as the reason for the existing inflexibility of service provision, and as a source of considerable frustration for them. In a 'cash strapped' system, the aim of many HACC-funded services was to provide basic maintenance and support. The shift of power and resources to another group of health professionals was seen by many Community Nurses as marginalising their profession.

In summary, the Community Nurses' experience of coordinated care was coloured by a pre-existing, threatening policy environment in which the Trial was just one more factor threatening to erode their professional position. A 'devil shift' was evident in their criticism of the care coordinators behaviour and their apparent power and influence in the system, but not of their motives per se.

Allied health experiences

Allied health professionals were included in the 'non-GP service providers' surveyed by the local evaluation team in 1998, and in the follow-up postal survey of Intervention group service providers in 1999. Face-to-face individual and group interviews were also held with selected Intervention group 'non-GP' service providers.

Allied health service providers found that the administration of coordinated care was less onerous than originally expected and that they had good relationships with the care coordinators with whom they came in contact. Disaggregating the results by profession, it was clear that approval for the trial from allied health, particularly Occupational Therapists and Physiotherapists, increased over the course of the trial.

While allied health professionals were experiencing a generalised sense of threat - the sector as a whole was concerned about job losses, there was little evidence of a perception of specific professional threat posed by care coordinators. One of the key differences between allied health and Community Nurse service providers is that the allied health professionals' involvement with clients is more likely to involve short periods of intensive therapy whereas the Community Nurse involvement is generally less intense over a longer period of time. As such, the trial had less of an impact on the day-to-day practices, and client/provider relationship, of allied health professionals than Community Nurses.

It was difficult to ensure effective communication of trial rationale and initiatives to allied health professionals and this did lead to some miscommunication. Yet because of the lack of other causes of mistrust or threat, any difficulties that did arise were usually described and explained as one-off misunderstandings that were quickly resolved and not repeated.

Belief systems did not become an issue of contention with this group. Instead, the main factor impacting on the allied health professionals' response was associated with the organisational structure in which they operated. Generally, relationships between the care coordinators and private-for-profit organisations employed by the trial were very good. This included both allied health and other services: personal care, home help, gardening, home maintenance, transport, psychology, podiatry, physiotherapy, massage and homeopathy.

There was no evidence of a 'devil shift' amongst allied health professionals. While there was a generalised sense of threat in the policy environment, some organisations benefited from the business generated by the trial. There was no sense of specific competition. When communication was less than optimal, there was enough of a sense of trust between the coordinators and the allied health professionals to resolve it quickly.

Overcoming the devil shift: strategies that worked

There are no ‘quick fixes’ for the personal and professional tensions that necessarily accompany large-scale change in health system operations. The Tasmanian trial was, however, able to ameliorate the ‘devil shift’ in some instances.

Opportunities and incentives for overcoming a ‘generalised sense of threat’

The main source of the ‘generalised sense of threat’ expressed by stakeholders in the Tasmanian trial was the individual and organisational repercussions of health system reform and restructuring. While the Coordinated Care Trials were part of the process of system reform, they also presented an opportunity for organisations to ‘buy in’ to the process, thus gaining some sense of control over the results of reform.

Funds pooling was one of the levers that stakeholders could use to try and tip the reform balance in their favour. In Tasmania, the Commonwealth and State health departments, plus some HACC-funded organisations, contributed to the funds pool. Each organisation was aware of the potential risk involved, in that funds contributed could be applied to purchase alternative services. There was the opportunity to use funds from other pool contributors to purchase services from their own organisation, thus increasing their share of the ‘market’.

The HACC-funded organisation that benefited the most from this strategy had also recently reorganised the way in which their coordinators’ workloads were structured, had implemented administrative efficiencies through information technology, and had undertaken an internal analysis of their unit costs and financial position. Having undergone this process, the organisation was positioned to realise efficiencies in its own assessment time. The organisation estimated that the work time saved through care coordination enabled their organisation to increase its services to the Trial without increasing its staffing capacity. New staff were eventually put on during the course of the trial, after the agency expanded its operations by developing two new service options specifically designed for trial clients.

Contractual clarity for overcoming profession-specific competition

When dealing with the direct threat of individual health provider competition for clients, it is more difficult to allow for ‘buying into’ the change. An alternative strategy was to clearly specify what was expected in the new role and enforce it. Care coordinators, therefore, developed a formal Agreement of Care with Community Nurses, a legal contract confirming the conditions under which services would be purchased and delivered. The Agreement of Care was an agreed-upon schedule of what care would be provided by which provider, at what time, and on what day/s. It also included commencement and review dates. Care coordinators used the Agreement of Care to gain service provider compliance to the care plan and Careworks paid only for those services listed in the document. Services provided by Community Nurses that were not documented in the Agreement of Care would be delivered at the nursing services’ own expense.

Infrastructure for overcoming difficulties in communication

The Tasmanian experience underscores the importance of the infrastructure required to communicate new policy initiatives. The level of policy awareness amongst general practitioners, through the activities of the STDGP, assisted in reducing their sense of threat whilst increasing their ability to engage with the trial. It was not possible to engage with the nursing profession or allied health workers in this manner. If multi-disciplinary strategies are pursued in the future, it will be necessary to provide communications infrastructures such as parallel or integrated Divisions for these professions. The concept of Divisions of Primary Care has gained acceptance in some quarters and may be a fruitful line of enquiry in this matter.

Education and cooperation for overcoming an apparent clash of belief systems

The local evaluation documented conflicting approaches to care coordination within and between professions. Individual health providers within the same profession took different approaches to their role (as in the health provider or health administrator schema). More commonly, however, different professions assumed that their perspective was superior to others – that only they knew what was best for their patients/clients. The national evaluators reported similar conflicts, stating ‘care coordination works best when there is a multi-disciplinary team approach and all team members feel as if they have an equal role’ (National Evaluation Team 2001).

Therefore both the local and the national results point to a need for an increased respect for the opinions of other health care professionals. It is possible that, in practice, this may emerge through greater participation in multi-disciplinary teams. This end would perhaps be achieved with less conflict if it were supported by greater inter-disciplinary contact at undergraduate level. While some Universities have core units shared across disciplines, this is the minority approach, rather than the rule.

Summary

With regard to policy implementation, the 'devil is in the detail'. The local evaluation of the Tasmanian coordinated care trial goes beyond the national focus on relationships with GPs to show that the introduction of care coordination impacts on health professions differentially. Understanding this complex activity provides useful lessons for avoiding some sources of conflict in multi-disciplinary primary health care teams.

References

- Dawson M, Doherty T, McQueeney C, Ryan B, Webber S 1999, 'The Southern Tasmanian Coordinated Care Trial', in *The Australian Coordinated Care Trials: Background and Trial Descriptions*, Commonwealth Department of Health and Aged Care, Canberra.
- National Evaluation Team 2001, *The Australian Coordinated Care Trials: Final Technical National Evaluation Report*, Commonwealth Department of Health and Aged Care, Canberra. (Available on: <http://www.health.gov.au/hsdd/primcare/acoorcar/pubs/acct/contents.htm>)
- Sabatier P, Hunter S, McLaughlin S 1987, 'The Devil Shift: Perceptions and Misperceptions of Opponents', *Western Political Quarterly*, vol 41, no3, pp 449-476.
- Shannon E, Franz S, Hyland J, Ryan B 2000, *The Response of the Health and Community Services System to Coordinated Care*, University of Tasmania, Hobart.