# The changing attitudes of health professionals and consumers towards a coordinated care trial - SA HealthPlus

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## Abstract

*The national coordinated care trials have been a vehicle for health reform in Australia, driven by escalating health care costs and projections of an ageing population. The first round of trials conducted between 1997 and 1999 set the trials a challenge to reduce financial and system barriers to enable health professionals in all sectors and consumers to develop service delivery models which would give better outcomes for patients within existing resources. As part of a change management strategy, the developers of the SA HealthPlus trial assessed the attitudes of health professionals and consumers involved in designing the projects which made up the larger trial, prior to trial development and twelve months later. This paper reports on the results of the survey and how initial enthusiasm gave way to appropriate anxiety as the complexities of creating a new system of care from reactive to prospective patient centred care planning, became a reality. The survey enabled trial developers to show evidence of acceptability for the new model of care and identify areas of concern and appropriate strategies for the project teams. This type of survey and the issues identified may be of benefit to the second round coordinated care trials and health regions aiming to initiate coordinated care programs.*

## Introduction

The first round of coordinated care trials (July 1997-December 1999), an initiative of the Commonwealth and state governments through the Council of Australian Governments (COAG), aimed to facilitate reform of the health sector to improve the care of people with chronic and complex illnesses. The proposition was that pooling of commonwealth and state health funds to reduce financial barriers to coordination of care, accompanied by individual prospective care planning would lead to improved health comes within existing resources (Commonwealth Department of Health and Aged Care, 1999). Based on the results of an interim evaluation report (Centre for Health Advancement Flinders University and KPMG Management Consulting, 1999) the Commonwealth and States have agreed to a second round of coordinated care trials due to commence in 2001.

This paper reports on a survey repeated at two time points, of attitudes to coordinated care conducted with the same group of health professionals and consumers prior to the commencement, and twelve months into the SA HealthPlus trial, the largest of the nine conducted around Australia. The results and implications of the survey may be of interest to those developing the second round of coordinated care trials and health regions that are planning to introduce coordinated care programs for people with chronic and complex illnesses.

The political and economic climate at the time of the trials' planning resulted in anxiety in health professionals and health consumers, driven by fear of change. The driving force towards economic rationalisation of the health budget was a rapid increase in health care costs coupled with expected health needs of the ageing population (National Commission of Audit, 1996). At the time of the development of the trials, there was much media speculation about the introduction of North American style managed care into Australia. This had resulted in medical and consumer groups publicising their concerns and outright antipathy towards 'managed care' and coordinated care specifically (Cresswell, 1997).

Against this background, the chief investigators of the SA HealthPlus trial and the South Australian Health Commission (SAHC), sponsor of the trial, were interested in knowing as part of a change management strategy, the attitudes of service providers and consumers of services for people with chronic illnesses, to the proposed model of coordinated care. It was recognised that in order for the new model of care to be successfully implemented, it would be necessary to know what were the barriers, incentives and disincentives to those who deliver and receive care on a daily basis. Once these were known, misinformation or lack of information could be corrected and/or aspects of the survey results incorporated into the trial design and implementation.

## Methodology

The HealthPlus trial at the developmental phase consisted of 10 project groups which were geographically based around medical conditions (eg, southern respiratory) or service delivery (eg, maternal health)(Commonwealth Department of Health and Aged Care, 1999). The project groups were facilitated by one of the authors (MB). The groups consisted of health professionals and consumers who had either expressed an interest in being involved in the development of a coordinated care trial, or who were representatives of an organisation considered by the key project proponents to be a stakeholder in the delivery of coordinated care for the client group.

A questionnaire was designed to seek information about three aspects of attitude formation ie, knowledge, behaviour and emotional response (Triandis 1971), to determine current beliefs and expectations in relation to coordinated care. The questionnaire also sought responses about specific aspects of the proposed trial concepts or methodology which may have been novel or controversial depending on which group of health professionals or consumers were responding. The self administered questionnaire was distributed by MB at the beginning of the first project group meeting before detailed information about the trial was given. Those attending had been given some limited written information as part of the invitation to attend the meeting and may have had access to SA Health Commission circulars, general practice newsletters, professional organisation newsletters and the general media. The same survey was administered by post to the initial respondents and other project members twelve months later, with one written reminder to return the questionnaire. Confidentiality was assured with each respondent identified by number only to allow comparison with the initial and the subsequent questionnaire responses. Eight of the 10 projects were sampled.

At the time of the administration of the second questionnaire, project teams were in place, clinical guidelines for each project had been finalised and recommended services based on severity and complexity of each condition agreed. Large numbers of health workers and consumers had attended an extended program of introduction/orientation seminars held across the metropolitan and some rural areas. Recruitment of care-coordinators (GPs) was completed and training of 40 service-coordinators had taken place. The process of enrolling patients was well under way with 20% of the final 4500 patients enrolled into the trial. Twenty percent of these had completed the initial care-planning phase.

## Results

The data represents the knowledge, beliefs and expectancies of participants in the coordinated trial project teams prior to the first workshop (pre trial) and twelve months later in the post development phase (post). The number of completed questionnaires were 71 pre-trial and 59 at post development. 34 respondents completed both questionnaires. The two groups generally corresponded to each other in terms of background, as follows:

General practitioners (pre=21.2%, post=27.4%)
Hospital specialists including surgeons, psychiatrists and cardiologists (pre=18.2%, post=21%)
Allied health including nurses, psychologists and social workers (pre=39.4%, post=33.9%)
Others including patients (consumers), managers, academics and researchers (pre=21.2%, post=17.7%).

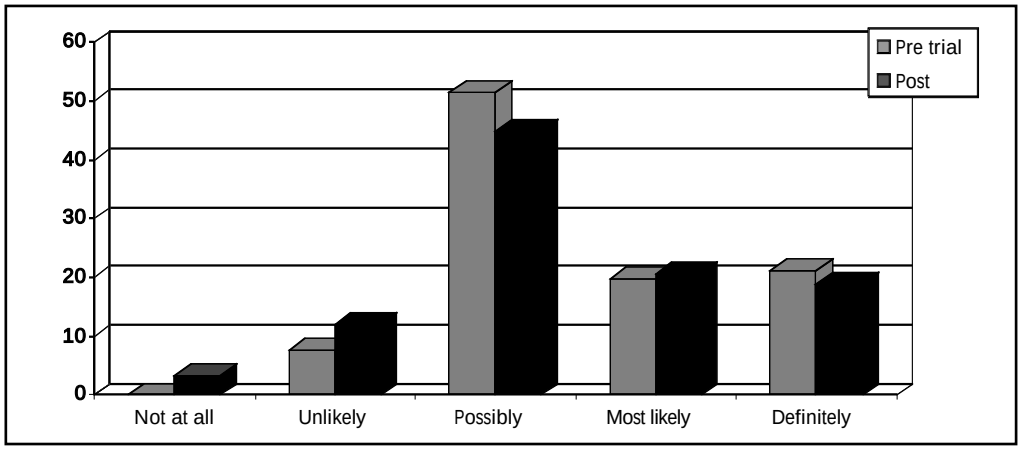
Those participants who responded to both questionnaires showed a marked increase in their perceived knowledge of the trials.

Questions relating to who was responsible for planning and conducting the trials showed a mixed response, which suggests some confusion among participants that had not changed by the time of enrolment. Approximately thirty percent thought that the trials were planned by the South Australian Health Commission (SAHC), others were divided between divisions of general practice, COAG and Professor Peter McDonald (CEO SA HealthPlus) Relatively few were aware of the involvement of the Federal Government (pre=10%, post=15%). Opinion as to who was running the trial was fairly equally divided between divisions of general practice, hospital specialists, community agencies and SAHC, at both sampling points. However, in this and other responses included here, absolute percentages do not show the transitions that individuals may have made across groups between administrations of the questionnaire.

In contrast, most participants from the outset grasped that the funding for the trials was a combination of State/Federal funds (pre=83%, post=80%). However, the belief that pooled funding means money from state/federal governments featured strongly at pre-trial (61.4%) but had reduced to 40.4% a year later, with a corresponding shift toward the idea that Medicare/Pharmaceutical benefits/hospitals and Community agencies would act as the source of pooled funds. That the trials were aiming to enrol patients with chronic/complex conditions was clear to respondents from the outset and was maintained at the second time point (pre=84%, post=95%).

There were mixed responses with regard to the possibility of involving colleagues in the trials, with around 40% of respondents most likely/definitely to encourage a colleague to participate whereas the majority (pre=51.5%, post=44.8%) would possibly encourage a colleague to be involved (Fig 1).

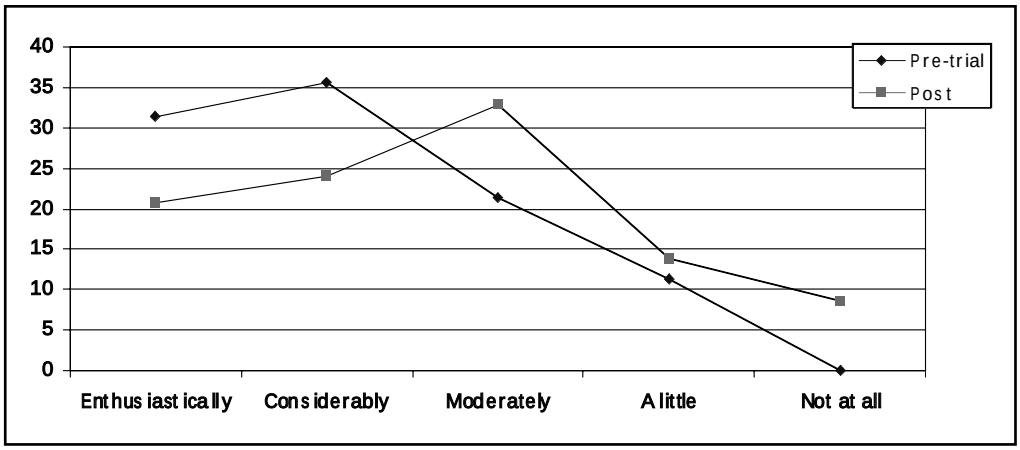
Figure 1: responses to the question “Would you encourage a colleague to participate in the trials?”




Most felt that they would be happy to be enrolled as a patient in the trial (pre=59.4%, post=63.8%), with some (pre=33.3%, post=24.1%) unsure and less than 4% were of the view that they would definitely not wish to participate as a patient.

Pre-trial interest in personal involvement with the projects was high, 67.1% indicating enthusiastic/considerable interest, which by the time of patient enrolment had fallen to 44.8%, with 22.4% having little or no interest by that stage (Figure 2).

Figure 2: responses to the level of interest in being involved in the project




Pre-trial, 84.5% regarded the trial as positive or exciting, which by the time of enrolment had fallen to 66.7%, still an overall positive idea. At enrolment, a small but significant number (19.3%) had developed the view that the trials were anxiety provoking in contrast to 7.0% pre-trial.

A range of questions addressed individual interest in various aspects of the trials. A summary of responses at both sampling points for each question is given in Table 1.

Table 1: responses to the question "Which aspects of the trial interest you?"

| Aspect | | % respondents | | |
|---|---|---|---|---|
| | | Considerably or a lot | Moderately | Slightly or not at all |
| Coordinated Care | Pre | 79 | 17 | 4 |
| | Post | 63 | 23 | 14 |
| Sharing professional responsibility | Pre | 77 | 21 | 2 |
| | Post | 66 | 24 | 10 |
| Patient / consumer involvement | Pre | 77 | 20 | 3 |
| | Post | 64 | 19 | 17 |
| Care planning / problems & goals | Pre | 68 | 24 | 7 |
| | Post | 63 | 23 | 14 |
| Funding arrangements | Pre | 40 | 45 | 15 |
| | Post | 44 | 39 | 17 |
| Outcomes | Pre | 91 | 8 | 0 |
| | Post | 83 | 14 | 3 |
| Reducing costs | Pre | 4 | 44 | 7 |
| | Post | 36 | 47 | 17 |
| Reducing hospital costs | Pre | 45 | 49 | 6 |
| | Post | 41 | 42 | 17 |
| Behaviour change in patients | Pre | 80 | 19 | 1 |
| | Post | 76 | 19 | 5 |
| Behaviour change in health professionals | Pre | 85 | 15 | 0 |
| | Post | 66 | 31 | 3 |

As can be seen, the majority of respondents remained very positive about the aims of the trials, there had been a slight cooling of enthusiasm and some had clearly decided that the trials were not of interest. Funding and reduction of costs were the least interesting aspects overall. However, interest remained in the trial outcomes and producing behaviour change in patients and health professionals.

The questionnaire addressed the expectation of the trial continuing to completion and at the same time improving outcomes for the same or less cost. Pre-trial, 75% of respondents thought the chances of the projects continuing to the 2-year post-enrolment completion were better than 50-50. This had reduced to 58% a year later. Similarly, positive (better than even) chances of producing better outcomes for the same or less cost had fallen from 73% pre-trial to 51% by the second sampling point.

Coordinated care is a process that requires health professionals and patients to behave differently in terms of how an individual receives help for health problems. A number of important issues related to the perceived difficulty of establishing and maintaining the projects to completion were examined (Table 2). The results give an overview of those trends. The data has been collapsed to represent positive, neutral and negative expectations from all respondents at both sampling stages.

Table 2: responses to the question "What degree of difficulty do you anticipate in.."

| Task | Positive Expectancy % | | Neutral % | | Negative Expectancy % | |
|---|---|---|---|---|---|---|
| | Pre | Post | Pre | Post | Pre | Post |
| Deciding the team | 45 | 42 | 37 | 36 | 18 | 22 |
| Deciding the project leader | 52 | 52 | 31 | 28 | 17 | 20 |
| Defining patient selection criteria | 40 | 35 | 44 | 36 | 16 | 30 |
| Defining point of entry for patients | 45 | 40 | 35 | 33 | 20 | 27 |
| Defining control groups | 32 | 38 | 27 | 29 | 41 | 33 |
| Working as a team | 43 | 34 | 35 | 47 | 22 | 19 |
| Describing current process of care | 33 | 45 | 42 | 28 | 25 | 27 |
| Shifting control of the care process: | | | | | | |
| Between care providers | 13 | 23 | 39 | 21 | 48 | 56 |
| From care providers to consumers | 11 | 21 | 38 | 36 | 51 | 43 |
| From hospital to community | 23 | 33 | 26 | 22 | 51 | 45 |
| Enrolling patients | 39 | 20 | 39 | 39 | 22 | 41 |
| Establishing Problems & Goals | 43 | 40 | 36 | 34 | 21 | 26 |
| Defining outcome measures | 20 | 21 | 29 | 36 | 51 | 43 |
| Coordinating the patient with all of their care providers | 15 | 21 | 34 | 36 | 51 | 43 |

Tables 1 and 2 summarise percentages of all respondents at each of the two sampling points. Comparison of the responses of those who completed both questionnaires was also carried out. Histograms of the responses to each question showed that distribution of responses at each time was skewed. In addition, numbers were relatively small (n=34) and the type of scale employed was ordinal and not interval. Therefore, the Wilcoxon Signed Ranks Test, a nonparametric test, was used. Only two subsections produced significant change, those relating to interest in the funding arrangements of the trial (sig.=.016) and the estimated difficulty in enrolling patients to the trial (sig.=.011). Interest in funding arrangements had increased, as had the estimated difficulty of successfully enrolling patients. The same procedure for responses relating to estimates of the chances that the trial will be established to the point of enrolling patients, continuing to completion, and showing better outcomes for the same or less costs showed no significant change.

Comparison of median scores for those who responded to both questionnaires demonstrated a more widespread shifting of attitude. As noted above, interest in funding arrangements shifted from "moderate" to "considerably" (median score = 3 to 4). Median scores for all other elements remained as "moderate" or "considerably" throughout.

Similarly, there was increased expectation of difficulty in shifting control of the care process between care providers and patient enrolment. Issues of defining outcome measures and coordinating patients with all of their care providers showed a reduction in perceived difficulty. All other responses remained unchanged.

## Discussion

The majority of respondents were people who wanted to be involved in developing a coordinated care program and were therefore not necessarily representative of health professionals as a whole. From the data represented by the pre-trial questionnaire it is clear that the coordinated care trials were being viewed in a positive way by the majority of project team members, although there was a significant minority who had negative attitudes to coordinated care at the outset. These health professionals were presumably present at the project group to protect their individual or organisational interests or were sceptical about the use of public money to be invested in the trials and the potential to improve patient outcomes.

The difficulties or concerns identified appear to be the natural anxieties expected when professionals change their patterns of work. Overall, most professionals and projects expected that the trials would start and run to completion, and would show better outcomes for the same or less money. Specific areas of concern for most professionals in the trials were consumer involvement and the possible power shift from one professional group to another. This was highlighted in areas such as shifting control between care providers. GPs and hospital specialists expected the least difficulty, whereas allied health professionals anticipated much more difficulty. Only hospital specialists had some degree of confidence in shifting control to consumers.

Most groups were highly interested in specific aspects of the trial such as care coordination, behavioural change and care planning, with the only exceptions being in the area of costs and funding. Overall, the combined groups - although not against the possible changes in funding - did not see this issue as the most important aspect of the trials. Allied health professionals were least concerned about the process of funding the trials, and hospital specialists were the most concerned about the prospect of the trials succeeding in reducing costs. All groups anticipated a lot of difficulty in reducing hospital costs.

By the time of the second survey, there were changes in attitude in a positive and negative sense. The first set of responses was sought at a time when the trial was in its infancy, when creative ideas and enthusiasm for the ideal of improved care may have given rise to a 'honeymoon' period. Increased familiarity with the implications of coordinated care, particularly in the stressful and demanding developmental phase, would have impacted on those closest to the trial. It was notable that the majority of respondents remained positive about the initiative overall.

The survey results had a number of useful applications. The survey group contained all health disciplines from a wide range of service groups in both metropolitan and rural areas of South Australia. At the political and senior health management level evidence was provided that the principles, concepts and proposed model of care for the trial were acceptable to a wide range of health professionals and consumers, who would be responsible for implementing the trial. This support was seen as crucial in providing local ownership of the trial and as evidence that there were local opinion leaders who would lead the process of change. This support from the service providers was a critical element in reinforcing the commitment of decision makers to the trial.

It also alerted the decision makers and trial developers to some of the areas of concern to the project teams. These were clinical process issues at one level, such as patient involvement in their health care management decisions, and shifting of power or control from one part of the health sector to another. They were policy and funding issues at another level, such as engagement of hospitals and hospital specialists. Strategies to address these disincentives and barriers were negotiations to provide funding to support hospital involvement and reinforcement of the importance of consumer/patient input to the care planning process so as to minimise territorial conflict and reduce barriers to change.

One of the principal outcomes of the survey was the trial developers' ability to address gaps in knowledge or misinformation regarding the trial. Good communication is one of the essential elements of a successful change process and it was important that the project teams were adequately informed as they would be the conduits to their colleagues understanding of and support for the trial. This led to the production of a trial information sheet which later became a newsletter targeted initially to those developing the projects.

Future coordinated care programs could note the clear evidence of altruism balanced with self-concern amongst project developers. Initial enthusiasm gives way to some anxiety and task orientated concern at the job to be done. Trial designers need to be aware of the range of attitudes of their stakeholders and how their individual learning style and perceptions will influence their ability to take on new information. A standardised questionnaire is one way of determining the change status of the work group, lets you know where their strengths and weaknesses are and where more support is needed. It allows barriers to change to be identified and strategies to be devised to prevent crises in the process of implementation.

## Acknowledgments

The authors would like to acknowledge the administrative support of Debra Sullivan in the distribution and collection of questionnaires and Anthea Williams in the preparation of the manuscript.

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