

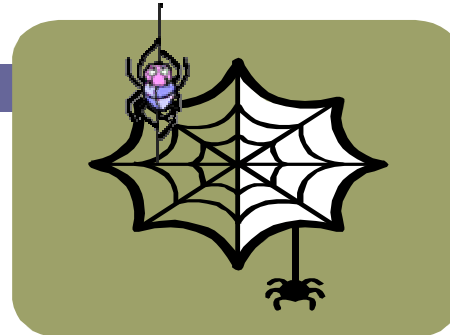


Anti-boredom interlude: if bored, have some fun!





Untangling the web: where does case management fit in the service delivery system?



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A bit of “R” time

- v Rationale – why is it the way it is?
- v Response – how it developed?
- v Reality check – where it’s at?
- v Revelation – what is the future?



Rationale: components of the 'web'

- v Funding structure – local, state, fed
- v Service delivery system structure – hospital, home, community
- v Workforce – a web in a web!
- v Consumer movement

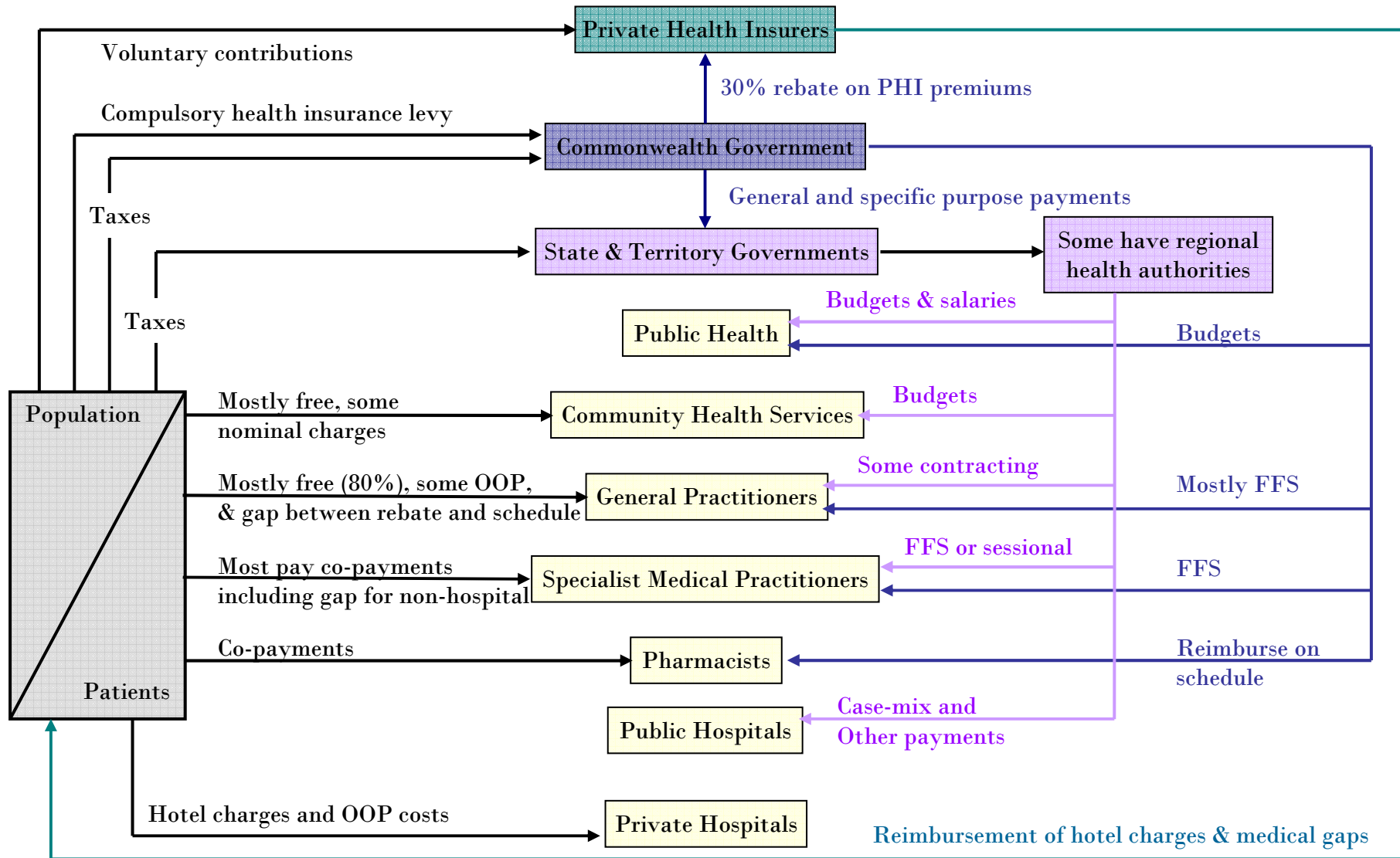


Rationale: influences

- v Current events
- v Medical breakthroughs
- v Pharmaceutical developments / Alternative medicine
- v Technological innovation
- v International trends
- v Emergent service delivery models



Rationale: a complex system



Source: Based on European Observatory on Health Care Systems, 2001. HIT Australia p75.



Response

- v Cope with the complexity
- v Coping mechanisms differ!
- v Opportunistic for some...



Response: cm abridged history

- v Practiced internationally for better part of the last century in some form or fashion
- v Practiced in Australia for over 3 decades
- v Social service provision formally first began utilising case management in the 80's – influence from the UK/USA
- v Applied in multiple settings (home, community, acute)
- v Now utilised in multiple service sectors (mental health, disability, aged, corrections, child protection, injury management, employment services, insurance and disease management...)
- v Private and public sectors
- v Workforce Issues
 - v Diversity of professional and non professional backgrounds (nursing, social work, physiotherapy, occupational therapy, psychology, teaching)
 - v Non standardisation of training and competencies
 - v Case manager as a profession in its own right?
 - v Currently anyone can do it?
- v Evidence of effectiveness mixed (most small scale studies, CCT, Cochrane reviews)



Response: existing cm programs

- v Mental health 'continuing care'
- v ABI
- v COP
- v CACPs
- v EACH / EACH Dementia
- v Transitional Care Projects
- v Flexible Care
- v ACAS – pilot projects
- v Innovative Pool
- v Workcover/ TAC
- v Commonwealth initiated Care Coordination Trials
- v HACC / local government
- v HARP - chronic and complex care (Vic)
- v Hospital in the Home
- v Private health
- v Correctional services state run programs



Response – birth of CMSA

- ✓ CMSA founded in 1996
- ✓ Non-profit organisation
 - “Publicise, advance and encourage the practice of Case Management in Australia”*
- ✓ Promote:
 - ✓ Professionalism
 - ✓ Evidence of effectiveness/efficiencies
 - ✓ Development of Standards



Response: cmsa

- v Australian Journal of Case Management
 - v Only Australian peer reviewed case management journal
 - v Research
 - v Reviews
 - v Practice Notes
 - v Book reviews
 - v Conference papers
 - v Professional development – what's on?
 - v Evaluation editorial
 - v Reports from Special Interest Groups



Response: service models

Service Model	Primary focus
Case management	The full range of health and social care needs of individuals with complex care needs.
Disease management	Co-ordination of clinical care and pharmacological needs of individuals with diagnosed diseases, conditions or illnesses.
Hospital Demand Management	Co-ordination of services which reduce the need for admission to hospital.
Self Care Management	Empowering individuals to care for themselves.
Wellness Management	Health promotion as opposed to 'sickness' and attempts to minimise health and social risk, preferably before the onset of disease.
Population Health Management	An established population group and the range of needs within that defined population.

Reference: ACSA/CMSA Case Management & Community Care: A Discussion Paper Consultation Draft Feb 06



Response: service models

Service model	Client Characteristics – Driver of coordination demand				Intervention Characteristics – Driver of coordination supply	
	Level of Care Needs by Client Target	Level of Risk of Future Health Deterioration (in short term)	Level of Coordination Needed	Number of Individuals Requiring Coordination	Level of Coordination Intensity	Unit Cost of Coordination
Case management	High	High	High	Low	High	High
Disease management	High	High	High	Low	High, Med	High, Med
Hospital demand management	Med	Med	Med	Med	Med	High, Med
Self care management	Low	Low	Low	High	Low	Low
Wellness management	Low	Low	Low	High	Low	Low
Population health management	High, Med, Low	High, Med, Low	High, Med, Low	High	High, Med, Low	High

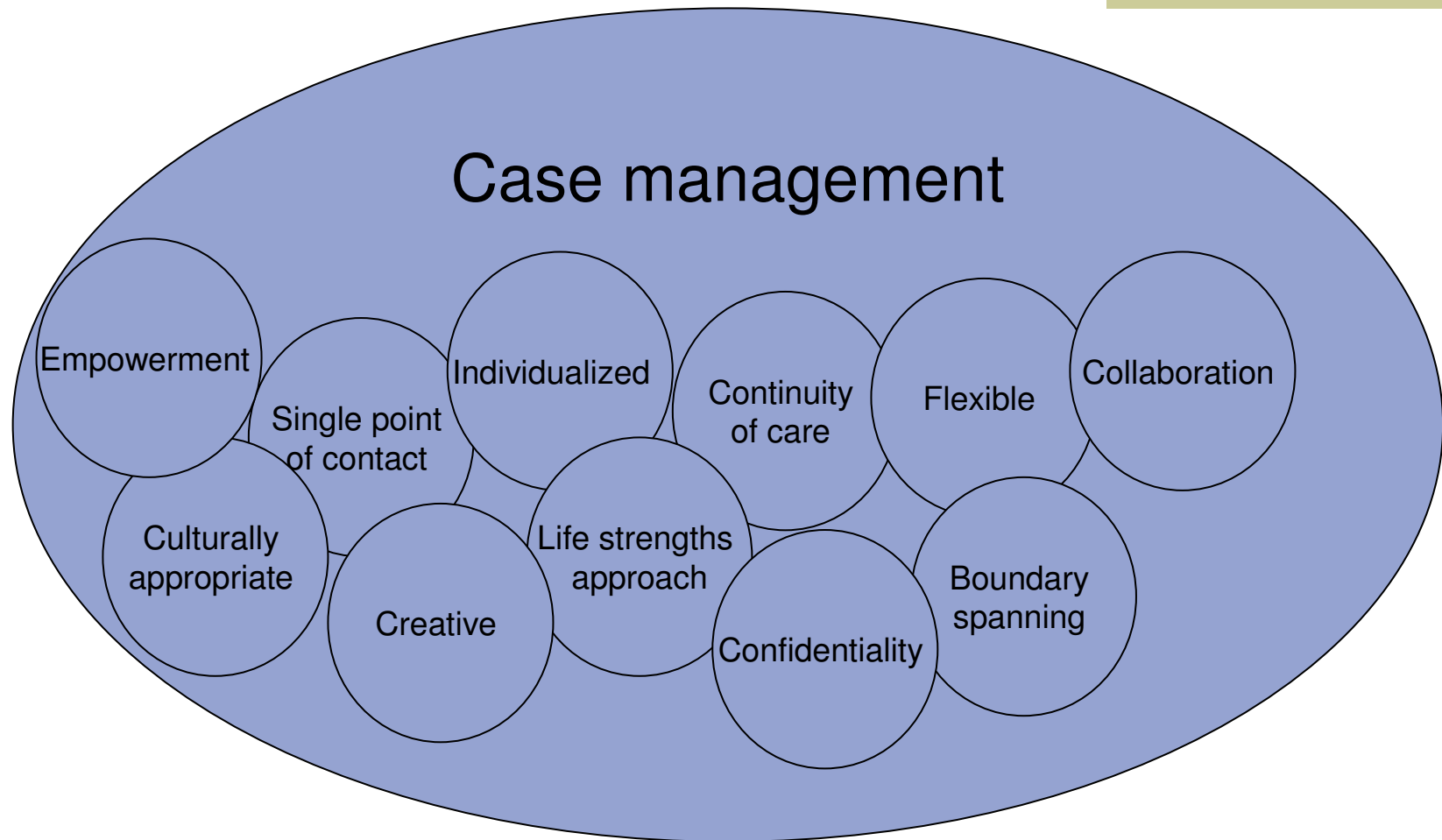


Response: discussion paper

- v Breath and depth is the difference!
- v Full range of health and social care needs for individuals with complex needs
- v Crosses boundaries (health, social systems that interlink)
- v Knowledge of how systems interact
- v Knowledge of how to access those systems
- v Response to need

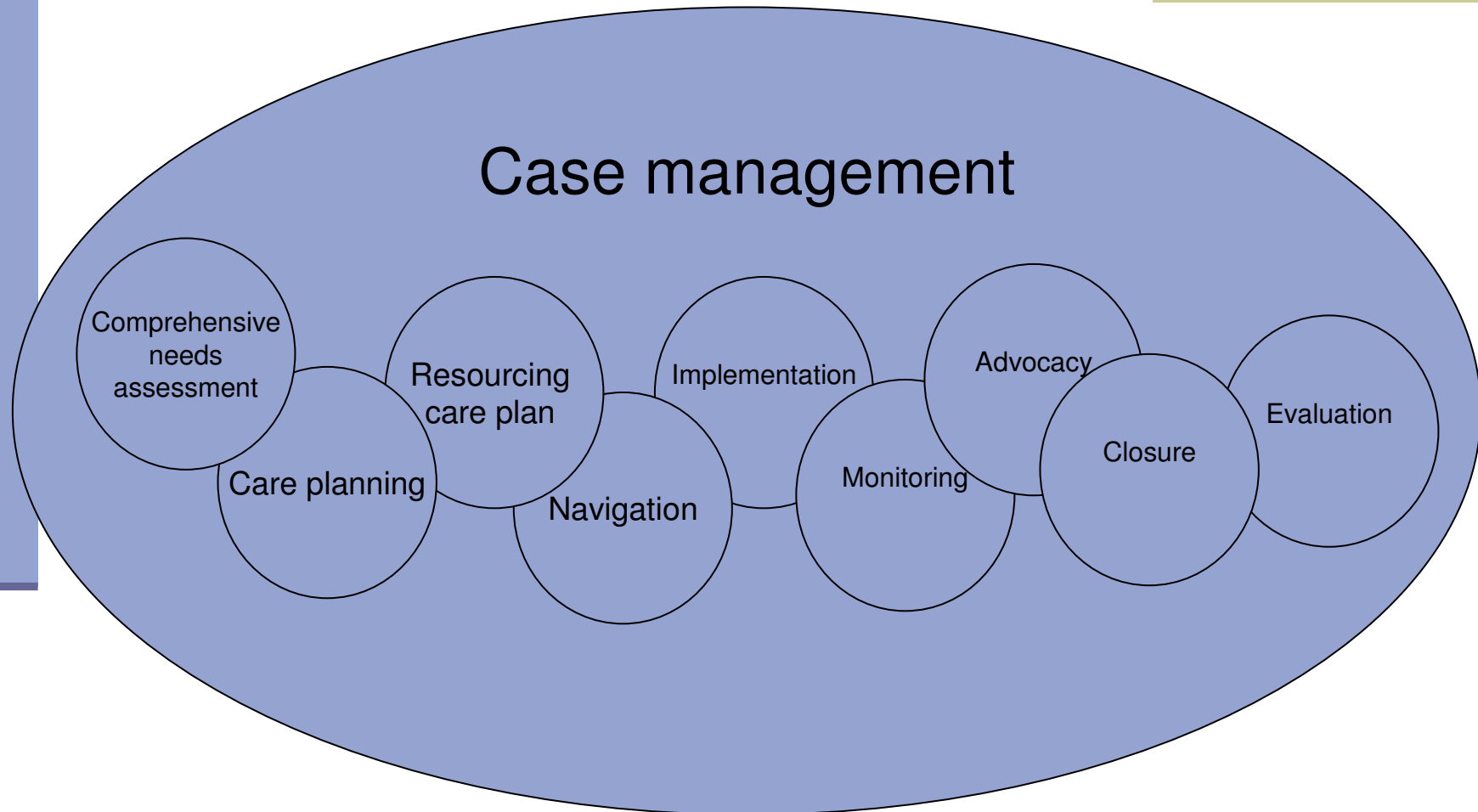


Response: discussion paper





Response: discussion paper



Reference: ACSA/CMSA Case Management & Community Care: A Discussion Paper Consultation Draft Feb 06



Response: Federal/State

- v COAG \$1.1 billion injection
 - v 24 hours hotline for medical advice and mental health counseling (July 07)
 - v Younger disabled out of aged nursing homes (\$244 million plan)
 - v Health checks for people over 45 who have risk factors for certain conditions (\$500 mil mark campaign for healthy living)
 - v Electronic medical record
 - v Elderly care in home and community setting
 - v More university places to train doctors

- v Mental health plan blue print (June)

Ref: <http://www.coag.gov.au/meetings/100206/index.htm#health>



Response: Federal

- v COAG Agenda
 - v Phase 1 Coordinated Care Trials

- v Phase 2 - Co-ordinated Healthcare trial

- v Inter-RAI tool and other assessment tools being considered at state level



Response: Federal

- v Position papers: A new strategy for community care - “The Way Forward” (2004)
- v Reviews: national review of HACCC services
- v Speaking series - “A Community for all Ages - Building the Future”



Response: Federal

- ▼ *A New Strategy for Community Care - The Way Forward Phase 2*
 - ▼ Research/consultancy focus
 - ▼ Assessment for Basic Care Services
 - ▼ Eligibility and Needs Assessment for the National Respite for Carers Program
 - ▼ Comprehensive Assessment
 - ▼ Eligibility for Community Care Consultancy
 - ▼ Entry Points
 - ▼ National Planning Framework
 - ▼ Community Care Program Standards and Quality Reporting Framework
 - ▼ Workforce Implications



Response: Federal

- v A Community Care Officials Group (Est November 2004)
- v Working group focus to guide the work progressing under The Way Forward.
 - v Eligibility and Assessment
 - v Packaged Care
 - v Planning and Accountability
 - v HACCC Renegotiation
- v The National Reference Group for the Review of Community Care (Established in 2003) – 18 members



Response: Federal

- v HACCC
 - v Government providing 60% of funds
 - v States and Territories providing 40%.
 - v \$1.301 billion provided nationally for the HACCC Program in 2004-05.



Response: Federal

- v Pilot programs:
 - v Aged care innovative pool
 - v Est 2001-02
 - v National pool of flexible care places available for allocation to innovative services outside of the Aged Care Approvals Round
 - v 2004-5 focus on younger pop in ns homes; high needs
 - v Retirement Villages Care Pilot
 - v Staying at Home and Safe at Home



Response: Federal

- v Sharing Health Care Initiative
 - v 1999/07: \$36.2 million
 - v Tender process
 - v 8 Demonstration projects
 - v 4 Indigenous demonstration projects



Response: Federal

v Funding

Enhanced Primary Care (EPC) Medicare Item
Numbers for GPs:

- v Care planning
- v Case conferencing
- v Medication review / pharmacy home reviews
- v NEW: Allied health EPC
- v Chronic disease management



Response: *Victoria*

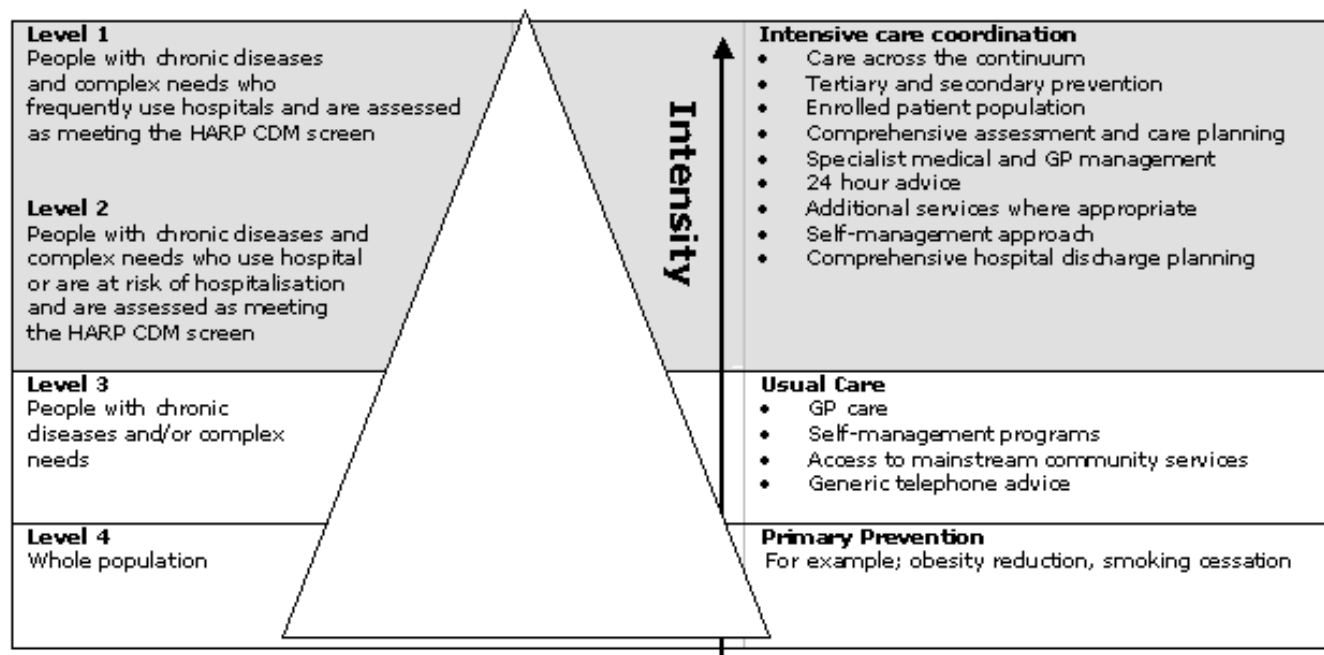
DHS allocated \$150 million over 4 years to June 2005 (HARP)

- to develop preventive models of care for patients with chronic conditions and complex care needs
- to focus on high volume and frequent users of the acute public hospitals



Response: Victoria

Table 1: Levels of chronic and complex care management



Reference: Victorian Chronic & Complex Care Program <http://www.health.vic.gov.au/harp-cdm/>



Response: Victoria

- ✓ Chronic and Complex Care Program Guidelines
 - ✓ State the required components of a program
 - ✓ Not prescriptive as to how this component is achieved
 - eg proactive monitoring and review is a required component however it may be via home visits or outpatient clinics
 - ✓ Governance and accountability
- ✓ CDM MBS items



Response: NSW

- v \$45 million over 3 years
- v Address 3 priority health areas:
cardiovascular, cancer and respiratory
- v 60 programs across 17 Area Health Services
- v Leadership and Oversight - Co-Chairs
- v Expert Clinical Reference Groups - Chairs



Response: NSW

- v Chronic Care Program
- v Currently in phase 2, and
- v Evolved into The NSW Chronic Care Program
- v Phase 2 will build on the 60 programs and develop sustainable models with strong links with primary care.
- v Access more information at http://www.health.nsw.gov.au/pubs/2005/chronic_care2.html



Response: Queensland

- v Queensland Health consulting on the Queensland Implementation Initiative for the Prevention and Management of Chronic Disease 2005-2015.

- v Access more information at

http://www.health.qld.gov.au/publications/discussion/chronic_disease/Discuss_ChronicDisease.pdf



Reality check!

- v Impact on client experience and outcomes
- v Impact from the organisations who do it
- v Impact on the professionals who practice it
- v Impact of professional societies like CMSA
- v Impact of competing interests



Reality check

- v Decision makers matter – do you know who they are?
- v Are you satisfied in your roles and with the organisations you work for?
- v Are you aware of more than what is in front of you?



Reality check

- ✓ Sustainability of nationally represented membership
- ✓ Australian National Standards of Practice – launched Oct 2004
- ✓ EOI – Demonstration Projects implementing national standards – 2005/6
- ✓ Lobbying political groups – Discussion paper with ACSA
- ✓ Heading to 10 annual conferences with international and local delegates
- ✓ Regional network meetings
- ✓ Peer Reviewed Journal/Bulletin
- ✓ Interactive website for members



Reality check

- v National Community Care Case Management Network – (COPs)
- v Queensland Community Options Program Statewide Network
- v Community Care Coalition – represented by 20 peak organisations
- v Community Care Issues Network – (CCIN) multiple providers of packages
- v ACSA/CMSA Working Group



Reality check: limitations

- v CMSA small EC voluntary committee
- v Membership growth
- v Evidence of effectiveness
- v Power base questioned
 - v Members do not include medical professionals
 - v Members include limited number bureaucrats
- v Can we still make a significant and sustainable impact?



Reality check: challenges

- v Multiple case managers per client -program boundaries
- v Perception that it is cost intensive
- v Lack of standardisation of case manager skills
- v Terminology continues to be contested
- v Different definitions and applications
- v Minimal 'hard evidence' that it works - multiple variables and biases
- v Lack of sustainable political interest
- v Lack of medical professional interest
- v Minimal private sector interest
- v Job satisfaction/dissatisfaction
- v Intermittent gravitation toward model, then on to the next...Newer models seeming to offer 'salvation'



Reality check – cm value

- v Conceptual model that formalises need for care coordination/provision
- v A 'whole of service system' perspective
- v It doesn't belong to any one program
- v Works across funding silos
- v Central focus on 'coordination need'
- v Central contact point for 'the black hole' (complex service system)
- v Individual advocating for client needs
- v Access to services where otherwise wouldn't
- v Breadth and depth is the difference!



Revelation: sustainability

- v Continually 'rebooting' of self, model, organisation
- v Clear articulation of benefits and limitations
- v Measure, report and publish on case management practice
- v Clear articulation of case manager roles and functions
- v Lobby professional groups that currently influence decision making in public and private sector



Revelation: get it right





Revelation: 2006 activity

- v Focus on key areas & 'special interest groups'
- v Political lobbying to all levels of government
- v Application of National Standards to practice settings
- v Viability of professional certification

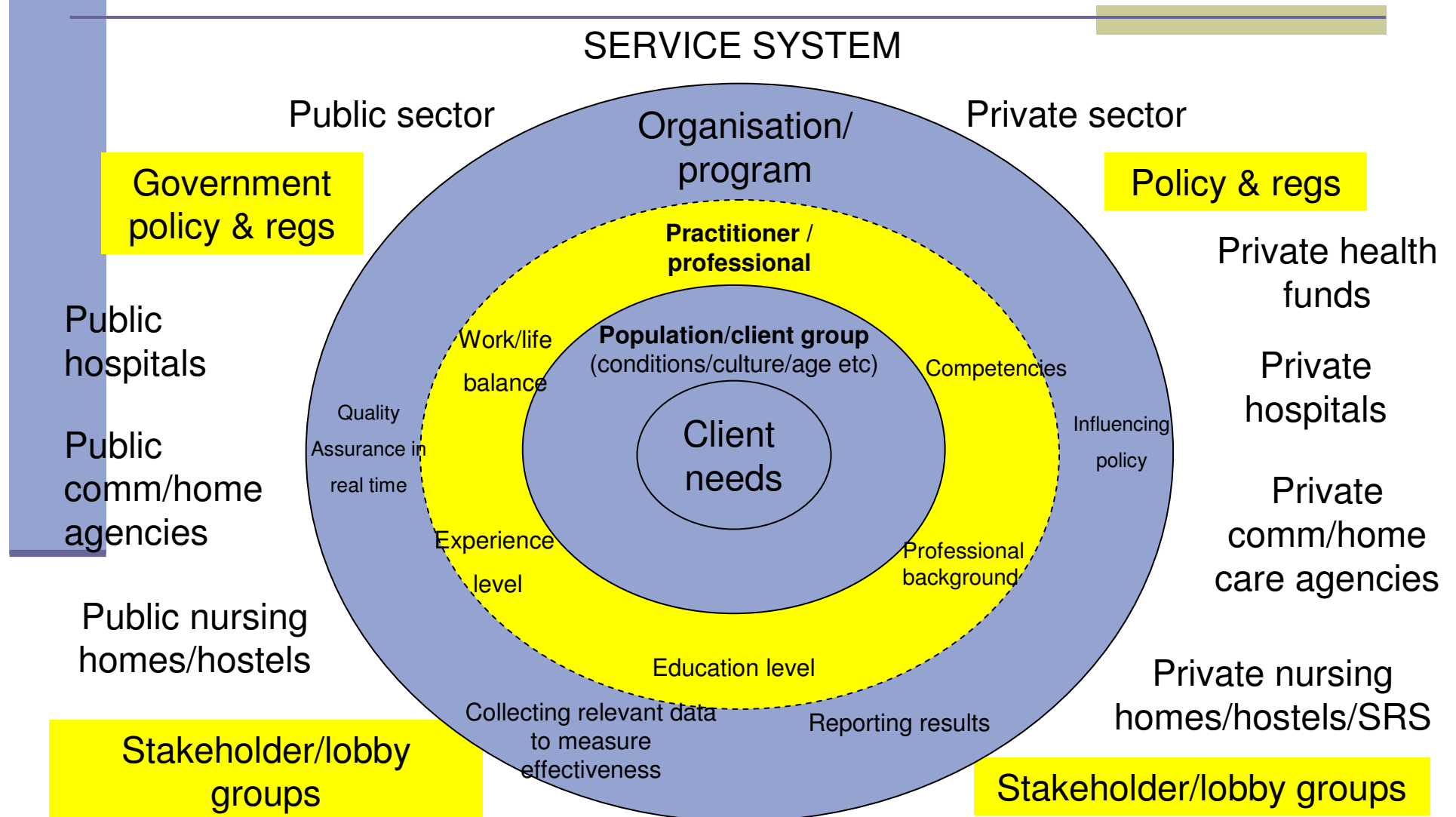


Revelation: cm future

- v Case management will continue to 'reboot' itself and be applicable in the Australian service delivery system
- v Clients view the advantages of case management in encouraging self management, not dependence
- v National recognition that some level of certification of case managers (where relevant) ensures high standard of service delivery
- v Case managers are supported and adequately remunerated
- v Collection of relevant data convinces fund holders that case management is an effective service delivery model
- v Case management is identified by key stakeholders to be a viable model of service delivery in relevant settings

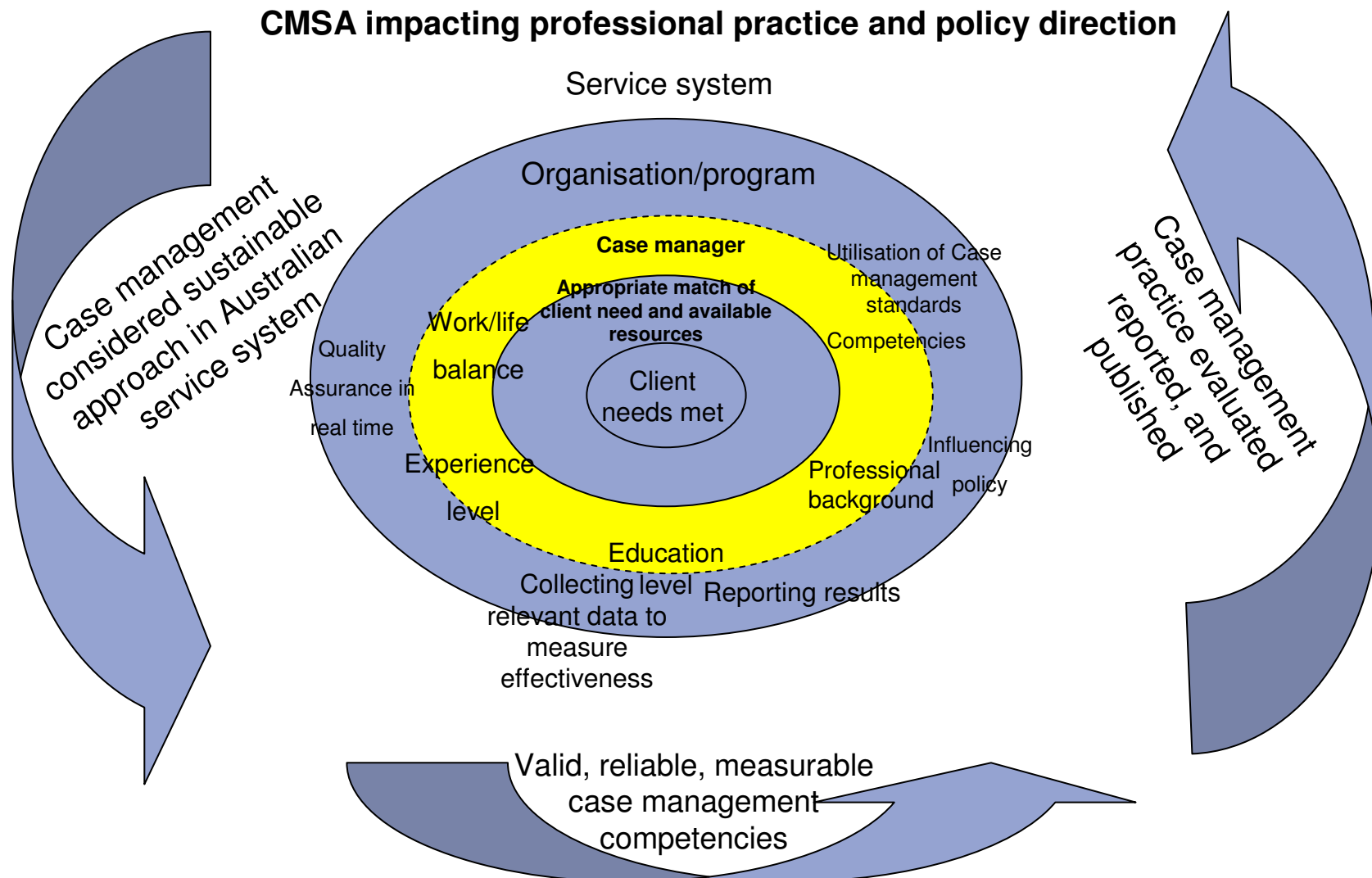


Revelation: a systems approach





Revelation: cm place in service system





Thanks

