Provider and consumer research regarding recent and future changes in home care

RESEARCH REPORT

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1. About this report

In July 2015, it became a mandatory requirement for all home care package providers to use a Consumer Directed Care (CDC) model of service delivery. Further changes to home care were announced in the 2015-2016 Budget (Increasing Choice in Home Care measure). These changes were intended to be implemented in two stages:

- In Stage 1, from February 2017, funding for a home care package will follow the consumer, enabling the consumer to choose a provider that is suited to them and to direct the funding to that provider. There will also be a national system for prioritising access to packages, managed through My Aged Care.

- In Stage 2, the Government announced its intention to move towards a more integrated care at home system, bringing together elements of the Home Care Packages Programme and the Commonwealth Home Support Programme.

The Department of Health (the Department) engaged TNS Social Research (TNS) to conduct research to assess the response of home care providers and consumers to the introduction of CDC and the forthcoming Increasing Choice (IC) measure. The aims of the research were to help identify:

- The extent to which home care providers have implemented a CDC service model when delivering the Home Care Packages Programme;

- Consumer’s experience and level of satisfaction with the recent introduction of CDC service model to the delivery of home care packages programme;

- The anticipated impacts of the introduction of the IC measure on 27 February 2017;

- Consumer response to the choice of changing home care providers when the new home care arrangements commence;

- Support mechanisms to assist providers and consumers to successfully transition to new home care arrangements arising from the IC Budget measure.

TNS completed in-depth interviews with a total of n=62 home care consumers and/or carers and n=52 home care service providers from 29 June to 4 August 2016.

This report provides a synthesis of the main themes and issues raised by study participants.

Key aspects to note about this report:

- Not all issues raised by every participant are necessarily included; rather the report offers a summation of the common aspects and issues encountered.

- The findings are based on feedback from consumers and providers, and any limitations with this in terms of response bias and potential disparity with other evidence sources should be acknowledged.

- Extracts from interviews are used throughout the report to illustrate some of the issues raised. Each extract is denoted in italics and includes attribution as follows:
  
  ➢ For service providers: provider role, site size, location type and state.
- For consumers: Consumer/ carer, provider type, level of home care package, location type and state.

- In some cases, some of the content of extracts/ attribution details may have been removed to protect participant confidentiality.

- In order to provide an indication of the magnitude of some findings, a broad approximation of the number of participants who responded in a certain way is provided. As the qualitative sample was not representative of the population of providers or consumers and not all issues were specifically raised in every interview, this should not be considered indicative of population proportions.

- Participants completed a short survey at the end of each interview. Some results from this survey are included within the report, and identified accordingly.
2. Executive summary & observations

The Department of Health (the Department) commissioned TNS Social Research (TNS) to undertake a programme of research with home care providers and consumers to explore response to the introduction of Consumer Directed Care (CDC) and the forthcoming Increasing Choice (IC) measure.

Specific objectives for the project were to investigate:

- The extent to which the CDC approach is being used through the delivery of the home care packages programme and the drivers and barriers to doing so;
- Administrative and operational issues that may have hindered the implementation of CDC;
- Perceptions of support and information provided by the Department to support the key elements of CDC;
- Consumers’ experience and level of satisfaction with the recent introduction of CDC service model to the delivery of home care packages programme;
- The anticipated impacts of the introduction of the IC measure on 27 February 2017;
- Consumer response to having the choice of changing home care providers when the new home care arrangements commence;
- Support mechanisms to assist providers and consumers to successfully transition to new home care arrangements arising from the IC Budget measure.

Qualitative in-depth interviews (IDIs) were undertaken with a total of n=62 consumers and/or carers and n=52 service providers, structured as follows:

- N=45 telephone IDIs with consumers currently in receipt of a home care package;
- N=14 telephone IDIs with carers of consumers currently in receipt of a home care package.
- N=3 in-home immersions, during which face-to-face IDIs were conducted with a consumer or their carer / advocate;
- N=43 telephone IDIs with home-care providers; and
- Three case studies conducted of larger sized home care providers. For each case study, a series of on-site face-to-face IDIs (n=9) were conducted with management staff, staff in administrative, operational and customer-facing roles.

All components of the research were conducted from Wednesday 29th June to Thursday 4th August, 2016.

A summary of key findings from the research is provided overleaf.
2.1 Summary of findings

2.1.1 Implementation of CDC: Providers

2.1.1.1 There is progress towards implementation of CDC

As summarised in Figure 1 (below), this research indicates that:

- The majority of home care providers are either accepting or adapting to the delivery of home care services on a CDC basis, having taken steps to adjust their systems and processes to embed the model into their operations. Most providers are therefore now offering a more flexible service to their clients. A smaller group of providers are embracing the reform and actively promoting a full service suite.

- Provider commitment to the approach strengthens over time, and the more experience a provider has with CDC, the more they are likely to embrace it - noting benefits for consumers, and sometimes their business;

- Those who are embracing CDC view it as an opportunity to expand their reach and service suite, and also recognise its benefits to their clients. Many of these providers were larger in size, profit driven, demonstrated strong natural alignment between their mission, outlook and existing service offering and CDC;

- Where there is resistance to the concept of change more broadly (that is, resistance to ‘any change’ in the sector, including those which are not related to CDC), some resistance to CDC persists. This appears driven by perceived and actual challenges associated with the process of adapting to change (the operational, administrative and technical shift required), rather than the specifics of delivering home care packages on a CDC basis. These providers are more likely to be smaller (< 20 home care packages), NFP / Government, or in rural and remote locations.

Figure 1: Provider continuum according to their stage of implementation of CDC
See How is CDC being implemented? for more detail.

2.1.1.2 Those who have progressed further with CDC cite positive results

As noted previously, it appears that once the systems and processes required to implement the CDC model were in place, providers’ attitudes to, and experiences with, the reform become more positive.

Those providers who had begun the process of implementation early (particularly those who had commenced this process before the formal introduction of CDC), appeared to have largely overcome any initial hurdles, and were now successfully delivering home care packages using the CDC model. Despite reporting some internal resistance to the reform initially, these providers were now appreciative of the value of the CDC model to consumers, and to the sector more broadly, and few negative outcomes to their current operations were noted.

These providers reported high levels of autonomy and control when implementing the CDC model. Their approach had been to take steps towards the CDC model gradually and methodically, allowing time to train staff, trial new procedures, and explain the changes to clients. The process of implementation was therefore smoother, largely avoiding significant disruption to business operations or resistance from staff, and resulting in a change in service that was more comprehensible to consumers. Many of these providers reported a direct change in the variety and quality of care they were able to provide.

As the CDC model becomes progressively embedded into the systems and processes of individual organisations, its positive impacts are increasingly recognised. They include:

- **Consumer impacts:**
  - Greater flexibility, broader service offering – thus allowing consumers to access a wider range of services, including services (and products) not previously available;
  - Consumer empowerment, more tailored service: the provision of greater consumer autonomy through CDC was thought to have allowed consumers an opportunity for choice which had not previously existed. The result was consumers were enabled to select services most suited to their individual needs and circumstances. A small number of participants suggested that in doing so, CDC contributed to a sense of “re-ablement” among their client base, with consumers able to feel independent and autonomous for longer than they had under the previous system.

- **Provider impacts:**
  - Extending service suite and reinforcing choice oriented focus: Some providers felt that in allowing consumers greater choice, CDC had provided opportunities to extend their service offering. This was most notable amongst providers who had previously felt restricted, and whose business model aligned with the CDC ethos. These providers had introduced new services and products and were actively marketing a full service suite;
  - More ethical approach, better quality service: The focus on transparency in delivering home care packages on a CDC basis was considered a more ethical, and more progressive approach to service provision. Moreover, in enabling consumers to be more attune to the value of the service they were receiving, CDC was associated with improvements in service quality;
- **More skilled staff, greater job satisfaction**: Providers who had implemented CDC early had often invested in the training of field staff to accommodate consumer demand for more varied services. Some felt that this had provided greater job satisfaction for field staff, and facilitated closer relationships with their clients; and

- **Preparation for IC**: CDC was thought to lay the groundwork for IC, allowing providers who had not previously prioritised flexibility or choice to adopt a more consumer focussed business model. This was considered an important initial step towards the delivery of home care under IC.

*See Provider response to CDC for more detail.*

### 2.1.1.3 The most challenging elements of CDC may be ‘short-term’, rather than systemic, in nature

The vast majority of providers appear to be **open and willing to transition to the CDC model**, and are motivated to ensure that they meet the mandated requirements. The challenges they have faced through transitioning to CDC, therefore, largely stem not from a reluctance to comply, but instead from issues associated with initial implementation. Again, these tended to be most problematic for smaller and not-for-profit organisations, reflecting the greater extent of operational and cultural change required within these organisations. Challenges identified by providers **more strongly related to the initial hurdle of implementation** and resistance to change, and generally diminished over time as familiarity with processes increased. These were:

- Implementation was perceived as a process that would hold some **administrative burden** as providers updated their processes and systems to accommodate CDC;

- **Operational and staffing challenges** in implementing CDC were experienced variously across the sector. Providers invested in training and upskilling staff to accommodate greater flexibility and increased client demands. While for early implementers, a more skilled staff base was considered to be a positive impact of CDC, the process of equipping staff with the skills to meet additional administrative and logistical requirements was often time-consuming and stretched resources;

- **Technical challenges** had arisen in the upgrading of systems and software to facilitate the CDC implementation. The CDC transition was also associated with technical difficulties relating to other areas of reform to the aged care sector – most notably the changes related to the My Aged Care portal. This demonstrates a tendency amongst some providers not to separate out challenges associated with the implementation of the CDC from challenges associated with sector reform more broadly;

- Some providers did not feel equipped to **educate their clients** about CDC. This was most problematic for those servicing the Indigenous and CALD communities, reflecting a need to accommodate cultural sensitivities and language constraints in any communication about the reform.

*See Challenges in implementation for more detail.*
2.1.1.4 Information and resources play an important support role

Existing communications and resources have played an important role in facilitating the transition to CDC: raising awareness and understanding of the changes, offering practical suggestions and instruction for the process of transitioning to CDC, and providing information and resources that can be passed on to clients and other staff. In terms of response to available resources:

- Many providers had attended workshops, forums and industry events, including those conducted by the Government and those conducted by peak bodies (including Leading Aged Services Australia, Aged and Community Services Australia, COTA Australia, Alzheimer’s Australia, the Better Practice Project). All of these were viewed positively, particularly as they provided opportunity for discussion and knowledge sharing;

- The Home Care Today website was also widely used as a source of information on CDC. Perceptions of this website were also positive – it was considered informative and accessible, and provided access to handouts and resources that were useful for explaining the changes to clients and lower level staff;

- Providers reported very limited awareness of information relating to home care on the Department of Health website;

- While the My Aged Care website was regarded as an authoritative and reliable source of information on this topic, views of its content were mixed. While some were positive about the information provided, others claimed that the information was too vague and did not take into account the specifics of their organisation.

See Support and information on CDC for more detail.

2.1.2 Experience of home care under CDC: Consumers

2.1.2.1 There is evidence of greater flexibility in the experience of home care under CDC

Around one quarter of consumers in the study described greater flexibility in their experience of home care. These consumers recalled their provider had invited them to consider:

- Uptake of a range of additional services (using a list to show the types of services for which they were eligible);

- Uptake of one or more specific types of service;

- Swapping services to choose a service of greater appeal; or

- Uptake of alternative set packages of services.

See Experience of home care under CDC for more detail.

2.1.2.2 Experiences of CDC are largely positive

Similarly to that noted among providers, the more experience a consumer has with CDC (in terms of being informed, and having experienced a change in their service), the more positive their attitudes. Many times, this appears to translate to an increased sense of satisfaction with their provider.

For those who could recall experiencing CDC related changes in their home care service (if not reflective of the full CDC offering), the experience was, for the most part, positive. The ability to exert more control
over their service was particularly appealing to carers of higher needs consumers, reflecting considerable reliance on the home care service for their care needs and generally high service expectations overall. For this group, the delivery of home care on a CDC basis was associated with empowerment for the consumer and a more flexible and accommodating service.

Overall, on a conceptual level, the benefits of greater choice in home care were also recognised by the majority of consumers (even those who had not experienced change). Nonetheless, many showed a disinclination to consider changing their care arrangements. This was particularly evident amongst lower level needs consumers, reflecting lower engagement with home care services generally. The personal relevance of the reform was also questioned by older consumers (75+), reflecting a (possibly generational) change averse and un-expectant predisposition.

See Drivers and barriers to engagement with CDC for more detail.

2.1.2.3 Engagement with CDC is also driven by the provider

The research suggests that the engagement and encouragement of the provider is critical in shaping consumers’ understanding and experience of home care under CDC. The provider plays a vital role by ensuring that consumers understand what is on offer, feel reassured that the change is both legitimate and positive, and that the process is easy and seamless. Overall, carers had a more involved relationship with management (case managers, supervisors or coordinators), which seemed to have a positive impact on their understanding of and engagement with CDC.

However, the research suggested that this level of encouragement or support was not always experienced – and that the CDC changes may therefore be insufficiently implemented or championed by providers, particularly for lower needs consumers.

See Drivers and barriers to engagement with CDC for more detail.

2.1.3 Providers’ response to IC

2.1.3.1 The IC reform is a topical issue amongst providers and has generated much discussion

The research indicates there has been much discussion amongst providers about the introduction of IC and its likely effect on the home care industry. In a broad sense, it was viewed as a substantive change to the sector, though there appears to be little understanding of the details of the reform or how it would be implemented. Nonetheless, the high level of engagement with the issue had led to much speculation about its likely impacts on providers and consumers.

Larger and for profit providers were most positive about IC. For these providers, IC was viewed as a much needed sector reform, as it moved to cater to the needs of an ageing population. Its potential impacts were predicted to result in benefits for consumers and providers alike, and included:

- A positive impact on the supply, quality and value of home care for consumers, resulting from increased competition between providers;
- A greater sense of independence and autonomy for consumers, extending on that already brought about by CDC;
An opportunity to **grow market share and increase reach**. For these providers, the easing of restrictions on the market, and particularly the removal of limits on scope and region were considered to be commercially advantageous.

Reflecting their limited understanding of the practical application of IC coupled with broad resistance to change, **not-for-profit providers** expressed more concern about the introduction of IC in regard to perceptions around:

- The **administrative requirements** that might be involved in updating systems and processes and transitioning clients;
- The impact on **staffing** – in particular the possibility that providers may need to make cuts to field staff;
- The **financial viability** of smaller providers, as a result of the need to compete with larger providers, and an anticipated reduction in revenue due to the portability of home care packages;
- The impact on the **quality of care**, reflecting a lack of awareness of accreditation processes for new entrants into the market.

*See Anticipated impacts of IC for more detail.*

### 2.1.3.2 Most providers are confident that they will be ready for IC

Around seven in ten providers in the study showed **high levels of confidence** that their organisation would be ready by February 2017 to deliver home care services under the IC changes, with confidence greatest amongst private and for profit organisations, though still evident amongst smaller and not-for-profit providers.

As Figure 2 (below) shows, most in the study had taken steps to prepare:

- The **majority of providers in the study were either ‘accepting’ or ‘adapting’ to IC**. ‘Accepters’ were taking initial steps to prepare for IC, with a focus on adopting a more ‘business-like’ outlook. Some had employed business consultants or marketing professionals to help in this transformation. Adapters were more proactive and more advanced in their preparations, with some having made adjustments to staffing arrangements, enacted marketing strategies, and invested in training of leadership and administrative staff.

- For a smaller number of providers, IC was viewed as a **natural extension of their existing business** model and, in this regard, it was embraced. Mostly, profit driven, the focus for these providers was on using the deregulated market to grow their business. In preparation, they had begun upgrading their marketing and communications, focusing on their brand offering and differentiating within the market, and training staff to ensure that they could meet anticipated increases in consumer demand.

- Preparation for IC was slower amongst providers who were **change averse**, and tended to lack the adaptability and business acumen of other providers. This cohort of providers was unsure of what action they should be taking. Similar to those whose implementation of CDC was less advanced, they tended to be smaller and not-for-profit organisations, and those in rural/remote locations.
2.1.3.3 There is appetite for information and support to assist in preparations

The majority of providers had already engaged with information from the Government regarding IC, but had sought out more detailed information and support to assist in their transition to IC. There was limited awareness of the Department’s webinars on the issue.

Specific information and support needs were identified as follows:

- **Primarily, targeted, detailed information** about the regulations, processes and likely impacts of IC;
- **Advice and instruction for preparation**, including additional training and industry briefings or seminars targeting NFPs;
- **Resources** for use when educating staff and clients about the reform;
- **Targeted information** for providers servicing special interest groups;
- Particularly for smaller, not-for-profit providers, there was a desire for **financial support** to ease the transition into a competitive market place.

*See Support needs and preferences for more detail.*
2.1.4 Consumers’ response to IC

2.1.4.1 The concept of IC holds strong appeal for consumers

There appeared to be low awareness of IC amongst consumers in the study. However, when broadly informed of the nature of IC (during the research process), perceptions of the reform were positive. Similar to their responses to CDC, consumers associated the reform with a range of benefits, reflective of the concept of extending consumer choice and control, including:

- Greater **autonomy** for consumers in allowing individuals to control the type and nature of care they receive;
- Greater **flexibility** for consumers, particularly as a result of the portability of funding;
- Greater **supply** of care and reduced waiting times;
- Better **quality of service** and value for money as a result of increased competition;
- Access to a greater **range of services**;
- Access to **more affordable** services.

*See 64 for more detail.*

2.1.4.2 Carers show greatest inclination to consider change under IC

In a very similar way to CDC, while the benefits of IC were quickly identified, its relevance and applicability to participants’ own situations were more often recognised amongst carers. Carers were more likely to be critical of their current service, and more interested in ‘shopping around’ for a better option. By contrast, while consumers were also positive about the reform, only one in five indicated they would be likely to change providers once they had the choice. For the most part, this was reflective of a change averse predisposition, reinforced by questions around the need for and efficacy of change and perceived challenges in the process of transitioning to another provider. The research also highlighted the influence of loyalty to the existing provider, with many consumers placing a high value on consistency of care and ongoing relationships with care workers, in some cases, over and above service quality.

*See Drivers and barriers to changing providers for more detail.*
2.2 Observations

The research highlights the following points for further consideration by the Department.

2.2.1 Supporting providers to transition to IC

The research suggests most providers are taking steps to prepare for the introduction of IC next year, and feel confident they will be prepared. Nonetheless, there remains a number of generally smaller, not-for-profit providers amongst whom there is apprehension about both the potential impacts of the reform and their operational preparedness. It could be concluded therefore that while larger and private providers should not be excluded during the Government’s next steps, the focus should be on not-for-profits. To this end, the research suggests there may be benefit in considering the following:

- **A continued focus on raising awareness, allaying concerns**: Continued efforts by the Department to raise awareness of the intricacies of IC are likely to help correct speculation currently surrounding the reform evident amongst some providers. In addition to communicating detail of regulations and processes associated with the reform, consideration could be given to recognising the concerns held by not-for-profits, and addressing these directly.

- **Promoting a ‘single-source’**: The appetite for detailed information on IC suggests there may be benefit in providing a single web-based source of detailed information on the topic, and positioning this as a ‘one stop shop’. Limited awareness of the detailed information on the Department of Health website highlights the need to promote any such source in all communications on the issue. Given the frequency of engagement with the My Aged Care portal, this could be considered as a potential access point. The research suggests providers’ content and resource needs include detailed information regarding all aspects of the reform, targeted fact-sheets, webinars, and forums/ live chat and FAQs.

- **Educating and guiding not-for-profits**: Smaller not-for-profit organisations continue to lag behind larger and for profit providers, and may benefit from more hands-on assistance in making the required adjustments to their operations and outlook. Among this cohort, the research points to the appeal of face-to-face advice and guidance, in the form of forums and workshops, offering the opportunity to ask questions and consult experts.

- **Communicating the changes to consumers**: Providers were uncertain of their role in communicating the changes to current and new clients, suggesting that there would be benefit in clarifying expectations to this end. Some providers further identified a need for standardised material about the changes to distribute to their clients; thereby ensuring consumers were receiving accurate and unbiased information.

2.2.2 Supporting consumers’ transition to IC

The research indicates that consumers are likely to view the IC reform as a positive development in aged care, resulting in a more flexible and better quality service with strong benefits for consumers and carers alike. In the first instance, the reform is likely to have greatest resonance for carers of higher needs consumers, who may be motivated to consider changing providers in an effort to find a home care provider that better meets their needs and expectations. By contrast, lower needs consumers, and those
in older age cohorts appear less likely to change existing arrangements. In this context, the research indicates the following for consideration:

- **Raising awareness while highlighting that change is not required**: Overall, a lack of awareness of the IC reform amongst consumers suggests there may be a need both to raise the profile of the reform (awareness) and inform consumers and carers about what it means for them (knowledge). Given the potential for consumers to be targeted directly by individual providers, consumers may need to be informed they are not required to make any change when the reform is introduced.

- **Providing content and resources**: Concern articulated around the process of changing provider points to a need to guide those who decide that they are interested in exploring other options through this process. There may be benefit in identifying the types of issues consumers should consider when assessing services (for example: Are they accredited? Do they conduct police checks of field staff? What are their administration/ case management fees? etc.) Consideration could be given to providing a checklist or template that enables consumers and carers to compare providers in a consistent way.

- **Promotion of online information**: Given low awareness of IC amongst consumers, there is a potential need for a central online source of information for consumers through for example, My Aged Care (noting, however, that My Aged Care appears to record low awareness among consumers and carers).

- **Providing offline sources**: While online information is likely to play a vital role in communicating detail of the reform, particularly for carers, it is evident from the research that not all consumers are comfortable navigating online environments. This highlights the importance of also providing access to ‘offline’ sources. Further, the potential for the process of changing providers to be fairly involved points to a role for face-to-face advice and instruction, particularly for older consumers and those with high level needs who have little informal support. Consideration could be given to encouraging healthcare professionals to act as a conduit. Peak bodies and advocates are also trusted sources and could assist in promoting the change through their communications and activities.

- **Addressing perceived complexity**: Concern about potential complexity in the process of transition appears to act as a barrier to change. Many consumers anticipate that changing providers will be complicated and time-consuming. This highlights the importance of assuring consumers the process will be simple.
3. Methodology

The research comprised qualitative research with home care providers and consumers across Australia.

3.1 Interview scope and structure

Qualitative in-depth interviews (IDIs) were undertaken with a total of n=62 consumers and/or carers and n=52 home care service providers, structured as follows:

- N=45 telephone IDIs with consumers currently in receipt of a home care package;
- N=14 telephone IDIs with carers of consumers currently in receipt of a home care package.
- N=3 in-home immersions, during which face-to-face IDIs were conducted with a consumer and/or their carer;
- N=43 telephone IDIs with home-care providers; and
- Three case studies conducted at larger sized home care providers. For each case study, a series of on-site face-to-face IDIs (n=9) were conducted with management staff, staff in administrative, operational and customer-facing roles.

All components of the research were conducted from Wednesday 29th June to Thursday 4th August, 2016.

All interviews were between 45-60 minutes in duration.

3.2 Location

For both target audiences, IDIs were conducted in urban, regional and remote areas across Australia. For further detail please refer Table 1, Table 2 and Table 3 for the breakdown of consumers and providers below.

3.3 Recruitment

Recruitment for this research was undertaken by Q&A Research as follows.

- **Consumers/carers:** A mixed mode of recruitment was used to recruit consumers and carers. First, an online pre-screener was sent to targeted panellists on Q&A’s database\(^1\). Panellists were initially targeted by age and living arrangements. These participants were then called and screened over the phone in a supervised central location office, using the approved recruitment screener. To target a number of the more difficult specifications (e.g. Aboriginal and Torres Strait Islander or LGBTI consumers), participants were sourced through home care service providers and screened in full over the phone.

- **Providers:** Providers were recruited from a database provided by the Department. All participants were screened over the phone in a supervised central location office, using the approved provider recruitment screener.

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\(^1\) Q&A’s database comprises Australian residents and is built over 10+ years of cold-calling, using random digit dialling to find new panellists.
For recruitment of both audiences, a minimum of 10% of the recruitment calls were validated by a supervisor to ensure they were correctly administered.

### 3.4 Incentives

As thanks for participating in the research, consumers were offered a financial payment of $80, while providers were offered $100.

### 3.5 Consumers and carers

In-depth interviews were conducted with n=47 consumers currently in receipt of a home care package and n=15 carers of consumers currently in receipt of a home care package.

The majority of IDIs (n=45 consumers and n=14 carers) were conducted by telephone with participants based in urban, regional and rural locations across Australia. In addition, three home visits were conducted in Sydney, Brisbane and Perth. For each home visit, a researcher conducted face-to-face IDIs with consumers and/or their carer.

The break-down of interviews appears below.

**Consumers (n=47)**

Consumer participants were recruited to represent a range of consumers in terms of gender, age, service level, provider type, and location. In total, this included:

- n= 32 females, and n=15 males;
- n=30 consumers aged < 75 years, and n=17 aged 75+ years;
- n=38 consumers receiving Level 1-2 home care packages, and n=6 receiving Level 3-4 packages, with n=3 uncertain about their package level;
- n=20 receiving home care from a government provider, n=14 receiving home care from a not-for-profit provider, n=7 receiving home care from a for-profit provider, and n=6 receiving home care from a community group.
- n=25 residing in urban areas, n=18 residing in regional areas, and n= 4 residing in rural locations;
- n=6 participants from culturally and linguistically diverse backgrounds (CALD), n=1 Aboriginal and Torres Strait Islander, and n=1 Lesbian Gay Bi-sexual Transsexual and Intersex (LGBTI) participant.

A more detailed break-down of consumer participants appears overleaf.

**Table 1: Breakdown of consumers interviewed**

<table>
<thead>
<tr>
<th>IDI</th>
<th>Gender (M/F)</th>
<th>Age (Younger &lt;75/Older 75+)</th>
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<th>Area</th>
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Carers of Consumers (n=15)

Carers were recruited on the basis of the service level and provider type of the person they were caring for, in addition to demographics and location. They included:

- n=12 females, n=3 males;
- Those caring for n=4 consumers aged <75 years and n=11 aged 75+ years;
- n=11 residing in urban locations, n=2 residing in regional locations, n=2 residing in rural locations;
- n=8 caring for consumers receiving Level 1-2 home care packages and n=7 caring for consumers receiving Level 3-4 packages;
- n=7 caring for consumers receiving home care from a not-for-profit provider, n=6 caring for consumers receiving home care from a government body, and n=2 receiving home care caring for consumers receiving home care from a for profit provider;
- There were n=5 CALD individuals and n=3 Aboriginal and Torres Strait Islanders included.

A more detailed break-down of carer participants appears in the table below.

Table 2: Breakdown of consumers and their carers interviewed

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<th>Area</th>
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3.6 Home care providers

A series of n=52 IDIs were conducted with home care providers. Providers were recruited to ensure representation of a mix of profit, not for profit and government organisations of different sizes, based in
urban, regional, rural and remote locations across Australia. The interviews were also conducted with a range of staff, including senior leadership, management and field workers.

The majority of these IDIs (n=43) were conducted over the phone with home care providers. Along with these, three case studies were conducted with service providers in Sydney, Brisbane and Perth. For each case study, a researcher spent half a day at the organisation, and conducted in-depth interviews with multiple staff, including: Leadership team, Management & Operations and Consumer facing staff. Each case study involved three interviews, nine in total.

The breakdown of providers participating in the study appears below.

Table 3: Breakdown of providers interviewed

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\(^2 N=37\) participants self-identified as ‘not-for-profit’ organisations, while n=4 participants self-identified as ‘community’ organisations. Given the similarities in the characteristics of these organisations, and the small number of community organisations participating in the study, they have been grouped together for the purposes of reporting.
3.7 Research process

All in-depth interviews, case studies and in-home immersion sessions were moderated by experienced consultants from TNS.

The discussion guides for all qualitative research, specifying the types of questions to be asked, were developed and submitted to the Department for review, comment and approval prior to their use.

A pro-forma questionnaire was also administered to all providers and consumer post-interview.

All research instruments are appended.
4. Implementation of CDC

There was general endorsement of the philosophy and intent of the CDC model, and the majority of service providers appear to be accepting, or adapting to, the delivery of home care packages on a CDC basis. Overall, private and larger providers are most advanced in embedding the CDC model, while smaller not-for-profit providers have found the process more challenging.

4.1 Provider response to CDC

Service providers were consulted from a range of locations (regional, rural and urban, across all states and territories), organisation sizes (small, medium, and large) and types (non-profit/ community, government, and for-profit), as well as special interest groups (including CALD, Aboriginal and Torres Strait Islander and LGBTI). Individual participants also represented a range of levels within the organisation, including leadership, operational staff (including assessment staff and nurses), managers and supervisors, and field workers.

Across the study, there was general support for the underlying philosophy behind CDC. A number of providers stated that the idea of the consumer making more autonomous decisions about their own care was in line with their own beliefs about what consumers and their family members wanted. Some providers said that their organisation’s outlook had always been in line with this approach, with CDC resulting in administrative and funding changes, rather than differences in their philosophy.

Overall, the reform was associated with a range of benefits for consumers and providers alike.

Perceived benefits for consumers

- **Greater flexibility, broader service offering** Positive qualities such as flexibility, and increased consumer empowerment were brought up, particularly by participants at Leadership level, who believed that these qualities should be encouraged by the sector. It was asserted that CDC allowed consumers the opportunity to be more selective about the kind of care they received, including the (incorrect) belief that the model allowed funding for equipment (wheelchairs, home modifications) not provided for under the present system. It was expected that this flexibility was/would be welcomed by consumers.

  "I love the CDC, it's so exciting. It's wonderful because it gives [consumers] the opportunity to do what they want and makes them happy."

  (Home care provider, NFP, medium, urban, QLD)

- **Consumer empowerment, more tailored service**: the provision of greater consumer autonomy through CDC was thought to have allowed consumers an opportunity for choice which had not previously existed. The result was to enable consumers to select services most suited to their individual needs and circumstances. A small number of participants suggested that in doing so CDC contributed to a sense of “re-ablement” among their client base, with consumers able to feel independent and autonomous for longer than they had under the previous system.

  "The Consumer Directed Care is about transparency for the service user or the client and [it’s about] arming them [the client] with the relevant information they require so that they’re empowered to make decisions"
Perceived benefits for providers and the home care sector

- **More ethical approach, better quality service**: The focus on transparency in delivering home care packages on a CDC basis was considered a more ethical, and more progressive approach to service provision. Moreover, in enabling consumers to be more attuned to the value of the service they were receiving, CDC was associated with improvements in service quality.

  “The changes have really, really benefited the clients themselves. The transparency of everything and being aware of what is available to them, rather than being provided hours in regards to care workers... That whole discussion about the budget – well this is what I’d like, and this is what I’d like to incorporate in that as well. It’s great”

  *(Leadership, NFP, medium, regional, SA)*

- **More skilled staff, greater job satisfaction**: Providers who had implemented CDC early had often invested in the training of field staff to accommodate consumer demand for more varied services. Some felt that this had provided greater job satisfaction for field staff, and facilitated closer relationships with their clients. This was predicted to increase over time, as familiarity with the process increased.

  “I had a client who was in hospital and in the old system she would’ve gone on hold and I would never have seen her again but with the CDC I was able to go and visit her. She had no family but for six months I saw her twice a week in hospital and became her only visitor so it is really lovely. It really improved her quality of life”

  *(Field worker, NFP, medium, urban, QLD)*

- **Extending service suite and reinforcing choice oriented focus**: Some providers felt that in allowing consumers greater choice, CDC had provided opportunities to extend their service offering. This was most notable amongst providers who had previously felt restricted, and whose business model aligned with the CDC ethos. These providers had introduced new services and products and were actively marketing a full service suite.

- **Preparation for IC**: Some of the providers who were knowledgeable about the upcoming IC changes asserted that the CDC was a positive move as it laid the groundwork for these, allowing providers who had not previously prioritised flexibility or choice to adopt a more consumer focussed business model. This was considered an important initial step towards the delivery of home care under IC.

### 4.2 How is CDC being implemented?

Following on from the mostly positive perceptions of the CDC model observed amongst providers, the vast majority were open and willing to deliver home care packages on a CDC basis. Nonetheless, there were differences in their commitment to implementation, reported readiness for the change, and uptake of different aspects of the CDC model.

These differences appeared to reflect a variety of internal (belief driven) and external (situational/environmental) factors, which influenced both the provider’s inner resolve, commitment and responsiveness to change, and the practical and logistical challenges that needed to be overcome in the process. For instance:
The **outlook, values, and resilience** of individual providers tended to shape their philosophical alignment with the principles of increasing consumer choice and their responsiveness and adaptability to the CDC model;

- The **size, resources and financial situation** of the organisation either enabled or impeded their capacity and capability to change;

- The **culture and mission** of the organisation and its existing approach to care commonly determined the extent of change required to use the CDC model;

- The **skills and expertise of staff**, and their attitudes to adjusting to a more commercial outlook either facilitated or delayed the process of implementation.

- The profile and needs of the **client base** impacted the effort required to explain and promote the delivery of home care packages on a CDC basis; and

- **Environmental factors**, in particular the remoteness of the organisation and proximity to other providers had a considerable bearing on the ease or difficulty of offering flexibility.

These factors combined in different ways to shape the approach that individual organisations had taken to implementing the CDC model. Broadly, they could be grouped into four categories according to their commitment to delivering home care package on a CDC basis:

1. **Embracers**: Providers who had embraced the philosophy and ethos of CDC, **embedding** the model into their organisational systems and processes;
2. **Adapters**: Providers who were taking specific action to increase flexibility and enable their clients to acquire greater control of the services they receive;

3. **Accepters**: Providers who were accepting of the need to transition to the CDC model, and had begun to change their processes and service to some extent;

4. **Resisters**: Those who were resistant to change and had taken few steps to use the CDC model within the organisation.

These segments appeared to be somewhat sequential, with some providers progressing from resisting the CDC model through to accepting, adapting and embracing the reform. The research indicated that experience with the CDC model brings about more favourable attitudes to the reform – with providers who had been delivering home care packages on a CDC basis for longer periods more likely to note positive impacts for their consumers, and sometimes their business. Those providers who had begun the process of implementation early (including before the formal introduction of CDC), for example, appeared to have largely overcome any initial hurdles, and were now successfully using the CDC model. Despite reporting some internal resistance to the reform initially, these providers were now appreciative of the value of the CDC model to consumers, and to the sector more broadly, and few negative outcomes to their current operations were recounted.

Noting the limitations of qualitative research in measuring incidence, it appeared that at the time of fieldwork, most providers in this study were either ‘accepting’ or ‘adapting’ to using the CDC model, with a smaller number ‘embracing’ or ‘resisting’ the reform, as illustrated in Figure 4 below.
The characteristics and outlook of each segment are described in more detail overleaf.

### 4.2.1 Embracers

"As an organisation we develop products for them that are really innovative, things to do with IT, something we call 'Value Pack' which if you sign up for this you get x, so there are more hours this way. Even within the CDC model we give them even more choice and products that meet their needs more. If you are more into IT, there is a product there on the IPad, which helps those people that are home bound. We have another one called the social pack which has a whole lot of organised trips, outings and things like that. There is something called the gardening pack for people who want more gardening than the ordinary person. We tailor packs so they can choose beyond the normal services that you would get from any ordinary organisation, beyond personal care, domestic care. And that's the true choice that you give them. So for me, CDC works well with the type of organisation we are. It actually supports the direction that we want to go."

*(Provider, Manager, for profit, large, urban, VIC)*

**OUTLOOK:** ‘Embracers’ were most positive about the CDC model, associating it with **transparency, flexibility, and increased consumer empowerment.** These qualities were generally considered to be aspirational and progressive, signifying a positive course for home care provision in Australia.

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3 Prevalence is based on the findings of qualitative research with a non-representative sample of n=52 in-depth interviews with providers. It is not an exact measurement and should not be construed as indicative of population proportions.
‘Embracers’ were often of the view that delivering home care packages on a CDC basis was better both for the consumer and their organisation, and instilled these values in their staff.

For many of these businesses, CDC aligned closely with their existing culture and business model, whereby consumers had a high degree of choice. As a result, they generally felt confident about the CDC model and their ability to navigate the changes, and were also likely to report that they were ready to implement the IC changes in February next year.

“We’ve always said that the client is the owner and driver of the package. We were doing CDC-like things before it was even thought of. In preparation for the CDCs, we engaged the client and talked to them individually, we gave them and their families a hand out with information, we had a training campaign for all staff which had compulsory attendance.”

(Leadership, NFP, medium, urban, TAS)

PROFILE: ‘Embracers’ generally showed an adaptive attitude and a sense that being organised was essential in order to succeed in implementation. Two provider cohorts generally displayed ‘embracer’ attitudes and behaviours:

- **Private providers**: who naturally adopted the CDC model in both philosophy and practice, and were enthusiastic about the opportunity it afforded their business. The business mindset of these organisations had made the uptake of a user-pays system to be less of a philosophical shift than it had been for not-for-profit organisations. Private organisations reported positive attitudes towards the CDC model, as well as commitment to its principles. Viewing the provision of home care in this way as a marketable point of difference for their business, these providers were often actively “selling” its benefits to current and prospective clients.

- **Early implementers**: A small number of not-for-profit providers had implemented the CDC model early or undertaken a gradual transition. Generally adaptable and responsive by nature, leadership within these organisations recognised the importance of adapting their operations to the CDC model sooner rather than later. They therefore reported high levels of autonomy and control when delivering home care packages on a CDC basis. Their approach had been to take steps towards the CDC model gradually and methodically, allowing time to train staff, trial new procedures, and explain the changes to clients. The process of implementation was therefore smoother, largely avoiding significant disruption to business operations or resistance from staff, and resulting in a change in service that was more comprehensible to consumers. Many of these providers had moved from general acceptance of the CDC model when it was first announced, to actively supporting the reform as their experience with delivering home care on a CDC basis increased. Some reported a direct, positive change in the variety and quality of care they were able to provide.

“Back in 2011 we applied for the pilot CDC program and we have been delivering CDCs since then ... About 14 months out [from July 2015] we put a plan in place to transfer everyone over onto CDCs, so they had their statement, documents, care plans... We were lucky that we were ahead: other businesses didn’t make that change and we were a little bit astounded.”

(Leadership, NFP, medium, regional/rural/remote, NT, Aboriginal and Torres Strait Islander)

“We started preparing for CDCs 18 months before they came in. It was important that we achieved a culture shift and change because it’s a different way of doing things.”

(Leadership, NFP, medium, urban, TAS)
"We were monitoring the discussion [proposed changes] since 2012. We felt we were already delivering a consumer centric approach and we took part in a pilot program and early preparation to be ready for the changes. We had a few early hiccups but our clients really like it."

(Manager, for profit, urban, QLD)

**ACTION:** These providers were the most advanced in terms of their transition to CDC, to the extent that the CDC model was now firmly embedded into their processes and systems. They were now actively promoting a full service suite, some through marketing and communications. In order to deliver this, some had brought on private contractors, casual staff, or additional in-home carers in response to consumer need.

### 4.2.2 Adapters

"We reviewed our whole practices on how we were delivering our services and how we could change to ensure that the consumers were provided with the information so that they could make choices and were supported to do that. We of course had to introduce new systems to capture the reporting requirements of CDC and to enable us to give people budgets. Our organisation has never charged anything for our services so just talking about money was a big deal for us and our clients. So in order to ensure we were doing that with as much as support as possible we decided to employ a project officer. There is another program in the North of our state which is looked after by a person similar to myself and we linked in with Melbourne, and we all worked as a team to decide how we were going to do that. To ensure we could capture all the information and do budgets, we bought an IT package. This is just a snap shot of the mechanics that went in. We then had to talk to our clients and our staff on what it would mean for them, and how this could be a positive change for them."

(Team Leader, NFP, medium, urban, TAS)

**OUTLOOK:** For the ‘Adapter’ segment, the implementation of the CDC model required more of a change in their organisational culture and operations. However, ‘Adapters’ were generally pragmatic about this, recognising the benefits of adopting a more commercial mindset as an essential first step towards operating in the changing market place. Some were also enthusiastic about the opportunity to provide more services, especially if they had felt restricted under the previous system. Unlike ‘Resisters’ and ‘Accepters’, ‘Adapters’ accepted that a consequence of delivering home care packages on a CDC basis would be the loss of control over consumers’ service decisions, and it was felt that this was in line with what consumers wanted. They understood that consumers now had greater control over their packages, and could therefore be selective about their service, and were committed to providing a service that would allow this. Not all organisations had accepted this willingly, but a number felt the changes would be positive in the long term.

**PROFILE:** Generally medium - larger not-for-profit/ government providers and those whose existing culture aligned with CDC

**ACTION:** As well as updating their systems and processes, these providers took an active role in educating their clients about the changes, and about possible additional services, through scheduled in-home visits and the distribution of written material. They also began arrangements for extended brokerage, so that clients could now choose from a wide range of possible services.
"We had to change the whole way we speak to clients – explaining subsidies, client contributions, fees associated with the organisation, fees for individual services. Making clients aware of what the services were and how they utilise their package funds."

(Leadership, NFP, medium, regional, SA)

4.2.3 Accepters

"Clients are not interested in a different philosophy, they want service and that is what we provide. I understand we should be providing under the new philosophy which we are trying to implement, but it will take time to provide education and full understanding of among people, because we are the only agency they can get service from. They can’t shop around, they don’t understand how they could activate anything else and unfortunately there isn’t any other agency to activate from, so basically we are trying to do our best and they have to try their best to understand where we are coming from. We are trying to make it as plain as possible and are trying to improve our information delivery and I understand that by February next year we need to be fully operational under the CDC."

(Manager, Government, medium, regional, QLD)

OUTLOOK: Accepters recognised the need to embed the CDC model. Their existing business model was typically less philosophically aligned with the notion of consumer choice, but they were motivated to take steps to change this.

PROFILE: Generally, smaller organisations and medium not-for-profits, with greater resources and more proactive leaders than ‘Resisters’.

ACTION: Accepters were typically in the early stages of adopting the CDC model. Some had begun to offer additional specific services, such as gardening or social visits, to allow the consumer greater choice. In order to facilitate greater flexibility, some had implemented new brokerage agreements to allow consumers a wider range of options and a greater sense of control over their services.

However, providers who had implemented these changes still saw themselves as caretakers for their clients and were unwilling to give up their control over consumers’ packages. They did not feel the need to educate consumers fully about the CDC model and did not fully recognise their clients’ ownership of their service needs.

4.2.4 Resisters

'We can’t keep up with all the changes. There’s too much happening all the time – your policy and procedure have to change every five minutes because the wording changes every 5 minutes ... and every time they change it we have to go back and change all our policies. And you change all the wording and now I’ve given up because in February it will all change again.’

(Coordinator, NFP, medium, rural, SA)

OUTLOOK: Resisters were least committed to the CDC model. Although many of these providers were positive about the notion of increasing consumer choice generally, many had concerns about the impact that a ‘user-pay’ model might have – both on their organisation and the wider industry.
This segment displayed broad **resistance to change**, fuelled by a sense of being somewhat overwhelmed with the many changes to the sector brought in over the past few years (including those unrelated to CDC). Their uptake also appeared to be impeded by a range of practical barriers to making required operational, technical and administrative changes linked to their size and resources. Additional challenges were encountered amongst those in remote locations or servicing a low socioeconomic, CALD or Indigenous client base, reflecting a need to overcome language, cultural, or sensory challenges in explaining the changes to their clients.

**PROFILE**: Generally, smaller not-for-profit organisations together with those organisations which serviced special interest groups, or those in rural and remote locations.

**ACTION**: ‘Resisters’ had undertaken a minimum of implementation – with a focus on administrative compliance. Some had attempted to present alternative service options, by allowing clients to choose between a limited menu of packaged services (for example, ‘Shopping, Cleaning and Social’ or ‘Gardening, Shopping and Showering’). However, there was little attempt amongst these providers to broaden their service suite or implement brokerage agreements as a means of providing additional options.

### 4.3 Challenges in implementation

The majority of providers appeared to be open and willing to transition to the CDC model, and were motivated to ensure that they met the mandated requirements. The challenges faced through transitioning to CDC, therefore, largely appeared to stem not from a reluctance to comply, but instead from issues associated with initial implementation. Again, these tended to be most problematic for smaller and not-for-profit organisations, reflecting the greater extent of operational and cultural change required within these organisations. Overall, most of the **challenges identified by providers more strongly related to the initial hurdle of implementation, and resistance to change, and generally diminished over time as familiarity with processes increased.**

Providers’ views of the most challenging aspects of transitioning to the CDC model are described below.

#### 4.3.1 Challenges in implementing CDC: Administrative

Around three-quarters of the providers in the research reported that they had experienced administrative challenges brought about by the implementation of CDC, with around half of these providers claiming that they were ‘less than I expected’ and half claiming that they were ‘more than I expected’

The reform involved change to the processes and roles within their organisation, and these providers asserted that the workload of the administrative staff had increased, particularly those whose job involved initial assessments for new clients (most often the case manager).

> “The nurses experienced some issues, huge amounts of paperwork in implementing the CDC, it’s a lot of work and they’re pretty overwhelmed. They have a lot to do when they sign up clients for the package and once a month they have to follow through”

Following the qualitative interview, providers were asked to complete a number of survey questions: This finding refers to proportional response to the question: *Thinking about any administrative issues you have experienced to date relating to the implementation of CDC, would you say they are: More than you expected; About what you expected; Less than expected; No issues experienced*
Specific administrative challenges included:

- **Budgeting**: Around three-quarters of providers highlighted challenges associated with adapting to the new system of **budgeting and preparing statements** for clients. This was voiced in regard to setting up the budgeting approach and designing templates initially, as well as through the process of developing and updating budgets for clients on an ongoing basis. Challenges associated with budgeting were seen to reflect increased pressure on workloads and a **perceived lack of knowledge or skills** in this area: staff whose job now included writing budgets for clients were often qualified nurses who had no background in budgeting.

  "We devised a budgeting tool using Excel and we purchased electronic tablets so when we visited the clients we immediately put in the contribution and looked at what they would like to achieve. It meant we could negotiate from the very beginning – 'If you have six of those, you won’t afford it, so why don’t you have four of those and two of these’”

  (Leadership, NFP, medium, urban, TAS)

  "We purchased a template from a solicitors’ group that was doing that sort of thing – for a budget document that showed us what could be allowed within budgets ... we looked at that”

  (Coordinator, NFP, small, rural/remote, QLD)

  "Budgeting was one thing which the coordinators hated... They're nurses and their initial reaction was, 'We're not accountants, we shouldn't have to do this’ so that was a big hurdle for us.”

  (Leadership, NFP, large, urban, VIC)

  "We had to sit down and work out what real costs were. ... we had to look at our own unit costs and organisation costs and we had to find out what sort of costs could be covered within the budget... neither of us are accountants so it was a bit tricky to go down that path”

  (Coordinator, NFP, small, rural/remote, QLD)

- **Setting fees**: Around half of the providers in the study reported experiencing some confusion in setting **appropriate fees** for the service they provided. Many of the non-profit organisations in the study had not set service or administrative fees previously and, as a result, appeared to feel uncertain about an appropriate amount to charge. There was particular confusion around:

  - **Determining administrative fees**: Some providers had used “unspent funds” from additional packages under the previous system to cover some of their administrative and operational costs. These “unspent funds” came from those clients who did not use the entirety of their package, and had been absorbed by the business in the previous system. As this was not possible under the CDC model, providers were uncertain as to how administrative fees should be set.

  - **Price-competitiveness**: Non-profit providers were also mindful of the need to be price-competitive with for-profit organisations under the forthcoming IC reform. They had little awareness of what other organisations were charging which was said to make it difficult to determine appropriate price points.
“I know it’s really hard but I’d like the Government to tell us how much we can charge for the admin fee. I’d like to know if we’re overcharging and undercharging. We’ve been told we’re low in our hourly rate and a bit higher in the admin/management fee. It’s really difficult because we don’t want to get it wrong”

(Leadership, NFP, medium, regional/rural/remote, NT, Aboriginal and Torres Strait Islander)

- **Determining service coverage**: A small number of providers claimed to be challenged by the need to ensure high knowledge levels regarding CDC among all levels staff. It was asserted that field workers, in particular, showed confusion regarding what exactly was covered by CDC, and what was outside of clients' budgets. This seemed to apply to additional services, as well as when the client needed to purchase extra care through the same service provider. Interviews with field workers themselves revealed that areas of confusion remained.

- **Initial assessment and preparing “care plans”** were also identified as an administrative challenge by a minority of providers. Assessment often appeared to involve an in-person interview conducted by the assessor in the client’s home, during which a number of issues pertaining to the care needs of the consumer were discussed. This was then used to develop the home care agreement. This could be a time-consuming process, though there was acknowledgement that it was likely to be done more efficiently in the future as staff adapted to new processes.

### 4.3.2 Challenges in implementing CDC: Operational

Around three-quarters of the providers in the study identified operational challenges associated with the implementation of the CDC, with around six in ten of these indicating that these were ‘about what I expected’ and the remaining indicating that they were ‘more than I expected’. Specific operational challenges were cited as follows:

- **Training**: For many providers, the major operational challenge in implementation, particularly in larger organisations, was thought to have come in training all levels of staff in the delivery of home care packages under the CDC model. This was mentioned by around three-quarters of providers in the study.

  Overall, training of administrative and managerial staff was seen as a challenge primarily associated with initial implementation only. Several providers pointed to the benefits of Government and industry seminars and presentations in educating staff in using the CDC model (see Challenges in implementation).

  Many providers felt that training field workers had been more challenging. However, this was largely due to the logistical difficulty of convening training seminars for the many field workers who worked on a casual or part-time basis, and tended to visit the central office only rarely, if at all. Some

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5 Based on response to survey question: Thinking about any operational issues you have experienced to date relating to the implementation of CDC, would you say they are: More than you expected; About what you expected; Less than expected; No issues experienced.
provers asserted that, given their frequent contact with clients, there was a risk that field workers could be spreading erroneous information or appear ignorant of important changes.

For most providers, a more ongoing challenge was seen to arise in the need to “upskill” or “multi-skill” staff in order to ensure they were able to meet the new demands of flexibility. Cleaning staff, for example, often had no qualifications or experience in aged care. Nonetheless, many providers said that these issues were likely to resolve as CDC came to be seen as “the way we do things” and field workers were orientated within the new system.

- Coordinating a flexible service: One of the unexpected changes brought in with CDC was a new need for flexibility, where consumers were now able to change their care needs as required, and could request certain field workers with whom they had formed a relationship or to whom they had taken a liking. This led to a need for increased flexibility amongst field workers, which some providers found challenging to coordinate. Providers’ response to these demands appeared to be very closely tied to the type of organisation: larger organisations tended to continue to separate cleaners and carers, while smaller organisations felt pressure to meet the requests of their clients in asking for the same field worker for every service.

- Meeting service requirements: Similarly, some providers reported feeling challenged by the need to meet clients’ increased service requirements. Whereas under the previous system, providers had allocated arrival times for home care based on available staff, the client was now able to choose the arrival time. This could be difficult when a number of consumers requested carers or cleaners at the same time, leading to a need to put on additional staff, though without being able to provide the hours to sustain them. For example, while leadership and administrative staff understood that clients preferred to shower first thing in the morning, they had only a limited number of staff members available to provide showers, and felt unable to meet demand if several clients requested showering at the same time. Larger organisations did not comment on this, presumably because they had more staff and were consequently better positioned to accommodate clients’ needs.

### 4.3.3 Challenges in implementing CDC: Staffing

Around half the providers in the study claimed to have experienced issues relating to staffing in the implementation of CDC. Many of the reported challenges in this regard were tied to the operational and administrative issues discussed above, and, amongst those who were more advanced in the implementation of CDC, were felt to have eased once the transition phase was complete. Those providers who had been slower in their transition to the CDC model also predicted that staffing related issues would be likely to dissipate as familiarity with the process increased.

Specific issues were identified as follows:

- **Stretched resources:** The initial administrative and logistical challenges outlined above were said to contribute to increased workload, particularly among administrative and nursing staff. Many providers claimed that the process of understanding the CDC and the ways in which it would affect staff had been more time consuming than they had expected.

- **Allied to the above, staff in leadership positions reported having to manage negative responses amongst case managers at this change to their role and workload. Similarly, some providers reported that they had encountered resistance from field workers in relation to the broadening of
their responsibilities to accommodate the flexibility required to deliver home care packages on a CDC basis. Some personal carers, for example, did not see their role as including cleaning, and resented that this was now required. It was asserted, however, that in the longer term, staff would feel a greater sense of job satisfaction through their involvement in a broader and more holistic approach to care.

4.3.4 Challenges in implementing CDC: Engaging with consumers

Around three-quarters of the providers in the study asserted that engaging with consumers about the CDC had sometimes been challenging.

- Some observed that older clients in particular were slower to understand the personal implications of CDC, and tended to be generally change averse. By contrast, however, some providers felt that it had been easier to engage consumers who were younger, or who had high levels of informal care such as family members who were actively involved in their care. Providers explained that these consumers were enthusiastic about the idea of having new options, of being able to choose the services they could obtain, and appreciated the autonomy over and ownership of their package.

- Some providers asserted that placing control in the hands of the consumer resulted in a change in the perspective of some clients, which meant that they now had greater expectations around the care they received and were motivated to request additional services. Conversely, around a quarter of providers in the study claimed that a minority of consumers had received a reduction in their level of subsidised care, as they had been previously using the “unspent funds” from other clients’ packages to accommodate those whose needs could not be covered by their own package.

“We spent a lot of time explaining statements, a lot of time explaining the summaries, a lot of time explaining that the subsidy doesn’t belong to the client. It’s provided by the government for their use. And elderly people, statements. When they get their bank statements a lot of them don’t really understand them completely line by line, and it’s the same sort of thing with the CDC statements. We’re still providing that clarification. We keep sending templates and newsletters out to our clients, saying this is what you’re going to be sent…”

(Leadership, NFP, medium, regional, SA)

“I have found 9 times out of 10 when I call people they have no idea who I am and quite often they just hang up on me. I have to try several times just to get them to talk to me and then they understand. I will go through the whole process with them, remind them, and tell them how it can help them and things we might be able to do. If someone just approves them for a package and says, okay now you have a package go out and get someone to deliver it for you, I don’t know if they will be able to do that very well.”

(Team Leader, NFP, medium, urban, TAS)

4.3.5 Specific challenges for special interest groups

The research suggested that providers servicing the Indigenous and CALD communities had faced specific challenges in implementing the CDC model.

- Administrative issues: Many of these providers claimed that they had been particularly challenged by the administrative requirements associated with the CDC model. This was attributed to the need
to accommodate cultural awareness and sensitivity in the development of monthly statements and pricing schedules, as well as tailoring and translating information about the changes to their clients.

- **Operational issues**: Some special interest providers highlighted the limited skills of their staff. This was reported to make it difficult to complete the additional administrative requirements associated with the CDC model and deliver a more multi-faceted service offering. Some also asserted that the absence of pooled funding had made it difficult to pay for staff training.

- **Consumer issues**: These providers also reported difficulty in taking their clients through the intricacies of the reform. Further, it was asserted that some clients were mistrustful of various aspects of the CDC model, most notably the allocation of funding. Some providers had found it challenging to explain changes such as the introduction of accounts and the schedule of fees, particularly when they were affected by high travel costs and translation services.

  ‘How am I meant to justify to someone that a load of washing costs $58.’

  *(Provider, NFP, medium, remote)*

### 4.4 Support and information on CDC

It was clear from the research that existing communications and resources played an important role in facilitating the transition to CDC: raising awareness and understanding of the changes, offering practical suggestions and instruction for the process of transitioning to CDC, and providing information and resources that could be passed on to clients and other staff.

It is important to note that in the discussion on information and support related to CDC, providers referenced both material that they had received in 2015 and material that had been accessed more recently (online or through seminars/workshops). It is possible therefore that their observations may have been based on material that has since been updated. Nonetheless, overall, around three-quarters of the providers in the research expressed satisfaction with the amount of information on CDC provided by the Government, and around six in ten claimed they were satisfied with the type of information on CDC provided by the Government.

The following findings should be viewed in this context.

- **Around half the providers in the study claimed to have attended workshops, forums and industry events.** There was a positive response to both those run by the Government and those conducted by peak bodies, (including Leading Aged Services, Aged and Community Services, COTA Australia, Alzheimer’s Australia, the Better Practice Project). These types of events were overwhelmingly considered to be both informative and instructive, while the opportunity for discussion and knowledge sharing particularly appealed.

- **Newsletters, email and direct mail**: Many providers reported receiving Government information through fact sheets, informational one-page letters, and links to online resources. Information received through these channels was thought to be targeted towards leadership staff, who were

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6Based on response to the survey question: On a scale of 0 to 10 where 0 is completely dissatisfied and 10 is completely satisfied, how satisfied are you with the following: The amount of information you have received from the Department about CDC; the type of information you have received from the Department about CDC.

Satisfaction score: 6-10
thought then to have a responsibility to disseminate this information among their staff. The majority of those in senior management positions took this seriously, with some setting up compulsory information sessions and training sessions to educate staff and answer queries directly. It was largely felt that the information was helpful and clear, though a few providers expressed the view that some of the material lacked depth.

- The **Home Care Today website** was used by a number of providers, particularly those in administrative and management roles. Those who used the website claimed that the interface was clean and easy to use, and said that they had come to rely on the site as a valuable resource.

In particular, providers used the **handouts and resources** available on the site. These were said to be helpful in explaining the changes to clients and lower-level staff. A number of providers commented that these resources appeared to have been designed with consumers’ specific needs in mind, such as large print for those with poor eyesight and easy to read language for those for whom English was a second language.

  “I use COTA and I find that really helpful. It’s very user friendly. The document we give out is the Your Guide to New Choices in Home Care – it’s very helpful, I leave that with consumers. It’s a guide, it’s really easy to read, the words are big which is helpful for people who can’t see well.”

  *(Manager, for profit, large, regional, NSW)*

- Despite the pertinent information on the CDC model available on the **Department of Health website**, there was very limited awareness of this amongst the providers in this study. By contrast, the profile of the My Aged Care website was higher, and some in the study were using this as a source of information of the CDC reform. It is important to note, however, that, when searching for information relating to CDC on My Aged Care, providers may have, in fact, been directed to the Department’s website, without realising this. More detail on the perceptions of My Aged Care appears in Section 3.4 below.

- **Targeted communication for special interest groups**: Response to targeted communications for special interest group varied. Some reported receiving extensive and targeted information, and were generally satisfied with the amount and content of information they had received from the Government. It appeared that these providers had a closer relationship with the Government in any case, and that lines of communication between providers and Government contacts were open and easy. Others, however, felt that the culturally specific information they had received was not particularly appropriate and was of little value overall. Many were producing their own information to use with their clients instead.

- **Peer support/ networking**: Importantly, the research highlighted a great degree of inter-organisational discussion and information/ resource sharing on the topic. This occurred through industry events and informal conversation, as well as through voluntary sharing of information by larger providers with those organisations with more limited resources. In particular, a number of providers from larger organisations said that they had delivered information which they had initially prepared for internal purposes to smaller providers, who did not have the processes or resources to produce these themselves.

  “I’m an educator from way back, I prepared a PowerPoint and went around the state and engaged them in CDCs. I also did that in some other organisations which were smaller than us.”

*(Manager, for profit, large, regional, NSW)*
4.4.1 Financial support

The vast majority of providers recalled receiving financial support from the Government to assist with the transition to the provision of home care packages on a CDC basis. Nonetheless, not all providers understood that the CDC Transition Grant was a one-off contribution for the costs incurred in 2014/15 for retraining and reskilling the workforce for the transition to the CDC model, with some assuming that it was intended to alleviate additional expenses more generally. Possibly as a result, around a third of the providers in the study indicated that they were satisfied with the \textit{type} of support they had received. Similarly, a third of providers also expressed satisfaction with the \textit{amount} of support provided.\footnote{Based on response to the survey question: On a scale of 0 to 10 where 0 is completely dissatisfied and 10 is completely satisfied, how satisfied are you with the following: The amount of support you have received from the Department for implementing CDC; The type of support you have received from the Department for implementing CDC. Satisfaction score: 6-10}
4.5 My Aged Care

Through the research, participants often discussed their experiences using My Aged Care in reference to the process of transitioning to the CDC model.

Overall, participants’ main engagement with My Aged Care was through the My Aged Care Provider Portal as a means of processing referrals for service and updating client records. Fewer participants were using ‘myagedcare.gov.au’, though some expressed an opinion on its appropriateness for older people.

My Aged Care portal

Much of the discussion on My Aged Care related to issues associated with the portal which were seen to be obstructing the delivery of home care packages. The need to consult the My Aged Care portal to register interest in delivering a package and pick up referrals was considered time-consuming. Concerns about the portal were voiced most strongly by providers who had previously used paper for all referrals and record-keeping, and who had found it challenging to convince staff to adopt the new system. There was broad acknowledgement that this was likely to improve as staff became more technically proficient however.

My Aged Care website and contact centre

My Aged Care was seen by some as a familiar and authoritative port of call for information about CDC. There was a general expectation that the CDC information on My Aged Care would be up-to-date and unbiased.

However, perceptions of the quality and usefulness of the content found on My Aged Care varied amongst providers. While some providers remained positive about the information provided, others claimed that the information was not sufficiently detailed or tailored to accommodate the specific requirements of their organisation. Others found it difficult to navigate and were resistant to use it for any purpose, including information-gathering. To some extent, this seemed to relate to the individual’s experiences using the My Aged Care portal; unsurprisingly, those who reported technical issues in using the portal were unlikely to use My Aged Care as an information resource.

Some providers said that while they found My Aged Care useful, it was a resource more suited to industry professionals than consumers. This reflected the perception that some older consumers were unfamiliar with accessing information online and generally found the process challenging, as well as more site-specific difficulties with My Aged Care. These issues were thought to relate to a complicated referral process, whereby consumers needed a number of referrals to fulfil their care needs.

Providers asserted that many older people preferred to access information either face-to-face or by telephone, and therefore saw the contact centre as playing an essential role as a source of information for consumers. Nonetheless, some providers were of the view that the helpline was staffed by people who did not always have the knowledge base to address consumers’ queries adequately.
5. Experience of home care under CDC

Some consumers are experiencing greater flexibility of service through the delivery of home care packages on a CDC basis. While CDC is overwhelmingly viewed as a positive approach to the provision of home care, it appears to hold greatest relevance for carers of those on high level packages. Drivers of engagement with CDC include both the attitudinal predisposition of the consumer as well as the provider’s commitment to championing the reform.

5.1 Experience of home care under CDC

Overall, around one in five of the consumers/carers participating in this research could recall experiencing CDC related changes in their home care service. It is difficult to assess whether the limited experience of service change under CDC reflects low recall of the change amongst consumers, or a failure on the part of the provider either to have implemented the reform fully, or to have communicated the changes adequately to their clients – or perhaps a combination of all of these factors. It was apparent, however, that those consumers who were more informed about the CDC, and more cognisant of having experienced a change in their service were more satisfied with their provider generally. Recall of change was also generally greater amongst carers in the study.

Of those who had experienced CDC related change, the experience was, for the most part, a positive one, though their responses suggest that their experience was not always reflective of the full CDC offering. Perhaps the most salient impact of CDC on the experience of service provision for consumers was in the increased flexibility it offers in terms of service selection. Most of those who could recall a CDC related change in their service recalled that their provider had offered them alternative or, in some cases, additional services. Some consumers recalled having been taken through service options by a case manager, though there was evident variation in their recollections of exactly what was on offer:

- In many cases, providers had told them that they were now eligible to receive a specific type of service, rather than leaving the choice up to them.
- Others had been informed that they could now swap services if they wished to, but did not recall being told that they could request additional services;
- A few had been invited to actively consider additional services and provided with a list of those from which they could choose
- Very few understood that they had the opportunity to have greater say in the management of their home care package.

For the most part, those on lower level packages had been informed once that they had the ability to choose additional/alternative services, while carers of those on higher level packages were reminded of this far more frequently, reflecting their much more frequent contact with the provider, and the greater salience of their care plan generally.

Overall, carers in the study appeared to be more likely to make a change to their service arrangements. Many were appreciative of being able to input into the services they received, while others were simply grateful to have access to additional services.
‘It was excellent because mum got the care at the level she needed it when she needed it. If I had been injured and couldn’t get time off work, I could have rung up and said up the level of nursing, up the level of social and they would have done it.

(Carer, Level 3/4, NFP Provider, Regional, NSW)

‘It’s great. You get what you need not what you’re given.’

(Carer, Level 3/4, NFP Provider, Regional, NSW)

Figure 5 below depicts the consumer experience of CDC amongst study participants, including the observed changes in service delivery and consumers’ typical response to this.

**Figure 5: Consumer experience of CDC**
5.2 Drivers and barriers to engagement with CDC

The research suggests that the drivers and barriers to engagement with the delivery of home care packages on a CDC basis may be the result of both consumer attitudes towards home care, and provider commitment to the CDC model.

5.2.1 Drivers and barriers: Consumer attitudes

Despite low awareness of the CDC model, when informed of its intent and philosophy, both consumers and carers were positive about the reform, associating it with a range of important benefits broadly in keeping with the idea of greater consumer choice. Overall, it was seen as a clearly customer centric strategy, designed to empower consumers around their care needs. Importantly for this audience, this was seen to tap into a desire for autonomy felt by many older people. Interestingly, while the CDC model focuses on offering more control and flexibility around care, some consumers also saw the reform as an opportunity to access additional services.

While few concerns were expressed about the change on a conceptual level, the research demonstrated quite distinct differences in engagement with the CDC model amongst study participants on a personal level – most markedly amongst carers of older people on higher care packages and consumers (who, in this study, were primarily receiving lower level packages).

**Carers’ engagement with CDC**

Carers of those on higher level packages expressed a high degree of engagement and interest in the delivery of home care on a CDC basis. This reflected both greater reliance on the home care service for their care needs and generally higher service expectations overall.

It was clear from the research that caring for an older person, particularly a loved one, is an emotionally charged time and brings with it considerable change to the lives and lifestyles of families. Carers in the study were not only reconciling the reduced capabilities of a loved one, but attempting to adapt, both emotionally and logistically to a demanding carer role, that brings with it tensions and anxieties for themselves, the older person and the wider family. Their primary concern was to protect and care for the older person, but this often appeared to be bound up with a sense of guilt at not being able to do enough, and inadequacy at having to rely on external support.

All of this seemed to heighten both the importance of home care, and the relevance of the CDC for carers in the study. They explained that, for higher needs consumers, home care is fundamental to their day-to-day life. The impacts of the service are therefore felt strongly – by the older person, by the carer and by the wider family, and if the service is inadequate, everyone is affected. Seemingly as a result, carers, who appeared to assume ultimate responsibility for the care, were often critical of their existing service, more motivated to increase the quality of care and more willing to explore opportunities for improving its effectiveness.

Further, carers in the study were typically younger than consumers, used to being control of their purchase decisions, showed greater expectations about services generally, and did not appear to be averse to change in the way that consumers in the research were. For this group, the CDC was therefore strongly aligned with their outlook and priorities.
Consumers’ engagement with CDC

By contrast, while generally positive about the CDC model on a conceptual level, for the majority of the consumers in the study, there were question marks around the personal relevance of the reform, and a general disinclination to consider applying for additional services. Indeed, the research revealed something of a misalignment between the notion of ‘extra choice’ and the general outlook and priorities of this cohort of consumers, as described in more detail below.

- This cohort of consumers appeared to be largely un-expectant about services and subsidised care, not feeling a sense of entitlement around the receipt of services. As a result, they were grateful to be receiving any service, and did not want to seem unappreciative. This was reinforced by a sense of (possibly generational) social disapproval about using government funded services unnecessarily, or being overly critical about them. Similarly, they were concerned about burdening others by demanding extra care.

- Further, the majority of consumers exhibited a desire to protect a sense of independence, and were keen to demonstrate their capability to live without relying on extensive assistance, and assert a positive, capable ‘young’ disposition generally. This appeared to translate (accurately or otherwise) to an assessment that they were not in need of extra services, and, in some respects, many seemed actively opposed to receiving anything but a very basic service. While they recognised the benefit of

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“There’s still choice at the moment but it tends to be a bundled package – you get various things at once, that’s how I see it at the moment, but you can be completely free to choose the things you want, so long as they fit into the budget. There is a dollar sign attached at the moment but you’re restricted currently and they offer the choices, but in the future you can pick exactly what you want. Of course it’s better, because you’re getting it custom-made.”

(Carer, Level 3-4, NFP Provider, City, NSW)
increasing consumers’ eligibility to a broader range of services, this was largely considered more relevant for older people with higher care needs;

- In addition, the majority of consumers demonstrated a clear dislike of change generally, and were reassured by a fairly structured, routine and familiar lifestyle. This manifested in contentment with an often sub-standard service, and resistance to trying anything new. This was often rationalised by a perception that home care was unlikely ever to be of a high standard, given the low wages of workers and high demand for services, leading some to conclude that there was little point in changing arrangements. The perceived process of transitioning to an alternative arrangement was also off-putting;

- Allied to this, for several participants in the study, change was not only disliked, but, in a sense, actually feared. Concern was voiced about ‘rocking the boat’ by requesting changes to the existing service package, in the fear that services might be withdrawn altogether. Many also asserted that there may be security risks associated with letting unknown workers into their homes.

Figure 7: Attitudinal barriers to engaging with CDC for low needs consumers

‘I’m grateful for whatever I’m able to get. I’m not a demanding person. I prioritise peace of mind and I accept what I get.’

(Consumer, Level 1/2, NFP Provider, regional, QLD)
5.2.2 Drivers and barriers: Provider commitment

The engagement and encouragement of the provider also played an important role in shaping consumers’ understanding and experience of home care on a CDC basis, by:

- Ensuring that consumers understand what is on offer, including that they have more say in terms of how their package is used;
- Providing a sense of reassurance that the change is both legitimate and positive – hence directly challenging any fear of change;
- Demonstrating the benefit of an additional service or change in service arrangements to their individual needs and requirements;
- Informing and reminding them of their entitlements regularly; and,
- Making the process easy and seamless, without requiring any particular input from the consumer.

The research suggested that this level of encouragement or support was not always experienced – and that the CDC changes may therefore be insufficiently implemented or championed by providers, particularly for lower needs consumers.

- Overall, carers of people with higher levels of care needs tended to have more contact with provider – including regular phone calls, meetings and home visits with the case manager to discuss the needs and progress of the client. In the main, carers were positive about the level of contact they received, and were, overall, fairly well informed about both issues relating to their individual care needs and arrangements, as well as those relating to organisational or systemic change. Many recalled having been taken through the changes with the provider, and receiving printed material when CDC was first introduced. They stated that they were glad to keep the material for reference, even if they did not always refer back to it, and had not always engaged with the topic when the material was first given out to them.

Though they were rarely aware of the CDC by name, carers were generally cognisant of the changes in the way that providers were explaining their care entitlements, and the introduction of budgets and account statements that provided transparency around the costs of individual services and the level of government contribution.

‘Once a month the RN comes and checks up and see if we’re still happy with everything – are we happy with just having three days or do we want to have more? They would do it every day of the week if that’s what I asked for. And they’re the ones that got me on to getting the cleaning as well. They got someone to ring me about that. They said that mum could get her room cleaned and the bathroom cleaned.’

(Carer, Level 3/4, NFP Provider, Rural, NSW)

- By contrast, for those on lower level care packages, the primary contact was generally the field worker. There was an expectation that the case manager would convene catch-up meetings periodically, but these meetings were sometimes infrequent, with some reporting that they had not seen the case manager for several years. While for the consumer, this was not always concerning, particularly if they had a good relationship with the field worker, this was a key barrier to understanding their entitlements following the CDC reform.
Indeed, awareness and knowledge about CDC amongst consumers was limited. The name and acronym, in particular, elicited very little response. Responses around the changes ranged from flat-out lack of knowledge (e.g.: “I’ve never heard of that”) to vague recollections that “things are changing” without much knowledge about the specifics of what might be changing, or how they might change. Others confused the introduction of the CDC with other recent reform, including the roll-out of the NDIS, or other changes specific to individual provider organisations.

Further, while several study participants recalled receiving periodic account statements from their provider, these were frequently misinterpreted. They were often viewed as a type of invoice, recording how much the consumer was contributing to the service, but few were aware that they were also meant to show the remaining funds in their account which could be used for additional/alternative services. Others were confused by the reference to ‘Balance Remaining’ on the statement, leading them to wonder if they could access this as “actual” money, or use it as a tax write-off, or if it would form part of their estate when they died. Carers generally showed greater understanding, though also commented on the inaccessibility of the statements, particularly for older people. Several participants also reported that the statements were sent out irregularly, and sometimes contained errors.

“I don’t think that mum understood that we could have what we needed and when we needed it. If there was a need for improvement it would have been to explain the process to her a little better.”

(Carer, Level 3-4, NFP Provider, Regional, NSW)

‘I’m a 55 year old woman who works full time and I struggled reading the accounts and I spent a lot of time in contact with them. If my mother had done that on her own, she would never have been able to do it. She didn’t know how to use a computer; she’d never sent a text in her life. She struggled to even answer her mobile phone because of a hearing impairment – there are vulnerable people out there who don’t have someone like me in the background.’

(Carer, Level 3-4, NFP Provider, regional, NSW)

‘Every account I receive from [service provider] was incorrect and very hard to read. I’m no accountant but I found them very hard to read. In May I got the account for February and that’s when I realised they were over-paying the cleaner by half an hour a week, the phone had been overpaid – and I’d questioned that and they’d said ‘oh it will be rectified next month’ – it was never rectified.’

(Carer, Level 3-4, NFP Provider, Regional, NSW)

5.2.3 Drivers and barriers: Informal carers

The support of the family and/or carers was also significant in driving engagement with CDC amongst consumers. As reported earlier, CDC tended to resonate more strongly with carers (including family members) and they often encouraged consumers to consider their options under CDC. Family and carers played an essential role in both explaining the changes to older people, and facilitating the change on a practical level.
5.3 Satisfaction with provider

Around eight in ten consumers indicated a high level of satisfaction with their provider.8

For many consumers, satisfaction appeared to be driven to a greater extent by the relationship with the worker and the duration and consistency of that relationship rather than the quality of the service. Those who were most satisfied with their service tended to have seen an individual worker regularly over an extended period of time. For many, the relationship that had ensued had often become very important, providing routine companionship, in what was often an otherwise fairly lonely existence.

“The lady that I have does a very good job; she’s very particular and friendly. I feel she’s very trustworthy, they won’t come unless there’s somebody home to do the cleaning, she’s very good and very empathetic, she tells me what she does with other people and she’s a good all round human being”

(Consumer, Level 1-2, Government Provider, regional, NSW)

In other respects, there was general agreement that a good service provider was helpful and reassuring at the first point of call, then provided staff who were polite and courteous, punctual, spoke good English, and were hard-working. Nonetheless, many consumers appeared to allow a great deal of leeway in terms of how well they expected the cleaners to clean, how punctual and time-efficient they expected staff to be, the politeness levels of their service providers, and their more general expectations from the administrative and customer service team. Others had more specific ideas about what was acceptable and seemed more likely to speak up if they were unhappy with the service.

“Because I’m on the pension the charge is minimal, the people are very agreeable and I know that once a fortnight everything is spit-spot. Before, I would have tried to do a bit and then a bit more, and I was always running after my tail. So this means it gets a thorough go and that’s fabulous.”

(Consumer, Level 1-2, Government Provider, urban, VIC)

A number of consumers commented on what might constitute “reasonable” demands to make of the providers, but there seemed to be little agreement about what this included. Flexibility for one consumer, for example, was a willingness to change days and times at the consumer’s choice, while another might see flexibility as the chance to change the kind of service provided (e.g. swapping cleaning one week for a trip to the bank the next); some consumers bemoaned the lack of punctuality of provider staff, while others were prepared to allow some leeway.

“I don’t think you can say to them ‘I want you to prepare for a party for fifty’ but within reasonable parameters they’re quite flexible and they’ll take [changes] in their stride”

(Consumer, Level 1-2, Government Provider, urban, VIC)

Poor service experiences were widely recounted across the study, most frequently in relation to:

- **Reliability** and punctuality— There were reports of workers missing appointments or being late. This made it difficult for both consumers and carers to plan their day.

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8 On a scale of 0 to 10 where 0 is completely dissatisfied and 10 is completely satisfied, how satisfied are you with your home care provider in relation to the following: Overall. High satisfaction = 7-10.
- **Care and quality** – several consumers felt that workers tended not to take adequate care and/or were prepared only to do the ‘bare minimum’ that they were required to do. The view was often expressed that cleaners were “not allowed” by their employer to lift things within the consumer’s home, which impinging on their ability to effectively clean/vacuum/dust etc.;

- **Inconsistency** – many consumers reported that there was little consistency of care, with a fairly high level of turnover of workers. This could be distressing for older people who were reassured by a familiar carer/ service;

- **Attitude of workers** – workers often showed a fairly poor attitude to undertaking their work – for instance, cleaners or carers would leave before their allocated time was up, but still expect consumers to approve their time sheets stating that the full time had been attained.

  "I want the people who come to do the job, to do the job and I don’t just want them to come and have a chat, some of them are out the door after an hour and want to get paid for the hour and a half"

  *(Consumer, Level 3-4, VIC)*

- **Personability**: it was asserted that workers were occasionally impolite, or seemed surly or unfriendly, or disinterested in engaging with consumers, except in a perfunctory and uncaring manner.

- **Rigidity and inflexibility**: and a disinclination to undertake any alternate/ additional work on any given visit, or to deviate even slightly from service regulations.

  "We had cleaners steal and break things, they leave dirt around the house and they say they can’t pick up and do anything or they’ll hurt their backs. This and all their [the council’s] rules and regulations... they come and talk about all their own ailments and that’s the problem”

  *(Consumer, Level 3-4, Government Provider, rural, VIC)*

- **Cost**: the prices of some services were considered excessive by some.

  ‘Five weeks after my request for a bed and a chair, the bed and the chair turned up and the chair was too small and the bed was broken. And we were paying from the care plan $400 a month for that. ’

  *(Carer, Level 3-4, NFP Provider, regional, NSW)*
6. Provider response to IC

The research points to variation in response to the IC reform amongst providers. Overall, larger, private providers tended to be most enthusiastic about the reform, identifying benefits in terms of the supply, quality and value of home care, while also recognising commercial opportunities in the deregulation of the marketplace. By contrast, smaller and not-for-profit providers showed some apprehension about IC, reflecting limited understanding of the practical application of the reform.

6.1 Anticipated impacts of IC

The Increasing Choice (IC) reform is a prominent and topical issue amongst service providers, particularly at leadership and management levels. All of the providers in the research were aware of the reform and all saw it as a substantive change. Nonetheless, there appeared to be little understanding of the details of the reform or how it would be implemented, leading to much speculation about its likely impacts.

“When we talk about February 2017, there’s a lot of grey stuff there. There are a lot of people who are unsure. And I guess as a provider it does compromise getting prepared for that and I know they talk about business plans and that but for the frontline provider, it’s still a little hard to picture what will happen.”

(Leadership, NFP, medium, regional, SA)

Larger and for profit providers were most positive about IC. For these providers, IC was viewed as a much needed sector reform, as it moved to cater to the needs of an ageing population. Its potential impacts were predicted to result in benefits for consumers and providers alike, and included:

- A positive impact on the supply, quality and value of home care for consumers, resulting from increased competition between providers;
- A greater sense of independence and autonomy, extending on that already brought about by CDC;

An opportunity to grow market share and increase reach. For these providers, the easing of restrictions on the market, and particularly the removal of limits on scope and region were considered to be commercially advantageous.

“We have two offices and we have just bought a new place and set up a regional centre. We have also 3 new positions in state office – customer centric roles – client services. Great opportunity to grow market share.”

(Manager, for profit, large, urban/regional, QLD)

Reflecting their limited understanding of the practical application of IC coupled with broad resistance to change, not-for-profit providers expressed more concern about the introduction of IC in regard to perceptions around administrative requirements, the impact on staffing; the financial viability of smaller providers; and the impact on the quality of care. More detail appears below.

6.1.1 Anticipated administrative impacts
There was uncertainty around the likely administrative requirements in transitioning to IC. Nonetheless, providers associated any sector reform with increased administration, and anticipated that time would need to be spent:

- updating **policies and guidelines** to comply with IC requirements;
- **transitioning current and prospective clients** to the new system;
- **marketing** their services;
- competing for **referrals** through My Aged Care.

> "And next year they’ll get to pick the home care packages that they wish, it’s going to be more time consuming for us I think”

*(Field worker, for profit, large, regional, VIC)*

### 6.1.2 Anticipated staffing impacts

Around half of the providers in the research indicated a high level of concern around the impact of IC on staffing, with a further third indicating moderate concern about this issue. Predicted impacts of the reform on staffing were noted as follows:

- **Impact on field workers**: Many providers considered the possibility that they might need to make adjustments to the number of their field workers following the introduction of IC, in light of the potential for demand for their services to change. Larger providers speculated that they would need to increase staff levels in order to meet greater demand, while smaller providers appeared to feel more concerned about having to make staff cuts.

> "We think we’ve got a model that’s sustainable, but there’s a lot of staff insecurity which has been generated from the sector. The staff have seen the changes coming and there is some ambivalence and they are frightened. We can reassure them but when they’re constantly hearing different messages from the government and other organisations they draw their own conclusions. It’s an interesting period, certainly.”

*(Leadership, NFP, large, regional/rural/remote, VIC)*

> ‘Home care staff already have a very volatile working style in that they have a set workload, and then if someone goes into hospital or if someone goes into residential care, and all of a sudden they’ve lost 6 or 7 hours of their wage – so it’s very difficult to keep people. And most of the home care workers here work for 2 organisations so that they can get enough work and then that reduces the flexibility for when they work for me. I don’t know how we’re going to keep our staff happy with such a volatile way they’ll be working. It’s an unreliable wage.’

*(Coordinator, NFP, small, rural, SA)*

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9Based on response to survey question: “On a scale of 0 to 10 where 0 is not at all concerned and 10 is extremely concerned, how concerned are you about the following relating to the implementation of Increasing choice changes: How staffing will be affected”

‘High concern’ score: 7-10; ‘Moderate concern’ score: 4-6
Impact on case managers: Around a quarter of providers expected that IC would result in further changes to the role of case managers. It was assumed that case managers would need to focus on selling services and facilitating client demands, rather than providing care per se. It was anticipated that they would likely work in collaboration with field staff whose role it would be to identify areas of need, reflecting their more frequent contact with the client. There was some speculation that this may result in a need to make further staff adjustments, to ensure that staff skill-sets were well matched to new responsibilities. Other organisations had opted to offer case management as a specific point of difference to other providers.

6.1.3 Financial impacts

All providers anticipated that IC would have financial repercussions for individual organisations, with the majority showing either strong (six in ten providers) or moderate (three in ten providers) concern about the financial impacts of the reform on their business10.

For profit and larger providers were of the view that IC would allow them to grow market share and increase their reach. For these providers, the easing of restrictions on the market, and particularly the removal of limits on scope and region, presented a significant opportunity. This largely reflected a commercial mindset, greater resourcing, and a perception that their service was more competitive than smaller, not-for-profit alternatives.

“I think the changes will hopefully allow the business to grow because we won’t be confined by the packages we have been allocated. At present we have to refer higher need packages to other providers, but soon we’ll be able to grow our client base and offer higher packages. And our boundaries will change, we’ll go further west. So I’m hoping the clients we referred to other providers might come back to us if they were pleased with the service.”

(Leadership, NFP, large, regional/rural, NSW/ACT, Aboriginal and Torres Strait Islander)

There was a perception that the competition brought about through IC might disadvantage smaller and not-for-profit providers, as a result of their less commercial mindset and often more limited resources.

“I think smaller organisations will struggle, we have the luxury of infrastructure and size but if you’re a small provider who has fifty packages and ten choose to move somewhere else, you’ve just lost twenty per cent of your revenue. There’s a real risk for small providers, that they won’t exist after this.”

(Coordinator, NFP, large, urban/regional/rural, NSW/ACT)

Predicted financial impacts were also associated with the portability of packages under IC and the return of any surplus funding to the Commonwealth. This caused concern within the sector, especially in smaller organisations.

10 Based on response to survey question: “On a scale of 0 to 10 where 0 is not at all concerned and 10 is extremely concerned, how concerned are you about the following relating to the implementation of Increasing choice changes: How staffing will be affected”

‘High concern’ score: 7-10; ‘Moderate concern’ score: 4-6
“The thing is, nobody’s making money out of these packages – we’re all not for profits, so any unspent money has been going into development and supports and resources. I don’t know how that will play out in the future.”

(Leadership, NFP, large, regional/rural/remote, VIC)

“I am very concerned about the viability of the organisation come February next year. I don’t know how it’s going to remain viable. From February, any [funding] that is left will go back to the Commonwealth...My concern is – how are we going to be able to retain any funds to replace major works like buildings, computers, and so on? We have administrative costs and we have to be competitive so we can’t charge more than anybody else... I think the overheads are going to be so expensive.”

(Leadership, NFP, medium, urban, TAS)

### 6.1.4 Anticipated industry impacts

Uncertainty about the IC reform had also led to conjecture about its impact on the industry in a broader sense. It was clear from the discussion that the concept of deregulation had elicited an emotional response from many providers. The issues that they raised were not always well-founded, and possibly more strongly reflected resistance to change and fear of the unknown rather than an accurate understanding of the change ahead.

The following issues were commonly raised by providers in the study:

- **Resistance to commercialisation:** Around half of the providers in the study commented that CDC was already shifting the way that they saw the role of their organisation, from being focused on provision of care to a business driven by commercial interests. It was expected that this change would accelerate under IC as organisations competed for clients, leading to a stronger *focus on marketing and financial survival*.

  Further, some providers were of the opinion that IC would encourage consumers and their families to view services in commercial terms, with the risk that there could be an increase in demand for services without a genuine need for them.

  “Who is making the decisions for the client? The next generation, who are consumers looking for something different. They’re going to love this. They’re looking for value for money. They have different priorities”

  (Leadership, NFP, large, urban/regional/rural, NSW/ACT)

- **Monopolies:** Around half the providers who participated in the research speculated that IC may create service monopolies within the sector, with smaller providers either amalgamating or not surviving. The view was expressed that special interest providers, particularly those catering to clients with specific language or cultural needs, would be vulnerable, reflecting their increased overheads.

  “Smaller organisations, like an ethno-specific organisation - how do they compete? They have translating costs, interpreting costs. In the old way they were covered by the unspent money which went back into the business.”

  (Leadership, NFP, large, regional/rural/remote, VIC)
While this concern was articulated by many special interest providers, there was a perception among some providers servicing Aboriginal and Torres Strait Islander communities, that their service was so specialised that they were unlikely to find themselves competing with providers in the same way. Some Indigenous providers also mentioned that they received substantial funding from the Government, so had fewer concerns about financial viability.

**Less collaboration:** Around a quarter of the providers in the study asserted that there was a risk that the reform would lead to a reduction in collaboration and knowledge sharing between organisations in the sector. With increased competition, IC was predicted to have an impact on the sense of partnership and support between providers.

> "Some of us do things better than others—we often get people approach us and we might say, ‘You’re better off with [provider name]’—that’s one of the bigger ones around here—because they might want something like gardening or someone to clean their gutters, which we don’t provide. It’s a very sharing community and that’s one of the things I like about it”

*(Administrator, NFP, small, urban, VIC)*

> "There used to be a lot of sharing of information but there is increased competition which the government has introduced with this new model. We used to support each other and get transfers of clients and we all had different specialities. Having come from the disability sector originally I thought the aged care sector was lovely, but now there’s a lot of competition. Clients are starting to become just a number and it has a different feel to it."

*(Leadership, NFP, large, regional/rural/remote, VIC)*

### 6.1.5 Anticipated consumer impacts

The research revealed mixed views of the impacts of IC on the consumer amongst providers in the study. In many respects, the concept of giving the consumer greater control and greater choice was considered positive. Its primary benefits were thought to include:

**Consumer empowerment:** Providers could see that there would be benefits to consumers in allowing them to control their own care services, and there was broad agreement that this would make some consumers feel more autonomous and empowered. Marginalised groups, in particular LGBTI elders and socially disadvantaged people, were expected to benefit from this. Providers who catered to these groups stating that people who had been disempowered in other areas of their lives were likely to benefit from increased autonomy.

> "Increasing choice sounds nice, who’s going to complain about that? My clients would love to have more choice, definitely. The more choice you have, the more autonomy you have, even if you don’t make different choices you know you can, that counts for something.”

*(Field worker, for profit, medium, NSW)*

**Access to more services and reducing waiting lists:** There was acknowledgement that in opening up the market, IC would provide a greater number of services for consumers, thereby reducing waiting lists. Some of the providers who had previously only provided packages at levels 1 and 2 were enthusiastic about the opportunity to **maintain their clients as their care needs changed.** For example, a client who required in-home services at levels 3 and 4 had previously needed to go onto a wait list with a different service provider in order to have their care needs met.
It was expected that **this would also result in more flexibility**, allowing consumers to increase care when required, and return to their regular care arrangements if their abilities changed.

- **Greater affordability:** With increased competition, IC was also thought to make home care potentially more affordable, as providers lowered their fees in order to attract and retain customers.

Conversely, however, confusion and conjecture about the IC model had led to a perception that it could result in changes to the delivery of home care that may disadvantage the consumer. Views to this end were expressed as follows:

- **Reduced service for those with support needs beyond their package level:** Around a third of providers in the study expressed concern about the possible impacts of the portability of packages for those with higher support needs. It was asserted that, currently, many providers use unspent package funds to provide care for those with needs beyond their designated package level.

- **Reduced quality of care:** There was a lack of awareness of the continued use of Home Care Standards for new providers under IC. As a result, some providers showed uncertainty around how new providers would enter the home care sector, including what type of qualifications or experience they would require, whether there would be an accreditation process, and how quality standards would be assessed and monitored in the long term to ensure compliance. There was also an expectation that clients would be able to spend their funds on different kinds of services, so that a range of new organisations would be recognised as catering to the market. This, together with the anticipated impacts on the industry described above, was thought potentially to result in a poorer quality of care generally. Around a third of the providers in the study held this view.

- **Confusion amongst older consumers:** Around half of the providers in the study questioned the appeal of choice generally to older consumers. It was asserted that older consumers might find the delivery of home care under the IC model overwhelming or confusing. Providers at leadership level said that they anticipated a need to talk their clients through the changes in order to mitigate any resistance or concern. There was a strong feeling however, that current clients would most likely stay with their current provider.
6.2 How prepared are providers?

Around seven in ten providers in the study showed high levels of confidence that their organisation would be ready by February 2017 to deliver home care services under the IC changes, with the remainder moderately confident about their readiness for the reform\(^\text{11}\). Overall, confidence was highest amongst for profit providers and larger providers.

Unsurprisingly, there were strong parallels between the extent of providers’ preparation for IC with the extent of their commitment to the CDC. Those whose service was more strongly aligned with CDC were considerably more invested in taking steps to transition to IC, while those who had done little to enact CDC were less advanced in their preparations. As the figure below shows, however, most providers in the study had taken some steps to prepare.

**Figure 8: Provider preparedness for IC**

More detail around the extent of preparation for IC observed amongst different providers in this study appears below.

6.2.1 Embracers

‘Embracers’ were more likely to feel enthusiastic about the competitive market place and had always had a strong business identity, closely tied to business concerns. These providers expected to benefit from deregulation by increasing their market share by taking on new clients. In preparation, they had begun upgrading their marketing and communications, focusing on their brand offering and differentiating within the market. Some had employed marketing professionals or expanded their communications teams to prepare.

For these businesses, commercial concerns had always been paramount, and so major overhauls of processes and systems were not required. Rather, preparations focused on ensuring that they were able to meet the potential needs of an increased number of clients, and that their offering was sound so that they could begin targeting new clients as soon as IC was introduced.

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\(^{11}\) Based on response to the survey question: “On a scale of 0 to 10, where 0 is not at all confident and 10 is extremely confident, how confident are you that your organisation will be ready by February 2017 to deliver home care services under the Increasing Choice changes?” High score: 7-10.
In some cases, private providers had also begun employing and training new staff, including staff at administrative level and also home-care staff. It was expected that IC would mean an increase in demand, both with new clients and with current clients who became more aware of services available to them, which would lead to a need for more field workers in particular.

6.2.2 Adapters

Generally larger and with greater resources than Accepters, Adapters had been fairly proactive in preparing for IC. Some had restructured their entire business in preparation, making adjustments to staff roles and responsibilities, in an effort to optimise efficiency. Several had started to enact marketing strategies, including re-branding and developing communications to promote their offering.

Many had also begun training and education of their administrative and leadership staff, although the majority had not yet begun to inform field workers.

"We lost staff, we had initial phase of losing staff and we’re reducing again at the moment. All these changes are in a desire to reduce costs and overheads and we’re looking at being as efficient as possible and having a service offering that is competitive in the market come February. Along with that, as part of the restructure we’ve just undergone changes with marketing and communications – we want to bring our customer experience and marketing in line. We hadn’t previously branded ourselves in that way”

(Leadership, NFP, large, urban/regional/rural, NSW/ACT)

"Until we know what it looks like, whether people will move or not, we won’t know about our ability to keep staff employed.”

(Leadership, NFP, large, regional/rural, VIC)

6.2.3 Accepters

Accepters were committed to taking steps to prepare for IC, though had generally not progressed very far. Their preparations focused on the need to transform their mindset from one which was not motivated by commercial concerns to one which was more “business-like” in its outlook. Accepters were often of the view that organisations which were unable to adapt in this way would not be able to compete with private providers, and would therefore not remain viable.

Accepters were generally in the first stages of preparation. Some had employed business consultants or marketing professionals to help them adapt their business processes and systems to be more competitive and commercially minded.

6.2.4 Resisters

Similar to their response to CDC, Resisters were generally unprepared for the IC reform. These organisations tended to feel vulnerable to deregulation and competition from larger providers, but their lack of resources and business acumen meant that many had taken few steps to prepare. The sense of uncertainty as to how IC would change the sector, as well as gaps in their knowledge, meant that many not-for-profit providers felt that they would not be able to prepare more thoroughly until further detail of the policy was released.
“It’s really hard to know what to do. There’s still so much we don’t know. We really have no idea what will happen until it’s started. I think there’ll be a lot of surprises….”

(Leadership, NFP, small, regional/rural, VIC)
6.3 Support needs and preferences

Providers were eager to receive support and information, across a number of channels:

- Primarily, the perception that information to date had been quite general meant targeted, **detailed information** would be particularly valued. Nonetheless, a role for broader awareness-raising through a **communications campaign** was also identified.

- There was also support for **additional guidance, advice and training** and, in particular, industry briefings or seminars which targeted not-for-profits and addressed their concerns about the changing sector.

- It was also expected that there might be some additional **financial support** given to not-for-profits to ease the transition into a competitive market place.

- **Resources** which could be used for educating staff and current clients were also requested as a means of reducing pressure on already time-poor staff.

More detail about these requests is provided below.

6.3.1 Information

The majority of providers had already engaged with information from the Government regarding IC, but had sought out more **detailed information**, in particular regarding the logistics of implementation. As discussed, confusion was focused on a number of areas, all of which should be addressed in written communications.

In particular, providers sought detailed **information** on the following:

- **Regulation**:
  - The regulations and changes with which they would be forced to comply, as opposed to those which were optional;
  - Specific types of services and different providers which will be covered under IC;
  - Accreditation and quality standards, and the ways these will be monitored and upheld over time;
  - **How** brokerage will be regulated under the new system;
  - Rules and regulations, quality assurance and training around sub-contractors within the system;

- **Process**:
  - How funds will be managed, in detail: in terms of who controls the funds, how providers receive payment, how clients can apply for and access funds;
  - How existing clients’ package-based services and funding will change;
  - How new consumers will be put into the system, and whether My Aged Care will clash with existing waiting lists;
  - How existing clients will be transitioned to receive additional funding when their needs change;
  - The application process for new providers to enter the market;
Implications for staffing:
- The role of case managers in the new system;

Reassurance
- Any ways in which the Government intended to alleviate the fears of not-for-profits regarding the changing, newly-competitive market place;

Targeted information
- Information targeting special interest groups such as Aboriginal and Torres Strait Islander, CALD and LGBTI organisations, as well as information aimed specifically at smaller organisations.

The appetite for detailed information on IC suggests that there may be benefit in providing a single web-based source of detailed information on the topic, and positioning this as a ‘one stop shop’. Limited awareness of the detailed information on the Department of Health website highlights the need to promote any such source in all communications on the issue. Given the frequency of engagement with the My Aged Care portal, this would be an effective access point. Content should focus on detailed information regarding all aspects of the reform as detailed above, as well as targeted fact-sheets, webinars, and forums/live chat and FAQs to enable dialogue and discussion.

### 6.3.2 Communications campaign

The sensitivities surrounding the introduction of IC for not-for-profits suggest that communications could also play a role in helping to correct misconceptions and allay concerns. To this end, providers are likely to respond best to messages that adopt an informative, factual but reassuring tone. Message territories could be considered as follows:

**Table 4: Potential Message territories**

<table>
<thead>
<tr>
<th>GOAL</th>
<th>MESSAGE TERRITORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMPATHISE &amp; INVOLVE</td>
<td>Recognition that IC represents a significant change to the sector. Change is challenging for everyone.</td>
</tr>
<tr>
<td></td>
<td>The Department understands that there are many questions around how the changes might work, and that some providers are concerned about what it might mean for them.</td>
</tr>
<tr>
<td>POSITION DEPARTMENT AS SUPPORTIVE AND IDENTIFY SUPPORT</td>
<td>The Department is there to help providers make the necessary adjustments to their business strategy and operations. They are doing this in many ways (x, y, z). There will be a focus on advising not-for-profit providers on financial strategy, marketing and resourcing.</td>
</tr>
<tr>
<td>REASSURE</td>
<td>While the market will be deregulated, approved providers will still be required to meet the relevant standards and requirements.</td>
</tr>
<tr>
<td>DEMONSTRATE BENEFIT</td>
<td>With preparation, the reform is likely to benefit the sector:</td>
</tr>
<tr>
<td></td>
<td>▪ Enabling providers to deliver care that can be better tailored to the needs of individual consumers</td>
</tr>
<tr>
<td></td>
<td>▪ Providing opportunities for providers to extend their services to better accommodate local demand and consumer needs.</td>
</tr>
<tr>
<td></td>
<td>▪ Providing a more equitable distribution of packages to consumers based on individual needs and circumstances regardless of where they live.</td>
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</tbody>
</table>
In addition, the limited self-efficacy displayed by a number of providers in transitioning to a deregulated market place points to potential value in helping them to compartmentalise aspects of preparation. This could be approached through the provision of periodic emails on specific facets of IC, with links back to resources and events relating to that particular issue on the website. Case studies may also be effective as a means of showing providers what others (like them) are doing in a relatable and instructive way. Templates, printable resources and self-assessment tools that allow providers to assess their preparedness may also be helpful.

6.3.3 Instruction and guidance

Smaller not-for-profit organisations expressed a desire for more hands-on assistance in making the required adjustments to their operations and outlook. The research points to the appeal of face-to-face advice and guidance, in the form of forums and workshops, offering the opportunity to ask questions and consult experts. Providers had accessed some of the Government seminars and information nights, and had found this method of receiving information useful. It was suggested that this would be an effective way of reaching a number of providers from different organisations at once, and would allow for targeted information as seminars would likely be region-specific.

Face to face delivery of information was preferred as it afforded providers an opportunity to ask direct questions to the person delivering the information. Providers welcomed the transparency inherent in this method of delivery. Consideration could be given to focussing on adjustments that are likely to be most challenging for not-for-profit providers, including, most notably: business strategy, marketing and communications, and resourcing (human/ financial/ technological).

Given the close relationships within the industry, events and seminars might also be beneficial to foster support within the industry. It was hoped that providers could use these events to network and discuss the changes with likeminded organisations. This afforded an opportunity for information sharing, so that smaller providers could learn from the ways organisations with greater resources might implement the changes. The seminars were also viewed as an opportunity to receive validation for their concerns about the impact on industry, both from other organisations and from the Government representative.

6.3.4 Additional financial support

A number of not-for-profit providers hoped the Government would offer additional financial support to ease the transition. This was anticipated as a means of alleviating the financial strain on their organisation, which was expected to come through a loss of funding, as a result of changes to allocation of funds, revenue, through the potential of clients to take their business elsewhere.
There appeared to be a general expectation that organisations were likely to receive a one-off payment for every client to compensate for financial pressures, which might be similar to the $250 per client which they had received with the introduction of CDC. Not all providers accurately understood that the CDC Transition Grant was a one-off contribution to providers for the costs incurred in 2014/15 for retraining and reskilling the workforce for the transition to the CDC service delivery model, however.

Providers also hoped that some funding should be made available to cover unexpected costs of implementation, which might occur as a result of the changes. It was felt that valid claims for this might include new programs or software, upgrades of technology, additional training to staff, or even marketing costs (for example, for distribution of advertising material), which were seen as necessary to compete in the changing marketplace.

It was thought that this support might also come in the form of grants for which individual organisations could apply, especially those organisations which serviced a specific community.

### 6.3.5 Resources

A number of providers expected that they would be required to distribute information on behalf of the Government, particularly among their current clients. These participants felt that detailed, targeted written material would assist them in this task, and ensure that all clients were receiving unbiased and consistent information. Not-for-profits in particular were concerned that private companies might utilise an angle in their written material which they would not, in order to sway clients through fear.

It was hoped that the Government would ensure online and telephone assistance was available during the transition. It was suggested that the Government provide a helpline for system and technical issues, and another for implementation challenges and information-seeking queries.

However, it was stated that the usefulness of this kind of service would be contingent on the quality of call centre staff, who needed to have high levels of technical knowledge, and the assurance of low waiting times.
7. Consumer response to IC

While consumers show limited awareness of the IC reform, the research indicates that they are likely to see IC as a positive development in the provision of home care services. Nonetheless, few consumers in the study indicated that they would change providers once they had the choice to do so. For the most part, this reflects a change averse predisposition, reinforced by questions around the need for and efficacy of change, perceived challenges in transitioning, and loyalty to the existing provider.

7.1 Awareness and perceptions of IC

Overall, the research revealed very little, if any awareness of the 2017 Increasing Choice reforms amongst the consumer cohort. While a few recalled some communication on forthcoming changes to the home care system, there was little understanding of the focus or intricacies of the changes, or their likely impacts. Carers, again, were relatively more informed, particularly those who were experiencing the delivery of home care packages on a CDC basis.

When informed broadly of the nature of the IC reform, perceptions were largely positive. Similar to their responses to CDC, consumers associated the reform with a range of benefits, reflective of the concept of extending consumer choice and control. More specifically, consumers speculated that it would likely provide:

- Greater autonomy for consumers in allowing individuals to control the type and nature of care they receive;
- Greater flexibility for consumers, particularly as a result of the portability of funding;
- Greater supply of care;
- Greater quality of service and value for money as a result of increased competition;
- Access to a greater range of services; and,
- Access to more affordable services.

"It gives you a choice and hopefully it's more regulated, and better in price"

(Consumer, Level 3-4, Government Provider, rural, VIC)

In a very similar way to CDC, however, while the benefits of IC were quickly identified, its relevance and applicability to participants’ own situations were often not apparent. Only one in five consumers in the research indicated that they would be likely to change providers once they had the choice.12

7.2 Drivers and barriers to changing providers

In a very similar way to CDC, while the benefits of IC were quickly identified, its relevance and applicability to participants’ own situations were more often recognised amongst carers. Carers were more likely to be critical of their current service, and more interested in ‘shopping around’ for a better option.

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12 Based on response to survey question: And on a scale of 0 to 10 where 0 is not at all likely and 10 is extremely likely, how likely are you to change providers once you have a choice? 'Likely to change' score: 7-10.
By contrast, for consumers, the change-averse predisposition which appeared to temper their response to CDC, was even more prominent in their response to IC. There was a sense of uncertainty around the changes, which centred on questions of whether they were going to have to do anything (fill in paperwork, undergo another assessment, or need to compare providers) and whether they were going to be better-off in their current arrangements. A fear of change manifested in various ways when considering the notion of changing provider, whether around outcome (What if it’s worse? What could go wrong? What is at stake?) or process (Will it be hard? Can I do it?). This concern was echoed in the thoughts of some providers, who worried that their clients might find the new changes overwhelming.

Conversely, the strong emotional appeal of the familiar was evident in the loyalty and commitment consumers often showed to a provider, despite also being very critical of their service.

**Figure 9: Barriers to engaging with Increasing Choice**

More specifically, the barriers to considering changing provider through IC, included:
Figure 10: Further breaking down the barriers to engaging with Increasing Choice

- **Questionable need**: Despite evident variation in the quality of the service consumers were receiving, most claimed that they were largely satisfied with their provider. As a result, they did not see a need to explore other options, and so did not view IC as holding much personal relevance;

- **Uncertain efficacy**: As for CDC, many questioned the efficacy of changing providers. The view was often expressed that the quality of providers was unlikely to vary greatly. Many also identified a risk that the service might actually be worse than their current arrangement, and that they might be ‘locked in’ to a less satisfactory arrangement.

  "She is happy with her service provider and wouldn’t consider changing. Sometimes I guess the devil you know... she is happy with what she is getting. She is concerned if she were to change and then not be happy with the service the new provider is providing. She doesn’t think it would be any different."

  *(Carer, Level 1-2 and Level 3-4, Government Provider, urban, VIC)*

- **Stress of transitioning**: Many questions were raised around the process of transitioning to another provider. There was an expectation that this was likely to be complicated, time-consuming and potentially stressful. They recalled the rigmarole and difficulty in accessing home care: some participants had been on a waiting list before receiving an assessment, and others had found the visits and assessments in the beginning tiring. Some consumers were reluctant to go through this again with a new provider.

- **Adapting to new systems, processes and people**: Similarly, many consumers were mindful of the potential difficulty of adapting to the systems and processes of an alternative provider – whether that was a new billing system, new approach to performing a service, or a new person. The point was made that this could be particularly stressful for older people, including those with mental health issues like Alzheimer’s or Post-Traumatic Stress Disorder, for whom stability and familiarity were very important.

  ‘It’s getting used to another provider and their system of billing. Will everything be the same? Will I have to pay another amount? Will another provider cut grass?’

  *(Consumer, Level 1-2, NFP provider, urban, ACT)*
"In our case it would be very difficult, because I guess my dad in his situation, he is comfortable with, and I think this is important, changing providers would probably mean changing the staff that come into the house, the carers, the physio's etc., so it would be difficult for someone to get used to new people that they have known for years. Over the years when people have been away on leave or whatever, and different people have come into the house it is just a little bit difficult for him to have new people showering him or providing a service. It is easier to stick to the same service provider with the same people."

(Consumer, carer, Government Provider, Level 1-2 and Level 3-4, urban, VIC)

**Loyalty:** Many consumers also displayed a high degree of loyalty towards their existing provider – particularly if they had been engaging their services for a longer period. Some had a good relationship either with individual carers or with the service provider (for example, where the service provider represented their religious affiliation or ethnic group).

**Legitimacy:** there was also a degree of apprehension about the reform, and questions around its legitimacy and intent. In particular, some were suspicious about the motives of the reform, hypothesising that they were most likely a government cost-savings measure.

In the main it was felt that only those who were in an unsatisfactory situation with an existing provider would consider making a change – for instance, if the quality of the work was very poor or if they had a poor relationship with the workers – or else if they moved locations. Some also showed an inclination to consider changing if there was financial benefit in doing so. There was speculation that it would be likely that consumers would be able to access lower cost services. This was a significant incentive for several participants in the study.

"Like with everything, I would be quite capable of doing my own administration but it’s not for everyone. I find administration fees and all of that comes out of the subsidy, and I think 'Well, I could save quite a bit of money’"

(Consumer, QLD, CALD)

"I'm happy with the lady I've got, I wouldn't be willing to change ... but it would depend on the savings, how much would I save as to whether [change] would be useful or not"

(Consumer, Level 1-2, For profit Provider, regional, NSW)

### 7.3 Information and support needs

The research clearly points to a need to inform and educate consumers about the IC reform, and this was widely acknowledged by participants through the research. Participants put forward a range of suggestions for how they would prefer to receive this information. Overall, their suggestions indicated a need for a broadly targeted awareness raising campaign, with more detail advice and instruction available for those considering changing their arrangements or requiring clarification.

‘They’d need to have it detailed – how to change, what benefit we would get from changing? Why has this come in? Is the government trying to save money? It really needs to be detailed out. We’re doing this because of what – and this is what you need to do to do it – very detailed, in common language.’

(Consumer, Level 1-2, NFP Provider, urban, ACT)

### 7.3.1 Awareness raising
Overall, following the interviews, many participants had a variety of questions and concerns about the changes – including, most prominently, if they would be required to change providers. Given the potential for consumers to be targeted by individual providers, it is important that they understand what the reform is about, and the opportunity that it offers – but are also reassured that they do not need to take any action at all. Messages could be considered as follows:

**Table 5: Messaging to increase awareness**

<table>
<thead>
<tr>
<th>GOAL</th>
<th>MESSAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAISE AWARENESS/REASSURE</td>
<td>From February 2017, people will have more choice about their home care service.</td>
</tr>
<tr>
<td></td>
<td>You will now be able to change your service provider if you wish to do so.</td>
</tr>
<tr>
<td></td>
<td>The change will not affect your current home care arrangement unless you wish to change providers.</td>
</tr>
<tr>
<td>LEGITIMISE/DEMONSTRATE BENEFIT</td>
<td>The Australian Government has introduced this reform to allow people to choose a provider that best suits their needs and circumstances. Changes will also:</td>
</tr>
<tr>
<td></td>
<td>Give people greater control about how and where they access care.</td>
</tr>
<tr>
<td></td>
<td>Ensure that funding is based on individual needs regardless of where you live.</td>
</tr>
<tr>
<td></td>
<td>For those choosing to change, existing funding packages, including any unspent funds, will be directed to the new provider.</td>
</tr>
<tr>
<td>INVOLVE &amp; DEMONSTRATE RELEVANCE</td>
<td>If you would like to consider another service provider, the choice is now yours to do that.</td>
</tr>
<tr>
<td></td>
<td>But if you are happy with your provider, nothing needs to change.</td>
</tr>
<tr>
<td>CALL TO ACTION</td>
<td>To find out more about your options, go to: &lt;&lt;website&gt;&gt; or call: x</td>
</tr>
</tbody>
</table>

**Channel preferences**

Participants suggested a range of media considered suitable for awareness raising communications:

- **Newsletters and brochures**: many consumers identified a need for printed communications on this issue, including newsletters and brochures. This view was commonly expressed by those who were less confident online, but even those who were more tech-savvy felt that it was important that printed material was available to keep and refer to as needed. This was viewed as a fairly reliable means of raising awareness of the reform.

- It was widely agreed that **peak bodies** and NFPs like Alzheimer’s Australia and COTA were trusted sources on aged care related issues, and could also help to raise awareness of the IC change through their communications and activities. While some felt that providers could also play a role, many were circumspect about the potentially commercial motivations of providers, trying to ‘spruik their services’ rather than providing impartial information.
Some also felt that there was a role for a multimedia campaign, using television and radio, and printed advertisements in aged care, veterans or pensioners magazines to increase awareness.

### 7.3.2 Instruction and advice

Both carers and consumers themselves felt that, for those who were considering making a change, the process of doing so was a potentially complex undertaking that consumers could find confusing. Many asserted that they would require assistance and instruction around how to go about this. Several suggestions were put forward to this end:

- **Instruction and advice** was considered to be essential for those with little access to informal support, and those not comfortable in online environments (typically older consumers) who were interested in/ had concerns about changing their provider. It was felt that a trusted health professional would be ideally placed to provide this advice, though there was recognition that many health professionals were time-poor and may therefore be disinclined to act in this capacity.

  "If someone could sit down and talk to me. Old people don’t want to read, and a lot of old people can’t take in what they read. I think sometimes it is better if someone explains it rather than hand them a piece of paper to tell them what’s happening"

  *(Consumer, Government Provider, Regional, SA)*

- There was interest in a telephone helpline amongst some of consumers and carers in the study. Concerns were voiced, however, about waiting times, and inconsistency of service.

  ‘I’m an internet person but some things I like to get a paper copy so then I’ve got it and I can read it – and I don’t have to go back to the internet. I would recommend that they give everyone a paper copy and then put it on the website as well.’

  *(Consumer, Level 1-2, NFP Provider, urban, ACT)*
8. Appendix

Please see below for the Providers and the Consumers discussion guides.
8.1 Consumers Discussion Guide

CONSUMERS

Department of Health Home Care Services (263104149)

Final Discussion Guide: 29/6/16

Method: In depth interviews – mix face to face and telephone (60)

Stimulus: Attachment 1 (CDC); Attachment 2 (Increasing choice fact sheet); Questionnaire

Note: This discussion guide sets out the proposed lines of enquiry for the interviews and is intended as a tool to guide discussion flow. Questions are indicative only of subject matter to be covered and are not word for word descriptions of the moderator’s questions.

1. Introduction and warm up 5 mins

Aim: To introduce moderator and participants, explain research purpose and process, build rapport with participants.

- Thank participants for their time and participation
- Introduce moderator and TNS
- Explain briefly nature of discussion, time required (45 mins – 1 hour)
- Introduce topic:
  - We’re here to talk about provision of home care services, including your recent experiences.
- Procedure:
  - No right or wrong answers – interested in honest opinions, different perspectives
  - Discuss participant confidentiality
  - Privacy and quality assurance disclosure – TNS adheres to AMSRS Code of Professional Behaviour
  - Inform about note-taking/ recording (audio) discussion – for later analysis and reporting purposes only
  - Mix of interview questions, discussion and tasks
  - If family and / or carer in attendance, explain that it is OK for anyone to answer the questions and make comments

- Just to start I’d like you to tell me a bit about you and your current home care arrangements
  - What sort of home care do you currently receive? Probe to ascertain level of care
  - What is the reason for receiving home care? Probe to ascertain level of need
  - How long have you been receiving home care services?
  - Which organisation provides your care?
  - Have you always used this provider?
    - If not, how many others? Which ones? How long have you used this provider? Why did you change?
  - As far as you remember did you have any choice in which organisation provides your care?
    - If yes, can you explain to me how this worked?
    - How did you go about making a choice?

2. Current provider 10 mins
Aim: **Understand satisfaction with current provider.**
- Let’s talk for a while about your current provider. What do you think they do well? What are the good things about them?
- What about the not so good things? What could they improve on?
- Have you noticed any change in the level or type of service they provide over time?
  - What sort of change?
  - When did you notice it?
  - Why do you think it changed?
  - **Probe for potential impact due to CDC**
- Would you recommend this provider to others?
  - Who to?
  - In what situations?
  - For what services?

3. **1 Attitudes to and experience of CDC**  
10 mins

Aim: **Understand current attitudes to and experience with CDC.**
- Have you heard about Consumer Directed Care, or CDC?
  - What have you heard?
  - What is your understanding of this? What does it mean?
  - Can you remember who you heard this from?
  - When you heard it?
  - Did your provider discuss CDC with in regards to your current home care package?

Read out.

Consumer Directed Care was introduced in July 2015. It gives people greater choice about the home care they can receive, by allowing them to decide what **types** of care and services they access and **where** and **when** those services are delivered.

*Use Attachment 1 (CDC) if necessary for more detail.*

- Have you had any experience of CDC yet?
  - What sort of experience? When?
  - How satisfied are you with it?
  - What improvements are required?
- What do you think the benefits of this approach are or could be for you?
- What are the potential issues or concerns about this approach?
  - Do you feel that your home care provider has given you enough information to enable you to make these kinds of decisions about your care?
- Do you think it will have any impact on the quality of your care?
- What does the change to have greater choice about your care mean for you?

4. **Likely response to Increasing Choice changes**  
10 mins

Aim: **Understand likely response to Increasing choice changes**
- Have you heard about the changes to home care that are being introduced in February 2017?
  - What have you heard?
  - What is your understanding of this? What does it mean?
Read out

From 27 February 2017, some changes will be made to the way you can access home care. You'll be able to choose the provider you want to use, and there will also be more providers available for you to choose from. Note that you will not have to make a change if you're happy with the provider you currently use, but the choice will be yours.

In addition, there will be some changes to the way that home care packages will be allocated to eligible people. It will now be based on people’s individual needs and circumstances wherever they live.

Use Attachment 2 (Fact sheet) if necessary for more detail.

- As I outlined, having this choice means that you will also be able to change providers if you want. I just want you to think about people like you in general, not just your situation...... What sort of situations might prompt people to consider changing their current provider?
  - Do you think this will be relevant to many people?
  - What sort of people?
  - Is it something that might be relevant to you?
- And thinking about people who wouldn’t consider changing providers, what might some of their reasons be for not considering change?
  - Do you think this will be relevant to many people?
  - What sort of people?
  - Is it something that might be relevant to you?
- How easy or difficult do you think it would be to change providers?
  - What would make it easy / difficult?
- How likely do you think it will be that you will consider changing providers?
  - Why do you say that?
  - Why would you change/stay with your provider?

5. Information and support

Aim: To understand what information and support consumers need

- What sort of help would make it easier for people in a similar situation to you to understand the changes?
- Who would you need help from?
- Where would you look for information?
  - When?
  - What sources?
  - What channels? Eg print, radio, electronic, social media
- Probe for respective roles of:
  - Family
  - Carer
  - Provider
  - Health professional
  - Support organisations (e.g. Alzheimer’s Australia)
  - My Aged Care
- Have you heard of the My Aged Care or the Home Care Today websites?
If yes, have you used these websites?
What for? What information were you looking for?
Did you find the websites easy to use?

6. Questionnaire

To finish up I have a few set questions that I would like to run through with you..... (questions in appendix).

7. Recap and close

Aim: Summarise and thank participants
- Is there anything else you would like to add that we haven’t covered today?

Thank you so much for your time today.

ADVISE THAT Q&A WILL DO FUNDS TRANSFER
**Questionnaire**

Screening information automatically populated.

Q How long have you been receiving home care services?

Q Who is your current provider?

Code if possible in terms of provider type and size

Q On a scale of 0 to 10 where 0 is completely dissatisfied and 10 is completely satisfied, how satisfied are you with your home care provider in relation to the following:

- Provider’s ability to meet your care needs in the way you want
- Timeliness
- Keeping me up to date
- Overall

Q And on a scale of 0 to 10 where 0 is not at all likely and 10 is extremely likely, how likely are you to recommend your current provider (0 to 10)?

Q And on a scale of 0 to 10 where 0 is not at all likely and 10 is extremely likely, how likely are you to change providers once you have a choice?
8.2 Providers Discussion Guide

**PROVIDERS**

Department of Health Home Care Services (263104149)

Final Discussion Guide: 22/6/16

Method: Case studies (3 including 3 depth interviews each – 9 total), in depth interviews – mix face to face and telephone (40)

Stimulus: Attachment 1 (Scene setting); Attachment 2 (Overview); Questionnaire

*Note: This discussion guide sets out the proposed lines of enquiry for the interviews and is intended as a tool to guide discussion flow. Questions are indicative only of subject matter to be covered and are not word for word descriptions of the moderator's questions.*

### 8. Introduction and warm up 5 mins

**Aim:** To introduce moderator and participants, explain research purpose and process, build rapport with participants.

- Thank participants for their time and participation
- Introduce moderator and TNS
- Explain briefly nature of discussion, time required (45 mins – 1 hour)
- **Introduce topic:**
  - *We’re here to talk about provision of home care services, including your recent experiences.*
- **Procedure:**
  - No right or wrong answers – interested in honest opinions, different perspectives
  - Discuss participant confidentiality
  - Privacy and quality assurance disclosure – TNS adheres to AMSRS Code of Professional Behaviour
  - Inform about note-taking/ recording (audio) discussion – for later analysis and reporting purposes only
- **Just to start I’d like you to tell me a bit about your organisation**
  - How long has your organisation been in business?
  - Where do you operate from? How many and which locations?
  - Do you specialise in any particular type of care?
  - Do you cater for special interest groups in the community? Which ones?
  - What is your role in the business?
  - How long have you worked here?
9. Involvement in CDC to date

Aim: Understand experiences to date with CDC

We are going to spend some time today discussing the reform of home care packages, and in particular Consumer Directed Care, or CDC, which was introduced in July 2015. This has resulted not in a new type of home care package, but rather a new philosophy and orientation to service deliver. It gives consumers greater choice by allowing them to decide what types of care and services they access and how those services are delivered.

Use Attachment 1 (Scene setting) if necessary for more detail.

I would now like to spend a little time hearing about your experience so far with the new Consumer Directed Care approach....

- To what extent have you applied the Consumer Directed Care approach to date?
  - In what ways has it been applied?
- What motivated you to do this?
  - Was there anyone that was critical in making this happen?
    - Who?
    - Why?
    - When?
    - How?
  - Was there a particular incident that prompted the organisation to start making changes?
    - What?
    - When?
    - What did it prompt?
- What makes / made it difficult to implement the CDC approach in your business?
  - What barriers are there to making changes?
  - Will this situation change over the coming months?
    - In what way?
    - Why?
    - When?
  - What assistance does the organisation need to help overcome this?
- In applying changes, have you experienced any administrative issues?
  - What in particular?
  - When?
  - Has this been resolved? How?
  - How could it be resolved?
  - What assistance does the organisation need to help resolve this?
- How would you expect to apply it?
- And have you experienced any operational issues?
  - What in particular?
  - When?
  - Has this been resolved? How?
  - How could it be resolved?
- Would you expect to experience any operational issues?
  - What in particular?
  - When?
10. Attitudes to Increasing choice 15 mins


- I’m just interested in finding out what your awareness is about the changes to home care services that are coming in February 2017....
  - Can you explain it to me from your perspective?
  - What do you think about them?
  - How did you hear about these changes?

Read out:

Increasing choice reforms will commence in February 2017 and will result in a number of key changes:

- Home care packages funding will follow the consumer
- There will be a consistent national approach to prioritising access to home care. It will now be based on the needs and circumstances of individuals, wherever they live.
- Existing providers of residential care and flexible care will be able to ‘opt in’ to become home care providers through a simplified process.
- Approved provider status will no longer lapse after two years if the provider does not hold an allocation of places. This applies across home care, resi care and flexible care.

Use Attachment 2 (Overview) if necessary for more detail.

- Thinking about it from the perspective of your organisation, what do you think the benefits of the changes are?
  - And what about for consumers?

- What about the potential issues or concerns related to the changes?
  - And what about for consumers?

- Do you think it will have a financial impact on your business?
  - What sort of impact?
  - When do you think this will become evident?
  - Is there anything that you can do to help prepare for this?
    - What?

- Do you think it will have an impact on staffing for your business?
  - What sort of impact?
  - When do you think this will become evident?
  - Is there anything that you can do to help prepare for this?
    - What? Are you aware of business support services that could help you with planning for this change?

- Do you think your business has the expertise or access to support that is needed to adapt to these changes?
  - If not, what expertise do you need?
  - How much of an impact will this make?
  - Is there anything you can do to help prepare for this?
    - What?

- If provider offers services to special interest groups:
Are there challenges related to the changes for the <INSERT SPECIAL INTEREST> community?
- What are they?
- Is there anything that you can do to help prepare for this?

### 11. Information and support to date

**Aim:** To understand what information and support providers have received to date on CDC

- What information have you received to date from the Australian Government about CDC?
  - Can you remember when you received it?
  - How did you receive it?
  - Did you think it was helpful?
    - Yes – in what ways?
    - No – why not?
  - How do you think it could be improved?
- Do you use / have any feedback on the following?
  - My Aged Care website content
  - Home Care Today website content
  - Other webpages, including Home Care Packages Reform, for both CDC and Increasing Choice reforms
  - Provider Newsletter and emails, which you can subscribe to from the department webpages

What support have you received to date from the Department of Health (or DSS) about CDC?

*Moderator note: Providers were given a once-off adjustment grant at $250 per consumer. There were also likely to have been information/websites/workshops provided about the changes.*

- Can you remember when you received it?
- How did you receive it?
- Did you think it was helpful?
  - Yes – in what ways?
  - No – why not?
- How do you think it could be improved?

### 12. Increasing Choice readiness

**Aim:** To understand what changes are required, and how ready organisations are for February 2017

- What changes does your organisation need to make to be ready for full implementation of the Increasing choice changes?
  - How much change is required?
  - How confident do you feel that this is possible?
    - What would get in the way of this?
  - How easy (or difficult) will it be?
    - What would make it easier?
  - What support do you need to make these changes?
    - Who from?
    - When do you need this support?
  - What information do you need to help you make these changes?
    - Who from?
• When?
• In what form?

13. Consumer perspective 5 mins

Aim: To explore their understanding of the consumer perspective

• What anecdotal feedback have you received from consumers about the changes?
  o What do you believe the general sentiment is among consumers?
  o What questions do they ask your organisation?
    ▪ Are you able to answer these?
    ▪ Do you need support for this?
  o How do you think the Department can help consumers?

14. Questionnaire 5 mins

To finish up I have a few set questions that I would like to run through with you (questions in appendix).

15. Recap and close 5 mins

Aim: Summarise and thank participants

• Is there anything else you would like to add that we haven’t covered today?

Thank you so much for your time today. If you have any queries please don’t hesitate to contact the Department using the details on this letter.

ADVISE THAT Q&A WILL DO FUNDS TRANSFER
Questionnaire

Screening information automatically populated.

Q Thinking about any administrative issues you have experienced to date relating to the implementation of CDC, would you say they are:

- More than you expected
- About what you expected
- Less than expected
- No issues experienced

Q Thinking about any operational issues you have experienced to date relating to the implementation of CDC, would you say they are:

- More than you expected
- About what you expected
- Less than expected
- No issues experienced

Q On a scale of 0 to 10 where 0 is completely dissatisfied and 10 is completely satisfied, how satisfied are you with the following:

- The amount of information you have received from the Department about CDC
- The type of information you have received from the Department about CDC
- The amount of support you have received from the Department for implementing CDC
- The type of support you have received from the Department for implementing CDC

Q On a scale of 0 to 10, where 0 is not at all confident and 10 is extremely confident, how confident are you that your organisation will be ready by February 2017 to deliver home care services under the Increasing Choice changes?

Q On a scale of 0 to 10 where 0 is not at all concerned and 10 is extremely concerned, how concerned are you about the following relating to the implementation of Increasing choice changes:

- The financial impact on the business
- Having the right skills to implement the Increasing Choice changes
- How staffing will be affected