Evaluation of the
Metro North Brisbane Medicare Local
HACC Consortium Model

Final Report
October 2015 (Updated 30 November 2015)

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The Australian Centre for Health Services Innovation, or AusHSI, is a research centre hosted by QUT to undertake health services research and evaluation with a focus on health economics and cost-effectiveness.

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Disclaimer

The views presented in this report are entirely those of the authors and not those of Queensland University of Technology or the North Brisbane PHN (formerly Metro North Medicare Local). While Queensland University of Technology staff aim to provide reliable analysis, and believe that the material presented in this report is accurate, it will not be liable for any claim by any party acting on the information in this report.
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### List of abbreviated terms

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<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Aged Care Services</td>
<td>Care services for people 65 years and older (and 50 years and older for people identifying as Aboriginal or Torres Strait Islander)</td>
</tr>
<tr>
<td>AusHSI</td>
<td>Australian Centre for Health Services Innovation</td>
</tr>
<tr>
<td>Consortium Model</td>
<td>The consortium based model of aged care service delivery adopted by the MNBML group; the focus of this evaluation.</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>HHS</td>
<td>Hospital and Health Service</td>
</tr>
<tr>
<td>MDS</td>
<td>HACC Minimum Data Set, held by the Federal Government of Australia. A condition of provider funding under the HACC program is to regularly upload data to the HACC MDS.</td>
</tr>
<tr>
<td>MNBML</td>
<td>Metro North Brisbane Medicare Local</td>
</tr>
<tr>
<td>MNBML Consortium</td>
<td>The Consortium of HACC providers managed by the MNBML; also referred to as the Consortium.</td>
</tr>
<tr>
<td>MNHHS</td>
<td>Metro North Hospital and Health Service</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>NDR</td>
<td>National Data Repository</td>
</tr>
<tr>
<td>Service Group</td>
<td>Categories of types of HACC services which are similar in the way in which they are delivered and have comparable units of output and unit costs.</td>
</tr>
<tr>
<td>QUT</td>
<td>Queensland University of Technology</td>
</tr>
</tbody>
</table>
Background

The Commonwealth Government Home and Community Care (HACC) Program\(^1\) was designed to provide community based care services to people aged 65 years and over (or aged 50 years and over for Aboriginal and Torres Strait Islanders), who are at risk of premature entry into residential care facilities. In providing such care, the HACC Program aims to improve the quality of life of older people by allowing them to remain in their own homes longer, assisting in rehabilitation, reducing avoidable hospital admissions and preventing or delaying entry to residential aged care.

In the Metro North Brisbane region in Queensland, a portion of the Commonwealth HACC Program was historically delivered by the Metro North Hospital and Health Service (MNHHS). The MNHHS relinquished its contract with the Commonwealth for some of its HACC service delivery in early 2013. In April 2013, the Metro North Brisbane Medicare Local (MNBML) was awarded the HACC contract for their region. The requirement to transition the care services for the existing clients of the MNHHS over a six week period was achieved by the MNBML through the formation of a consortium of HACC service providers (referred to as the MNBML Consortium or the Consortium). The MNBML manages the allocated HACC services through this Consortium Model, which includes local providers and aged care consumer and advocacy group expert representatives. This new model of delivering HACC services emphasises collaboration across the members of the Consortium. The objectives were to:

- Focus on client and carer needs
- Coordinate delivery of services
- Improve practices
- Develop an evidence base to inform policy development
- Share knowledge

In July 2013, the federal Minister for Mental Health and Ageing, Jacinta Collins, launched this new model for the Commonwealth’s HACC Program in the Metro North Brisbane region. The HACC program was to be coordinated by the MNBML through an innovative model that brought together established community care providers in a consortium partnership to deliver domestic assistance services to more than 3,000 older people in the region.

In September 2013, the MNBML appointed QUT, via the AusHSI research centre, to conduct an evaluation of this new Consortium Model of aged care service delivery. The evaluation project was conducted over two years and this report provides a final and overall outcome of the project. An initial interim report, submitted to MNBML in November 2014, demonstrated that the providers involved in the MNBML Consortium Model can and do work together collaboratively, openly and supportively in a traditionally competitive sector. This final report attempts to determine how that collaboration works and how it might work better moving forward.

\(^1\) From 1 July 2015, this program has been consolidated into the Commonwealth Home Support Programme
Evaluation focus

Detailed information on the evaluation purpose and design has been previously provided in interim reports, and is included here at Appendix 1 for reference.

In brief, three research questions guide this evaluation.

1. **Client satisfaction** - how does the client perceive the MNBML Consortium Model delivered services in comparison to previous MNHHS delivered services?
2. **Cost of service delivery** - does the MNBML Consortium Model deliver HACC services in a more cost-effective way that the previous MNHHS delivered services?
3. **Provider opportunities** - what opportunities or challenges does the MNBML Consortium Model create for service providers?

Data sources

The evaluation was informed by a number of data sources

- MNBML HACC clients (interviews, focus groups, surveys)
- MNBML Consortium HACC service providers (interviews, surveys, case profiles)
- MNBML Consortium consumer and advocacy group representatives (interviews, case profiles)
- MNBML Consortium (observation, case profiles)
- MDS Activity data on HACC clients and services (de-identified, linked client and carer data on activity provision), for two years pre and post the commencement of the Consortium Model of service delivery.
- Program Schedules for Aged Care Funding (contracts outlining costs and targets for service delivery)
Outcomes

1. Client satisfaction

*How does the client perceive MNBML Consortium delivered services in comparison to previous MNHHS delivered services?*

Client satisfaction was investigated in the initial phase of the evaluation project and has been previously reported (refer to interim report in Appendix 1). The initial results revealed a pattern of overall client satisfaction with aged care services provided under the MNBML Consortium Model, however the differences between the current (Consortium Model) and past (MNHHS delivery) service delivery models were minimal, with a slight preference for the previous service provision model. It should be noted that clients were comparing multiple historical years (mean 5.91 years) of prior service delivery with a single year of the new consortium model delivery and as such a degree of bias toward the previous service provision may have existed.

2. Cost of service delivery

*Does the MNBML Consortium deliver HACC services in a more cost-effective way that the previous MNHHS delivered services?*

The ongoing evaluation has investigated whether the Consortium Model is a cost-effective way of providing HACC services to older people in the Metro North Brisbane region, by examining the unit cost of providing the five Service Types described below, as well as looking at any changes in trends across the client group as they transitioned from the MNHHS to the MNBML Consortium. Due to the aggregation of MDS data, it is not possible to separate outputs by individual providers within the Consortium. Therefore, for this quantitative analysis the MNBML data is compared with the MNHHS data without breaking down outputs into individual providers. However, this aggregate reporting does not detract from the analysis as individual Consortium member detail is not required to compare the cost per unit of service provided under the Consortium Model with that of the MNHHS.
Table 1: HACC MDS Service Type Definitions (from HACC Program National MDS User Guide Version 2.0)

<table>
<thead>
<tr>
<th>Field</th>
<th>Description on service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Care Coordination</td>
<td>This service includes activities such as implementing a care plan, liaising with various service providers and advocacy required to help clients who need access to more than one service type.</td>
</tr>
<tr>
<td>Counselling/suppor, information and advocacy¹</td>
<td>Assistance with managing relationships and behaviours related to a client’s care needs. This includes dementia support and assisting a client with understanding which services they can access.</td>
</tr>
<tr>
<td>Domestic Assistance²</td>
<td>Help provided in the home, included but not limited to, cleaning, paying bills, washing dishes and clothes.</td>
</tr>
<tr>
<td>Social Support</td>
<td>Help in accessing community services or assistance in order to participate in community life. (This does not include support provided to clients in group environments for example in a facility away from their home.)</td>
</tr>
<tr>
<td>Transport</td>
<td>This is counted in one-way trips and is counted per client, regardless of whether or not the transport is provided as a group. It is intended to help clients get out of the house to participate in community activities or do chores such as shopping.</td>
</tr>
</tbody>
</table>

¹ Counselling, Support and Advocacy is now reported as “Care received in support” and “Carer received in support”. Items under these headings in the MDS data have been summed and included under this heading for the purposes of this evaluation.

² Domestic Assistance (pre-2014 service): House cleaning, washing, ironing, help with shopping, transport to and from banks and appointments and general household support.

Updated economic findings FY2014-2015

Since the interim QUT evaluation report, at the end of 2014, further data have been received from the MNHHS, regarding the costs of running HACC services prior to the transition of clients to the MNBML Consortium. Updated HACC MDS data, to the end of 2014-15, have also been obtained. This section of the report is therefore an update to the information and economic analysis provided in the preliminary report, from November 2014. In this report, for ease of comparison of costs over time, all costs have been inflated to 2014 prices. Inflation was a calculated according to the Reserve Bank of Australia’s online calculator².

Target unit costs for the MNHHS and MNBML Consortium are summarised in Table 2. Some of these have been reported previously but are included here for ease of reference. There have been some minor changes to the unit costs, in some cases, and corrected values are included in this report. None of the changes have a substantial effect on the outcomes reported.

As in the previous evaluation report, the target unit cost is estimated by comparing the total funding for a particular Service Type by the total units of output allocated in the funding agreements between the Commonwealth and the service providers (Program Schedules).

Table 2: MNHHS and MNBML Consortium Target Unit Costs

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Assistance</td>
<td>$51.72</td>
<td>$51.37</td>
<td>$51.57</td>
<td>$51.57</td>
<td>$51.19</td>
<td>$49.95</td>
</tr>
<tr>
<td>Social Support</td>
<td>$51.79</td>
<td>$51.44</td>
<td>$51.63</td>
<td>$51.67</td>
<td>$51.26</td>
<td>$50.01</td>
</tr>
<tr>
<td>Client Care Coordination</td>
<td>$77.84</td>
<td>$77.48</td>
<td>$77.77</td>
<td>$77.77</td>
<td>$77.21</td>
<td>$75.33</td>
</tr>
<tr>
<td>Counselling/Support, Information and Advocacy</td>
<td>N/A</td>
<td>N/A</td>
<td>$86.45</td>
<td>$86.79</td>
<td>$85.88</td>
<td>$83.79</td>
</tr>
<tr>
<td>Transport</td>
<td>$32.67</td>
<td>$32.72</td>
<td>$32.85</td>
<td>$32.84</td>
<td>$32.61</td>
<td>$31.81</td>
</tr>
<tr>
<td>AVERAGE ACROSS SERVICES</td>
<td>$51.50</td>
<td>$51.14</td>
<td>$51.55</td>
<td>$51.55</td>
<td>$51.18</td>
<td>$49.93</td>
</tr>
</tbody>
</table>

**MNHHS Unit Costs**

MNHHS unit cost information has been able to be calculated, since the interim project report was prepared, and the results are shown in Table 3, Table 4 and Table 5. For each Service Type, the cost per unit reported has been calculated using the total funding for the Service Type, divided by the units of output reported in the MDS datasets, received from the HACC MDS Data Steward. Similarly, the percentage of the output target is reported.

For the financial years 2010-11 and 2011-12, the full number of funded outputs for each year is recorded in the tables. However, for the 2012-13 year, the amount of funding and number of outputs transferred to the MNBML Consortium has been deducted from the figures (Table 5). Further, two annual totals have been reported in the tables, one excluding the figures for Transport and/or Counselling/support, information and advocacy, due to the low levels of outputs recorded for these Service Types. These services were managed by the Indigenous Health Service team of the MNHHS, which experienced high staff vacancy at the time and therefore low demand and data accuracy. These issues suggest that the low number of recorded outputs for the Transport and/or Counselling/support and Information and Advocacy services are related to reporting issues, however this assumption cannot be verified.
### Table 3: MNHHS Unit Costs - 2010-11

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Funded Units of Output</th>
<th>Total Funding</th>
<th>Total Units reported</th>
<th>% of Target</th>
<th>Cost per unit reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Assistance</td>
<td>179,105</td>
<td>$9,263,119.73</td>
<td>130,482</td>
<td>73%</td>
<td>$70.99</td>
</tr>
<tr>
<td>Social Support</td>
<td>5,843</td>
<td>$302,617.44</td>
<td>1,364</td>
<td>23%</td>
<td>$221.86</td>
</tr>
<tr>
<td>Client Care Coordination</td>
<td>2,000</td>
<td>$155,681.66</td>
<td>415</td>
<td>21%</td>
<td>$375.14</td>
</tr>
<tr>
<td>Counselling/support, information and advocacy</td>
<td>N/A</td>
<td>N/A</td>
<td>9</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Transport</td>
<td>5,004</td>
<td>$163,474.80</td>
<td>21</td>
<td>0.4%</td>
<td>$7,784.51</td>
</tr>
<tr>
<td>YEAR TOTAL</td>
<td>191,952</td>
<td>$9,884,893.63</td>
<td>132,291</td>
<td>69%</td>
<td>$74.72</td>
</tr>
<tr>
<td>YEAR TOTAL (Excl. Transport)</td>
<td>186,948</td>
<td>$9,721,418.83</td>
<td>132,261</td>
<td>71%</td>
<td>$73.50</td>
</tr>
</tbody>
</table>

### Table 4: MNHHS Unit Costs - 2011-12

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Funded Units of Output</th>
<th>Total Funding</th>
<th>Total Units reported</th>
<th>% of Target</th>
<th>Cost per unit reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Assistance</td>
<td>179,159</td>
<td>$9,203,051.05</td>
<td>135,801</td>
<td>76%</td>
<td>$67.77</td>
</tr>
<tr>
<td>Social Support</td>
<td>5,843</td>
<td>$300,543.74</td>
<td>1,545</td>
<td>26%</td>
<td>$194.53</td>
</tr>
<tr>
<td>Client Care Coordination</td>
<td>2,000</td>
<td>$154,959.32</td>
<td>1,128</td>
<td>56%</td>
<td>$137.38</td>
</tr>
<tr>
<td>Counselling/support, information and advocacy</td>
<td>N/A</td>
<td>N/A</td>
<td>-</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Transport</td>
<td>5,160</td>
<td>$168,828.37</td>
<td>360</td>
<td>7%</td>
<td>$468.97</td>
</tr>
<tr>
<td>YEAR TOTAL</td>
<td>192,162</td>
<td>$9,884,893.63</td>
<td>132,291</td>
<td>72%</td>
<td>$70.79</td>
</tr>
<tr>
<td>YEAR TOTAL (Excl. Transport)</td>
<td>187,002</td>
<td>$9,658,554.12</td>
<td>138,474</td>
<td>74%</td>
<td>$69.75</td>
</tr>
</tbody>
</table>
Table 5: MNHHS Unit Costs - 2012-13 (funding and outputs transferred to MNBML Consortium deducted)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Funded Units of Output</th>
<th>Total Funding</th>
<th>Total Units reported</th>
<th>% of Target</th>
<th>Cost per unit reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Assistance</td>
<td>149,682</td>
<td>$7,718,413.50</td>
<td>122,782</td>
<td>82%</td>
<td>$62.86</td>
</tr>
<tr>
<td>Social Support</td>
<td>3,993</td>
<td>$206,150.88</td>
<td>1,238</td>
<td>31%</td>
<td>$166.52</td>
</tr>
<tr>
<td>Client Care Coordination</td>
<td>900</td>
<td>$69,995.63</td>
<td>239</td>
<td>27%</td>
<td>$292.87</td>
</tr>
<tr>
<td>Counselling/support, information and advocacy</td>
<td>1,024</td>
<td>$88,526.37</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Transport</td>
<td>3,304</td>
<td>$108,529.75</td>
<td>354</td>
<td>11%</td>
<td>$306.58</td>
</tr>
<tr>
<td><strong>YEAR TOTAL</strong></td>
<td>158,903</td>
<td><strong>$8,191,616.13</strong></td>
<td>124,613</td>
<td>78%</td>
<td><strong>$65.74</strong></td>
</tr>
<tr>
<td><strong>YEAR TOTAL</strong> (Excl. Transport or Counselling/support, information and advocacy)</td>
<td>154,575</td>
<td><strong>$7,994,560.00</strong></td>
<td>124,259</td>
<td>80%</td>
<td><strong>$64.34</strong></td>
</tr>
</tbody>
</table>

Table 5 should be read with caution as it is not clear whether Commonwealth funding continued to be received by the MNHHS, or what service outputs continued to be provided in the 2012-13 financial year. Some reports stated that all funding for some Service Types was relinquished, however there were outputs reported for each of these Service Types in the HACC MDS data received by the evaluation team. As a result, the levels of funding and outputs funded shown in Table 5 are the original funding and output amounts, less the quantities transferred to the MNBML Consortium for the transition period. The percentages of targets reached calculated on this basis in Table 5 are not dissimilar to previous years (see Table 3 and Table 4).

From the available data, it appears that the MNHHS had difficulty meeting its output targets, reaching a maximum of 82%, for Domestic Assistance in 2012-13 (Table 5). Therefore the cost per unit reported is much higher than the target unit costs reported in Table 2. In the reported figures, the MNHHS was able to achieve a maximum of 80% of total output targets (in 2012-13), making the average unit cost $64.34 (Table 5).
Updated MNBML unit costs show in Table 6 and Table 7 and new data for financial year 2014-15 are shown in Table 8. Since the transition period, the unit cost of services provided by the MNBML Consortium has decreased over time. The latest MDS data for the MNBML Consortium show an increase in outputs since the transition period from delivering an average of 91% of the target outputs in the transition year (Table 6) to delivering 98% in 2013-14 (Table 7) and delivery above target across all Service Types relevant to this analysis, in 2014-15 (see Table 8).

Table 6: MNBML Unit Costs - Transition Period (2012-13)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Funded Units of Output</th>
<th>Total Funding</th>
<th>Total Units Reported</th>
<th>% of Target reported</th>
<th>Cost per unit reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic assistance</td>
<td>13,600</td>
<td>$701,400.00</td>
<td>12,077</td>
<td>89%</td>
<td>$58.08</td>
</tr>
<tr>
<td>Social support</td>
<td>798</td>
<td>$41,230.17</td>
<td>631</td>
<td>79%</td>
<td>$65.34</td>
</tr>
<tr>
<td>Client Care Coordination</td>
<td>180</td>
<td>$13,999.13</td>
<td>214</td>
<td>119%</td>
<td>$65.42</td>
</tr>
<tr>
<td>Counselling/Support, Information and Advocacy</td>
<td>204</td>
<td>$17,705.28</td>
<td>194</td>
<td>95%</td>
<td>$91.26</td>
</tr>
<tr>
<td>Transport</td>
<td>661</td>
<td>$21,705.95</td>
<td>917</td>
<td>139%</td>
<td>$23.67</td>
</tr>
<tr>
<td>YEAR TOTAL</td>
<td>15,443</td>
<td>$796,040.52</td>
<td>14,033</td>
<td>91%</td>
<td>$56.73</td>
</tr>
</tbody>
</table>

Table 7: MNBML Unit Costs - 2013-14

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Funded Units of Output</th>
<th>Total Funding</th>
<th>Total Units Reported</th>
<th>% of Target reported</th>
<th>Cost per unit reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Assistance</td>
<td>155,045</td>
<td>$7,937,385.06</td>
<td>148,546</td>
<td>96%</td>
<td>$53.43</td>
</tr>
<tr>
<td>Social Support</td>
<td>4,791</td>
<td>$245,596.15</td>
<td>6,686</td>
<td>140%</td>
<td>$36.73</td>
</tr>
<tr>
<td>Client Care Coordination</td>
<td>1,080</td>
<td>$83,388.88</td>
<td>1,846</td>
<td>171%</td>
<td>$45.17</td>
</tr>
<tr>
<td>Counselling/Support, Information and Advocacy</td>
<td>1,228</td>
<td>$105,465.33</td>
<td>1,752</td>
<td>143%</td>
<td>$60.20</td>
</tr>
<tr>
<td>Transport</td>
<td>3,965</td>
<td>$129,296.58</td>
<td>4,144</td>
<td>105%</td>
<td>$31.20</td>
</tr>
<tr>
<td>YEAR TOTAL</td>
<td>166,109</td>
<td>$8,501,131.98</td>
<td>162,974</td>
<td>98%</td>
<td>$52.16</td>
</tr>
</tbody>
</table>
Table 8: MNBML Unit Costs - 2014-15

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Funded Units of Output</th>
<th>Total Funding</th>
<th>Total Units Reported</th>
<th>% of Target</th>
<th>Cost per unit reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Assistance</td>
<td>155,045</td>
<td>$7,743,790.30</td>
<td>165,366</td>
<td>107%</td>
<td>$46.83</td>
</tr>
<tr>
<td>Social Support</td>
<td>4,791</td>
<td>$239,606.00</td>
<td>8,059</td>
<td>168%</td>
<td>$29.73</td>
</tr>
<tr>
<td>Client Care Coordination</td>
<td>1,080</td>
<td>$81,355.00</td>
<td>3,298</td>
<td>305%</td>
<td>$24.67</td>
</tr>
<tr>
<td>Counselling/Support, Information and Advocacy</td>
<td>1,228</td>
<td>$102,893.00</td>
<td>4,318</td>
<td>352%</td>
<td>$23.83</td>
</tr>
<tr>
<td>Transport</td>
<td>3,965</td>
<td>$126,143.00</td>
<td>4,409</td>
<td>111%</td>
<td>$28.61</td>
</tr>
<tr>
<td>YEAR TOTAL</td>
<td>166,109</td>
<td>$8,293,787.30</td>
<td>185,450</td>
<td>112%</td>
<td>$44.72</td>
</tr>
</tbody>
</table>
Overall Costs of Service under the Consortium model

1. Commonwealth Government Perspective

From the perspective of the Commonwealth Government, the cost of providing HACC aged care services is related directly to the funding allocated to service providers. From the available data, the MNBML Consortium has been able to provide the services at a significantly reduced cost to the Commonwealth Government when compared with the MNHHS. This is evidenced by the unit costs shown in Table 9.

Table 9: Comparison of unit costs between providers over time (per unit reported)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Assistance</td>
<td>$70.99</td>
<td>$67.77</td>
<td>$62.86</td>
<td>$58.08</td>
<td>$53.43</td>
<td>$46.83</td>
</tr>
<tr>
<td>Social Support</td>
<td>$221.86</td>
<td>$194.53</td>
<td>$166.52</td>
<td>$65.34</td>
<td>$36.73</td>
<td>$29.73</td>
</tr>
<tr>
<td>Client Care Coordination</td>
<td>$375.14</td>
<td>$137.38</td>
<td>$292.87</td>
<td>$65.42</td>
<td>$45.17</td>
<td>$24.67</td>
</tr>
<tr>
<td>Counselling/Support, Information and Advocacy</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$91.26</td>
<td>$60.20</td>
<td>$23.83</td>
</tr>
<tr>
<td>Transport</td>
<td>$7,784.51</td>
<td>$468.97</td>
<td>$306.58</td>
<td>$23.67</td>
<td>$31.20</td>
<td>$28.61</td>
</tr>
<tr>
<td>AVERAGE ACROSS SERVICES</td>
<td>$73.50*</td>
<td>$69.75*</td>
<td>$64.34*</td>
<td>$56.73</td>
<td>$52.16</td>
<td>$44.72</td>
</tr>
</tbody>
</table>

*Not including Transport or Counselling/support, Information and Advocacy.

In financial year 2014-15, the MNBML Consortium average unit cost was $44.72, compared with the lowest MNHHS unit cost of $64.34 in 2012-13. This difference in cost means the average unit cost of the MNBML Consortium was $19.62 lower than the MNHHS cost, a reduction of approximately 30%. This reduction represents a considerable saving when the annual output numbers are taken into account. By way of example, if the MNBML Consortium unit cost had been the same as the MNHHS unit cost ($64.34), an extra $3.6 million would have been needed to deliver the additional units of service. Alternatively, keeping the funding the same, but assuming the increased unit cost, over 56,000 fewer units of service (based on average unit cost across services) could have been delivered. From the Commonwealth Government perspective, this cost reduction demonstrates clear gains in efficiency since the MNBML Consortium has taken over the delivery of HACC services in this region.

2. Societal Perspective

While it is clear that there have been some major cost-savings and efficiency gains from the Commonwealth Government perspective since the MNBML Consortium took over the running of
HACC services in the region, many clients are now charged co-payments for some services. When calculating the full cost of a service, co-payments must be taken into account to reflect the true cost of providing the service from the societal perspective.

As described in the preliminary report, most MNBML Consortium providers reported that, since 2013-14, 95-100% of clients paid a co-payment for services and that the co-payments ranged from $6.00 to $10.00 per unit of service or $2.00 to $10.00 per trip for Transport. Again, costs have been inflated to 2014 prices, for ease of comparison.

**Co-payments by HACC clients**

*Correction to previous report, with respect to GST*

The preliminary report incorrectly reported co-payment amounts with GST deducted. However, no GST is charged on co-payments related to the provision of services under the *Home and Community Care Act 1985*.³

As GST is only 10% and the co-payment amounts are small, previously reported figures have changed only slightly. However, for the purposes of accuracy, corrected figures are presented in Table 10 and Table 11. Table 10 shows the total costs including co-payments, if the target number of outputs had been met and Table 11 shows the actual unit costs, based on the number of outputs reported in the HACC MDS data. Similar calculations for 2014-15 have also been included (see Table 12 and Table 13).

### Table 10: Target Total Unit Costs for MNBML Consortium – 2013-14

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Target Unit Cost</th>
<th>Co-payment Min</th>
<th>Co-payment Max</th>
<th>Total Min</th>
<th>Total Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic assistance</td>
<td>$51.19</td>
<td>$6.15</td>
<td>$10.25</td>
<td>$57.34</td>
<td>$61.44</td>
</tr>
<tr>
<td>Social Support</td>
<td>$51.26</td>
<td>$6.15</td>
<td>$10.25</td>
<td>$57.41</td>
<td>$61.51</td>
</tr>
<tr>
<td>Client care coordination</td>
<td>$77.21</td>
<td>N/A</td>
<td>N/A</td>
<td>$77.21</td>
<td>$77.21</td>
</tr>
<tr>
<td>Counselling/Information, Support and Advocacy</td>
<td>$85.88</td>
<td>N/A</td>
<td>N/A</td>
<td>$85.88</td>
<td>$85.88</td>
</tr>
<tr>
<td>Transport</td>
<td>$32.61</td>
<td>$2.05</td>
<td>$10.25</td>
<td>$34.66</td>
<td>$42.86</td>
</tr>
</tbody>
</table>

³ Section 38-20 (2) of the A New Tax System (Goods and Services Tax) Act 1999 states that:

“A supply of care is GST-free if the supplier receives funding under the Home and Community Care Act 1985 in connection with the supply.”
### Table 11: Actual Total Costs of MNBML Consortium Services – 2013-14

<table>
<thead>
<tr>
<th>Service Type</th>
<th>MNBML Actual Unit Costs</th>
<th>Co-payment Min</th>
<th>Co-payment Max</th>
<th>Total Min</th>
<th>Total Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic assistance</td>
<td>$53.43</td>
<td>$6.15</td>
<td>$10.25</td>
<td>$59.58</td>
<td>$63.68</td>
</tr>
<tr>
<td>Social Support</td>
<td>$36.73</td>
<td>$6.15</td>
<td>$10.25</td>
<td>$42.88</td>
<td>$46.98</td>
</tr>
<tr>
<td>Client care coordination</td>
<td>$45.17</td>
<td>N/A</td>
<td>N/A</td>
<td>$45.17</td>
<td>$45.17</td>
</tr>
<tr>
<td>Counselling/Information, Support and Advocacy</td>
<td>$60.20</td>
<td>N/A</td>
<td>N/A</td>
<td>$60.20</td>
<td>$60.20</td>
</tr>
<tr>
<td>Transport</td>
<td>$31.20</td>
<td>$2.05</td>
<td>$10.25</td>
<td>$33.25</td>
<td>$41.45</td>
</tr>
</tbody>
</table>

### Table 12: Target Total Unit Costs for MNBML Consortium – 2014-15

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Target Unit Cost</th>
<th>Co-payment Min</th>
<th>Co-payment Max</th>
<th>Total Min</th>
<th>Total Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic assistance</td>
<td>$49.95</td>
<td>$6.00</td>
<td>$10.00</td>
<td>$55.95</td>
<td>$59.95</td>
</tr>
<tr>
<td>Social Support</td>
<td>$50.01</td>
<td>$6.00</td>
<td>$10.00</td>
<td>$56.01</td>
<td>$60.01</td>
</tr>
<tr>
<td>Client care coordination</td>
<td>$75.33</td>
<td>N/A</td>
<td>N/A</td>
<td>$75.33</td>
<td>$75.33</td>
</tr>
<tr>
<td>Counselling/Information, Support and Advocacy</td>
<td>$83.79</td>
<td>N/A</td>
<td>N/A</td>
<td>$83.79</td>
<td>$83.79</td>
</tr>
<tr>
<td>Transport</td>
<td>$31.81</td>
<td>$2.00</td>
<td>$10.00</td>
<td>$33.81</td>
<td>$41.81</td>
</tr>
</tbody>
</table>

### Table 13: Actual Total Costs of MNBML Consortium Services – 2014-15

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Actual Unit Costs</th>
<th>Co-payment Min</th>
<th>Co-payment Max</th>
<th>Total Min</th>
<th>Total Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic assistance</td>
<td>$46.83</td>
<td>$6.00</td>
<td>$10.00</td>
<td>$52.83</td>
<td>$56.83</td>
</tr>
<tr>
<td>Social Support</td>
<td>$29.73</td>
<td>$6.00</td>
<td>$10.00</td>
<td>$35.73</td>
<td>$39.73</td>
</tr>
<tr>
<td>Client care coordination</td>
<td>$24.67</td>
<td>N/A</td>
<td>N/A</td>
<td>$24.67</td>
<td>$24.67</td>
</tr>
<tr>
<td>Counselling/Information, Support and Advocacy</td>
<td>$23.83</td>
<td>N/A</td>
<td>N/A</td>
<td>$23.83</td>
<td>$23.83</td>
</tr>
<tr>
<td>Transport</td>
<td>$28.61</td>
<td>$2.00</td>
<td>$10.00</td>
<td>$30.61</td>
<td>$38.61</td>
</tr>
</tbody>
</table>
Comparison of MNHHS and MNBML Consortium total costs

A comparison is provided in the following two tables of the costs of services as delivered by the MNHHS versus the MNBML Consortium. The first table (Table 14) represents the societal perspective, and includes the client co-payment introduced when the service delivery moved from MNHHS and MNBML. The second table (Table 15) represents the Commonwealth Government perspective (as previously discussed on page 14 of this report) and excludes the co-payment – thereby offering a direct comparison over time of the costs incurred in service delivery (and funded by the Commonwealth Government) by the MNHHS and MNBML Consortium models.

Societal Perspective

As the MNHHS did not charge co-payments, the total cost from the societal and Government perspectives are the same under the MNHHS. A comparison of these costs with those of the MNBML Consortium, from the societal perspective, is shown in Table 14 and demonstrated graphically (for Domestic Assistance only) in Figure 1.

Table 14: Unit Costs Comparison - Societal Perspective

<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Assistance</td>
<td>$70.99</td>
<td>$67.76</td>
<td>$62.86</td>
<td>$59.58</td>
<td>$63.68</td>
<td>$52.83</td>
<td>$56.83</td>
</tr>
<tr>
<td>Social Support</td>
<td>$221.86</td>
<td>$194.53</td>
<td>$166.52</td>
<td>$42.88</td>
<td>$46.98</td>
<td>$35.73</td>
<td>$39.73</td>
</tr>
<tr>
<td>Client Care Coordination</td>
<td>$375.14</td>
<td>$137.38</td>
<td>$292.87</td>
<td>$45.17</td>
<td>$45.17</td>
<td>$24.67</td>
<td>$24.67</td>
</tr>
<tr>
<td>Counselling/ Support, Information and Advocacy</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$60.20</td>
<td>$60.20</td>
<td>$23.83</td>
<td>$23.83</td>
</tr>
<tr>
<td>Transport</td>
<td>$7,784.51</td>
<td>$468.97</td>
<td>$306.58</td>
<td>$33.25</td>
<td>$41.45</td>
<td>$30.61</td>
<td>$38.61</td>
</tr>
</tbody>
</table>

Commonwealth Government Perspective

The cost of providing HACC services from the perspective of the Commonwealth Government relates to the funding provided by the Commonwealth Government only, rather than the full costs of providing the services (referred to as the societal perspective) which include other amounts, such as co-payments. As for the societal perspective, the trends in unit costs from the Commonwealth Government perspective are shown in Figure 1. These are represented by the solid line.
Table 15: Comparison of unit costs between providers over time (per unit reported) – (repeat of data presented at Table 9 above)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Assistance</td>
<td>$70.99</td>
<td>$67.77</td>
<td>$62.86</td>
<td>$58.08</td>
<td>$53.43</td>
<td>$46.83</td>
</tr>
<tr>
<td>Social Support</td>
<td>$221.86</td>
<td>$194.53</td>
<td>$166.52</td>
<td>$65.34</td>
<td>$36.73</td>
<td>$29.73</td>
</tr>
<tr>
<td>Client Care Coordination</td>
<td>$375.14</td>
<td>$137.38</td>
<td>$292.87</td>
<td>$65.42</td>
<td>$45.17</td>
<td>$24.67</td>
</tr>
<tr>
<td>Counselling/Support, Information and Advocacy</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
<td>$91.26</td>
<td>$60.20</td>
<td>$23.83</td>
</tr>
<tr>
<td>Transport</td>
<td>$7,784.51</td>
<td>$468.97</td>
<td>$306.58</td>
<td>$23.67</td>
<td>$31.20</td>
<td>$28.61</td>
</tr>
<tr>
<td>AVERAGE ACROSS SERVICES</td>
<td>$73.50*</td>
<td>$69.75*</td>
<td>$64.34*</td>
<td>$56.73</td>
<td>$52.16</td>
<td>$44.72</td>
</tr>
</tbody>
</table>

*Not including Transport or Counselling/support, Information and Advocacy.
Looking at Domestic Assistance by way of example, if lower co-payments were charged (dashed line), the MNBML Consortium could be seen to be providing the services at a lower cost to society ($59.58) than the MNHHS ($62.86) in 2013-14, (Figure 1, Table 14). However, if the higher co-payment was charged (dotted line), the MNBML Consortium’s total costs were greater than the MNHHS, at $63.68 (Figure 1, Table 14). In 2014-15, unit costs reduced even further, as a result of exceeding output targets, and so even if the highest co-payment was charged, unit costs ($56.83) were still lower than the MNHHS cost of $62.86 (Figure 1, Table 14). Similarly, from the perspective of the Government only (solid line), unit costs of providing HACC services have seen a steady decline over time.

**Summary of overall costs**

By 2014-15 the MNBML Consortium was able to provide HACC services at a much lower cost than the MNHHS was able to achieve, representing a considerable saving from both the Commonwealth Government and societal perspectives.
In the time from its formation to financial year 2014-2015, the MNBML Consortium has been able to achieve considerable efficiencies in the delivery of HACC aged care services across the Metro North region of Brisbane. This is evidenced by the steady and continued decrease in the unit costs of services is provides. The average unit cost of HACC services provided by the MNBML Consortium is now well below the unit cost able to be achieved by the MNHHS, prior to the existence of the Consortium. In 2014-15, this is true from both the Government and societal perspectives. While the levels of funding have not changed dramatically, the units of service provided by the Consortium now far exceed the targets set in its funding agreements with the Commonwealth. This means that although the costs to the Commonwealth Government remain the same, more services have been able to be provided to older Australians, helping them to stay at home longer.
3. Provider opportunities

What opportunities/challenges does the MNBML Consortium Model create for service providers?

The evaluation interim report, in November 2014, presented findings from initial and follow-up interviews with 20 representatives from nine MNBML Consortium service provider members and four advocacy group members. Interviews sought to determine the service provider, or advocacy group, experience with the Consortium Model and the transition process from old to new model of service delivery (refer to Appendix 1). For providers, the expectations of delivering services through a consortium model were mostly realised, although somewhat thwarted by the administrative challenges of the transition process and the overwhelming burden of policy change in the aged care sector at that time.

Following the interim report presented in November 2014, a final round of interviews with MNBML Consortium members was requested by MNBML, with a focus on the members’ assessment of the strengths and weaknesses of the model in order to make recommendations for the Consortium’s future.

The final phase of interviews with MNBML Consortium members commenced in April 2015 and concluded in May 2015. A total of 18 Consortium members and two MNBML stakeholders were targeted for interviews.

Interview Questions

These final interviews focused on members’ assessment of the strengths and weaknesses of the Consortium Model and recommendations for its future. They drew on previous interview analysis, so that comparisons could be made over the 2013-2015 period. The interview questions that guided each discussion with Consortium members were:

Guiding research question:

What opportunities/challenges does the MNBML model bestow on MNBML Consortium providers?

- Interview lead question 1: Can you define the Consortium Model today and into the future?
- Interview lead question 2: What are the strengths and weaknesses of the Consortium Model?

Supporting research questions, as required:

- Given your involvement in the Consortium over the last two years, what is your overall summation of how this model of partnership is working in the aged care sector?
- What direction do you see the Consortium going in the future?
- What recommendations would you make to strengthen the Consortium Model?
Sample & Methodology

Eighteen interviewees were targeted, with a total of 15 interviews conducted over a five week period from April to May 2015. Three eligible Consortium members were excluded from interview for the reasons outlined below (listed by member type):

- Provider Members (possible sample n=11)
  Ten provider representatives were interviewed; one was unavailable due to resignation (and their replacement was considered too new to the role to include in the interview sample)

- Advocacy & Advisory Members (possible sample n=5)
  Four advocacy or advisory members were interviewed; one was unavailable (on leave)

- MNBML Stakeholder Leaders (possible sample n=2)
  One MNBML leader was interviewed; one was unavailable

Interviews were conducted on-site at the local provider or advocacy group office (or at a mutually convenient location). Interviews went for 90 minutes to two hours.

The interviewer focused on two lead questions (see above), using supporting research questions and previous interview data as additional prompts. Interviews were recorded (with each interviewee’s individual agreement) and field notes taken by the researcher.

Data from the interviews were collated, reviewed and organised into thematic areas and patterns of comment within each area, along with recommendations from interview responses.

Interview Results

Table 16 provides a summary of the respondents’ description of the Consortium Model, stratified into thematic areas. Thematic areas were determined based on recurring patterns in response to and loosely align with the guiding and specific interview questions outlined above. Each thematic area is subsequently supported by patterns of comment that arose. Not all comments are included; rather exemplar statements that are representative of the emerging patterns across the range of interviews are reported. In some instances a summary statement by the researcher is provided in lieu of verbatim comments from interviewees. Verbatim comments are presented in italics. The thematic area and comment patterns are reinforced by recommendations from interview respondents for the future of the consortium. Interviewee comments are non-identified and are not grouped according to member type.
Table 16: Provider interviews – thematic areas and recommendations

<table>
<thead>
<tr>
<th>Thematic area</th>
<th>Interviewee comments or summary of comments</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Justification for the Consortium Model</td>
<td>Interviewees held different “justifications” for the existence (and continuation) of the Consortium Model, according to the sector they represented.</td>
<td>The Consortium Model, as defined by these members, is not seen as unified nor encompassing the breadth of members’ objectives or representing their own constituents’ needs. In order to develop a strong brand for the Consortium, a clearer vision defining the Consortium Model and a firmer commitment of members to promote that vision.</td>
</tr>
</tbody>
</table>
| Reasons given                                | - Providers & MNBML host group overwhelmingly supported the Model on the basis that it fit their own business needs  
- Advocacy & advisory Groups held concerns over the model being anything more than a means to funnel money to local providers |                                                                                  |
|                                              | - Small providers felt that they had a voice in numbers, they had another agency to do the grant-writing work, and they had access to funds and other providers’ services to meet their own client needs  
- Advocacy and advisory groups expressed that the voices of the aged (versus the providers of care) were being heard, but expressed concerns over the place the Consortium filled in terms of policy & practice related to aged care and if or how the Consortium was participating at the policy level (State and Federal) |                                                                                  |
| Definition of the Consortium Model           | - Collaboration  
- Strength in many voices  
- Settled and successful  
- A group of people similarly minded in philosophy contributing to decision-making  
- Diversity of skills, knowledge base brought together  
- Brokerage – sharing clients and services  
- Groups of organizations with similar purpose working alongside each other to achieve a common aim  
- Subcontractors to a funding group with varying levels of commitment and engagement  
- Not a “consortium” really, maybe a collaboration but more just a group of people together for a common purpose  
- A coalition of partners working together with a backbone structure (Medicare Local) to deliver service options  
- Consortium started as a pragmatic function to transfer clients to services.  
- Successful? This week yes because of receiving funding; last week I would have said | The shared definitions given by members attests to the vision they articulate about the Consortium Model. The challenge moving forward is to agree on a shared definition and promote it through Consortium member understanding. |
<p>| (presented in respondents’ own words)        |                                                                                                              |                                                                                  |</p>
<table>
<thead>
<tr>
<th>Thematic area</th>
<th>Interviewee comments or summary of comments</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| Benefits of the Consortium Model      | • Expand knowledge and awareness of other groups/sectors  
  • Brokerage – sharing clients and services  
  • Communication  
  • Protection (for smaller providers especially)  
  • Opportunity for growth (for all providers)  
  • Responsiveness to sub-communities of aged, including complex case, CALD, et  
  • Cooperation versus competition                                                               | Members were able to list multiple benefits of the Consortium Model. These comments provide a starting point for assessing the strength and weaknesses of the Consortium Model. |
| Concerns with or challenges to the    | • Competition between providers for clients and funds  
  • Bias or conflict of interest  
  • Standards, quality, accreditation, compliance  
  • Liability & risk issues with accreditation, subcontracting  
  • Performance issues: quality versus quantity  
  • Size and sector differences  
  • Growth—how big is too big?  
  • Needs to be a safe place for difficult discussion                                               | Members were articulate about areas in which the Consortium Model requires further development.                                                   |
| Consortium Model                      | Overwhelmingly, the consensus of the interviewees cited the main goal of the Consortium as ‘funding’ followed closely by individual needs of ‘expansion’ or ‘inclusion’ (for providers in terms of geographic reach of services and number of clients serviced, with a few noting opportunities to provide new services; for advocacy groups in terms of the opportunity to be included ‘at the table’) | The Consortium Model’s goals, as interpreted by these members, are vague and unable to be cited beyond ‘funding’. To build on the Consortium Model, a vision with citable goals needs to be articulated and committed to by Consortium members. |
| Goals of the Consortium Model         | • No real vision just delivering a service  
  • No collective philosophy of why Aged Services are important  
  • No identity, need to brand the Consortium  
  • Contractual partnerships to secure funding  
  • Marriage of convenience  
  • Need to evolve beyond a collaborative group of people coming together for purpose of funding    |                                                                                                                                               |
<table>
<thead>
<tr>
<th>Thematic area</th>
<th>Interviewee comments or summary of comments</th>
<th>Recommendations</th>
</tr>
</thead>
</table>
| **Structure of the Consortium Model** | Interviewees expressed different understandings of the structure of the Consortium Model which varied according to the sector they represented and the size of their constituency. Differences in the perception of shared ideologies and shared objectives were evident in interviews where smaller providers felt threatened by larger providers (even banding together in smaller groups to meet a need without having to invite the larger provider) and larger providers felt defensive in internal dealings with the Consortium. Advocacy/Advisory groups held less concern about the structure, feeling that their inclusion in the Consortium Model was a positive step although their lack of identification with many of the objectives was problematic. Membership in the Consortium was mentioned in nearly all interviews with the following concerns expressed:  
  • Who is missing at the table, with suggestions the inclusion of experts (in health, aged care, and business), policy or government, and consumer representatives?  
  • Where meetings are conducted, with several members suggesting meeting locations rotate.  
  • How meetings are conducted, with some members suggesting the role of meeting chair be shared (such as by having a rotating chair or a location host chair the session).  
  • When meetings are conducted, with many wanting more frequency.  
  • What is expected of attendees, with respondents noting the opportunity for each member to contribute to the discussion even if only an update of their status? | The majority indicated a more collaborative model needs to evolve in order to create an inclusive group where powers are shared and everyone feels like a ‘partner’. The main issues noted with the structure revolve around moving from perceived top-down control to a shared power dynamic and ensuring equal partnership and inclusive collaboration. |
| **Governance of the Consortium Model** | Interviewees across all types and sectors spoke of the need for clear governance structures that moved the Consortium Model beyond the basic efficiencies of a funding mechanism to a sound business model that mitigated risk, promoted growth, and fostered true collaboration. **Governance is so important to the process, we are just rolling along, that’s dangerous**  
  **Need more collaboration and feedback from all sectors at the table**  
  **Not enough sharing as a collective towards growth of Consortium** | Governance issues were cited repeatedly across interviews with a clear pattern of a desire for clarity, direction, and guidelines. The Consortium needs to do further work to develop the governance structure beyond the MOU agreement that exists between the Consortium members and... |
### Thematic area

**Interviewee comments or summary of comments**

- We are not equal partners. We want to be a partner... more equalization of power
- Too much back-room decisions, lacks transparency and inclusion in decision-making
- Collaboration is not interactive and the activities are not iterative
- Consortium feels like a franchise and providers the franchisees
- Need more detail on shared/common practice and benefits to consumers (and these need to be non-negotiable across members)
- Need minimum standards and guidelines to monitor compliance
- Need accountability process ... risk and liability issues need clear guidelines to handle
- Need accountability and transparency across all sectors including providers and Medicare
- Currently, contract allocations sit outside practice

**Recommendations**

- Specifically address the difficult issues of risk and liability, accountability and standards, inclusion and expulsion, quality and quantity, decision-making and transparency.

### Future of the Consortium Model

Interviewees were asked what they deemed important for the future of the Consortium Model

- need goals, prioritising what’s next, what funding to target and for what term
- need more than just funding and efficiencies of service, need a vision
- need contingency planning, a Plan B or a transition-out-of-business continuity plan, a 5-year strategic plan
- need time to reflect on impacts, to evaluate the model and demonstrate by data that the model is viable (generate growth?, expand or change base or services?, provide efficiencies with funding?) and need to utilise available data from advocacy, policy and research groups at the table

Members view the Consortium Model as having the potential to make a real difference in aged care in the future if the challenges articulated throughout the interview process are addressed in a meaningful way.

Interviewees were also asked to provide a vision for aged care that they deemed important for the future of the Consortium Model

- Model of practice in aged care
- A vision of integrated planning, referral pathways and diversity in meeting client needs
- Great capacity and scope to seize the opportunity to rejuvenate the service model of aged care...and lead in direction of moving from ‘doing-for’ to ‘doing-with’.

Members view the Consortium Model as having the potential to make a real difference in aged care in the future if the challenges articulated throughout the interview process are addressed in a meaningful way.
Discussion

This report presents the final results of a two year evaluation of a new model of aged care service delivery in South East Queensland. The report adds to the findings previously presented in November 2014 (refer to Appendix 1) and draws an overall conclusion of the evaluation.

As previously noted and discussed, overall, interviewed HACC clients were satisfied with the services provided by the new Consortium and during the transition period from the old to new service model. Key areas in which clients were less satisfied with the new model than the old related to consistency in cleaning service staff (noting that having the same worker for each visit was preferred), rostering and personalisation of cleaning services (with comments such as “cleaning the way I want” or “cleaning properly”), and financial arrangements (with clients demonstrating a preference towards the prior service model that did not require a co-payment). However, while the new co-payment arrangements caused financial difficulty or frustration to clients, others accepted the payment and acknowledged the convenience of using direct debit for payment of the co-payment to the service providers. It is worth noting here that the new co-payment arrangements are not unique to the Consortium and most HACC clients around Australia, regardless of provider, are now required to contribute a co-payment in relation to a number of HACC services.

Aged care service providers in the Metro North Brisbane region were initially motivated to join the MNBML Consortium due to the expectation that the umbrella organisation would assist in the management of operational and administrative issues related to the transition of large numbers of new clients from the MNHHS, in a short time frame. Providers were also motivated by a desire to remain, or become, competitive in a shifting policy and funding environment.

Initially, providers identified a range of benefits arising from joining the Consortium, including networking and professional development or training opportunities with other providers (facilitated by the MNBML Consortium), expansion of their client base, greater service flexibility, and enhancement of their individual business model through collaboration with other providers. Some challenges were experienced by providers, including increased administrative and reporting burden, however these were at least in part offset by the beneficial role that the MNBML Consortium played in centrally handling Commonwealth contracts and funding allocations.

Subsequently, the new results presented in this report reveal a continuing commitment of members to the ongoing development of the Consortium model. The existence of the Consortium was seen to benefit smaller providers by giving them a voice, adding strength to funding applications, and fitting both their business models and that of the MNBML. Providers expressed concern over the pace of development of the Consortium, and a need for it to mature beyond simply a funding mechanism to becoming a leader in aged care service and a voice for older Australians, in policy.

The next phase of development of the Consortium should place greater emphasis on exploiting the expertise of advocacy group representatives within the group, particularly given the context of the changing aged care sector.
The MNBML Consortium gives aged care providers and advocacy groups an opportunity share knowledge and be more responsive to the needs of their clients through brokering arrangements between providers. The Consortium provides protection for smaller providers and an opportunity for ongoing business growth for all providers. Conversely, the model also creates some competition between providers, and duplicates some administrative and reporting requirements.

Aiming to achieve equal partnership amongst all members and providing a structure to equalise the perceived power differentials between smaller and larger partners will aid the Consortium in moving forward. Addressing the ongoing concerns surrounding governance (guidelines, policy and direction) and ensuring that all members are in a position of equal partnership (decision-making, transparency and inclusion) will assure the continued development of the Consortium and potentially pave the way for it to flourish as a model in principle and in practice.

Limitations

- Recall bias of client and/or provider in comparing satisfaction with services a year (or more) ago and now.
- Unable to observe any quality changes from clients’ perspective between MNHHS and the Consortium (perhaps because the inner workings of the Consortium are not relevant to clients.)
- The cost/value of volunteer time was unable to be incorporated into the analysis as providers were generally unable to adequately quantify it. However most providers, including MNHHS, indicated they relied on volunteers for some aspects of service provision.

The issues presented above are noted for completeness and to ensure that they can be addressed in any subsequent follow up project. They do not change the substantive findings of this evaluation.

Conclusions

Evidence has been found of considerable improvements to HACC services arising from the transition from a MNHHS management structure, to leadership of a consortium of service providers by MNBML.

The MNBML approached the challenge of HACC service delivery with novel ideas and energy. The new model was based on working with a consortium of providers; each incentivised to deliver good services at lower cost and a co-payment was passed on to clients. Whether expectations were raised by the advent of the co-payment, and then met is not addressed by this study. Clients reported a largely unchanged experience as the services transitioned. This is a positive outcome, given the potential for issues to arise as new providers were engaged, reporting and responsibilities changed and clients were required to contribute to service costs.

The economic improvements are shown by better unit costs. These arise from valuing the capital and revenue cost bases for all service providers and sharing those costs across units of activity.
Improvements arise from some combination of lower capital and revenue expenditures and/or increases in units of activity. Regardless of how they happen the effect is the same, and increased value is being extracted from every dollar invested in service delivery under the new Consortium Model of service delivery. The efficiency gains enjoyed by the Commonwealth Government from the change of services are close to 30%, and this represents a strong result from the perspective of the Commonwealth. When a broader perspective is viewed, and the costs of the co-payments charged to clients are included, the results changes and savings are reduced. But importantly, the overall cost savings remain.

The final set of interviews with the service providers were designed to elicit information about their experiences working inside the Consortium Model. Members wanted a clearer vision to define the Consortium Model and a stronger commitment among members to promote it. Many pros and cons to describe the Consortium Model experience emerged from the interviews. The most interesting themes fell in the area between increasing co-operation and collaboration among providers and a desire by providers to increase market shares and so revenues. Here the MNBML needs to play the role of arbiter, and step in with formal or informal regulation to promote the needs and welfare of the clients. The governance role is a difficult job, but clearly an important one that needs to balance incentives, performance and benefits for providers and clients of the services.

Conclusion One: Client satisfaction was largely unchanged as the transition was made from old to new governance of services. It remained at a good level despite a risk of problems and challenges.

Conclusion Two: From the perspective of the Commonwealth, as a payer of services, the transition to the Consortium Model reduced costs dramatically. Many of these savings were funded by a co-payment passed into consumers, but not all. Because client satisfaction was not reduced, there is some evidence that the transition improved welfare and economic efficiency among the suppliers and users of services.

Conclusion Three: The governance role of the MNBML is an important one that likely drives the improvements among services, but it needs to mature and develop over time and continue to promote a positive relationship with and among service providers and advocacy groups and aim to maximise welfare among the clients of HACC services.
Evaluation Project Progress Report 1

MNBML HACC Transition Program

2013-2015

Submitted by

QUT’s AusHSI Evaluation Team

Progress Report 1

October, 2014

For Review by:

- MNBML per Contract Reporting requirement
- MNBML HACC Consortium
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Introduction

This document provides the first progress report on the 2013-2015 Metro North Brisbane Medicare Local (MNBML) HACC evaluation project by the Australian Centre for Health Services Innovation (AusHSI). As proposed in the March 2014 Interim Report, this report presents the initial findings examining both the social and economic impact from a change in the delivery of Home and Community Care (HACC) services. In 2013, HACC service delivery changed from a Queensland Hospital and Health Services activity to a service delivery provided by a network of local providers coordinated through the Medicare Local Consortium. This evaluation examines the impact of this transitional change on clients and providers as well as the economic impact on systems and services.

Structure of Report

Outlined below is an overview of the evaluation, including the purpose and objectives, key evaluation questions and the overall research design as presented in the initial report (March 2014). Following this overview is a summary of the social and economic components of the research design, including details of the sample sets, indicators, measurement process, data collection, analytic methodology. Initial findings from interviews, surveys, focus groups and economic data are presented in this first progress report.

The Evaluation

AusHSI, at QUT, was engaged in September 2013 by MNBML to undertake a two-year formative evaluation of the transition of HACC services from Metro North Hospital and Health Services (MNHHS) to the MNBML newly formed HACC Consortium. This first progress report highlights that transition and its impact on clients and providers as well as presents the economic output data related to transferring the HACC services from a state-level activity to a local community provider activity. Two additional reports will be forthcoming: a second progress report in March 2015 and a final report in September 2015.
Glossary

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged Care Services</td>
<td>For people 65 years and older (50 for Aboriginal &amp; Torres Strait Islanders)</td>
</tr>
<tr>
<td>AusHSI</td>
<td>Australian Centre for Health Services Innovation</td>
</tr>
<tr>
<td>HACC</td>
<td>Home and Community Care</td>
</tr>
<tr>
<td>HHS</td>
<td>Hospital and Health Services</td>
</tr>
<tr>
<td>MDS</td>
<td>Minimum Data Set</td>
</tr>
<tr>
<td>MNBML</td>
<td>Metro North Brisbane Medicare Local</td>
</tr>
<tr>
<td>MNBML Consortium</td>
<td>Consortium of HACC providers, managed by the MNBML</td>
</tr>
<tr>
<td>MNHHS</td>
<td>Metro North Hospital and Health Service</td>
</tr>
<tr>
<td>NDR</td>
<td>National Data Repository</td>
</tr>
<tr>
<td>Service Group</td>
<td>Categories of types of HACC services which are similar in the way in which they are delivered and have comparable units of output and unit costs.</td>
</tr>
</tbody>
</table>

HACC MDS Service Type Definitions (from HACC Program National MDS User Guide Version 2.0)

<table>
<thead>
<tr>
<th>Field</th>
<th>Description on service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Care Coordination</td>
<td>This service includes activities such as implementing a care plan, liaising with various service providers and advocacy required to help clients who need access to more than one service type.</td>
</tr>
</tbody>
</table>
| Counselling/ support, information and advocacy* | Assistance with managing relationships and behaviours related to a client’s care needs. This includes dementia support and assisting a client with understanding which services they can access.  
*Counselling, Support and Advocacy is now reported as “Care received in support” and “Carer received in support”. Items under these headings in the MDS data have been summed and included under this heading for the purposes of this evaluation. |
| Domestic Assistance ¹            | Help provided in the home, included but not limited to, cleaning, paying bills, washing dishes and clothes.                                                                                           |
| Social Support                  | Help in accessing community services or assistance in order to participate in community life. (This does not include support provided to clients in group environments for example in a facility away from their home.) |
| Transport                       | This is counted in one-way trips and is counted per client, regardless of whether or not the transport is provided as a group. It is intended to help clients get out of the house to participate in community activities or do chores such as shopping. |

¹ Domestic Assistance (pre-2014 service): House cleaning, washing, ironing, help with shopping, transport to and from banks and appointments and general household support

Assistance at Home (post-2014 service ): Practical support with activities of daily living such as support with hygiene and grooming; help to maintain the house environment including cleaning and washing; and keep a client’s home in a safe and habitable condition. This outcome group includes the previous service types of domestic assistance, home maintenance and personal care.
Background: Home and Community Care

Description of Commonwealth Home and Community Care Program
The Commonwealth HACC Program was designed to provide care services to people aged 65 years and over (or 50 years and over for Aboriginal and Torres Strait Islanders), who are at risk of premature entry into residential care facilities. In providing such care, the HACC Program aimed to improve the quality of life of older people by allowing them to remain in their own homes longer, assisting in rehabilitation, reducing avoidable hospital admissions and preventing or delaying entry to residential aged care.

Current Reform Environment: Home and Community Care to Home Support Program
Driven by National Health Reform initiatives that highlighted a rapidly growing and costly ageing population and an overly complex and unsustainable aged care system, the Australian Government shifted policy and funding responsibility for aged care services from States and Territories to the Commonwealth to enable more consistent, coordinated and potentially efficient care for older people in their homes and in aged care settings. This shift to a Commonwealth HACC Program came into effect on 1 July 2012. Under this program, the Australian Government took full funding, policy and operational responsibility for HACC services for older people in all States and Territories (except Victoria which will begin transitioning in 2015 and Western Australia which is still negotiating a HACC transition). Previously the HACC program (for all ages) was jointly funded by the Australian Government and the state and territory governments.

Following the first phase of this reform on Aged Care, the Government continues to roll-out additional changes, including the move to establish the Commonwealth Home Support Program combining several programs (including HACC) into a single national program effective from 1 July 2015. The main objectives of this program remain centered on helping older people living in community to remain in their own homes adding a strong emphasis on wellness and reablement.

According to the Australian Government’s Department of Social Services 2014 Vision statement,

“The Commonwealth Home Support Programme will help older people living in the community to maximise their independence. Through the delivery of timely, high quality basic support services centred around each person’s individual goals, preferences and choices- and underpinned by a strong emphasis on wellness and reablement- the Programme will help its clients stay living in their own homes for as long as they can and wish to do so. In recognition of the vital role that carers play, where the older person has a carer the programme will support that care relationship.”

2 Key Directions for the Commonwealth Home Support Programme Discussion Paper, 2014 Department of Social Services
The main goals of the Home Support program are:

- Consolidate existing programs into a single Commonwealth Home Support Programme (including National Respite for Carers Program, the Day Therapy Centres Program and the Commonwealth HACC Program).
- Focus on wellness and reablement through a standardised national assessment process (based largely on the Consumer Directed Care Initiative) and utilise allied health professionals and the current Day Therapy Centres to support wellness and reablement.
- Introduce a nationally consistent fees policy aligned with the costs of various aged care services and based on client means-testing.
- Provide support for sector workforce development.

In addition to the expansive changes to Aged Care, the Commonwealth Government also moved responsibility for aged care and ageing from Department of Health to the Department of Social Services in late 2013. This followed the September 2013 national elections that saw a change in political parties and, subsequently, a realignment of Commonwealth department portfolios and, in particular for aged care, a re-focusing from service entitlement to service sustainability.

Brief Review of Aged Care Policy in Australia

Historically, the Home and Community Care Act was passed in 1985 and HACC Program National Guidelines followed in 1989. The HACC National Service Standards, *Getting it Right*[^3], was published a few years later. The *Aged Care Act* followed in 1997 in response to a review (*Home But Not Alone*[^4]) of 10 years of HACC funding. Another review in 2002 (*Reid Review*[^5]) resulted in major changes to the purchaser-provider contract model of service delivery (utilized since 1996) followed then by a model of 3 year funding agreements. In 2004, the Australian Government released another report, *The Way Forward*[^6], calling for streamlining of the then 17 separate community care programs. In 2010, the Government commissioned the Productivity Commission Inquiry into Aged Care and a report, *Caring for Older Australians*[^7], was released in 2011. It developed regulatory and funding options for residential and community aged care (including the Home and Community Care program). In 2010, the government announced nearly a billion dollars would be invested in aged care bringing the Commonwealth Government’s aged care expenditure to over $12 billion in 2011-2012. Targeted areas included: 1) increasing capacity through aged care packages and Consumer Directed Care initiative, approvals of aged care facility developments, expansion of loans and support of consumer protection; 2) increasing access to primary care for all older Australians and services geographically for those in rural-remote regions; 3) supporting community care providers; 4) support older people to stay at home and in the community.

With Australia’s older population increasing and, subsequently, the demand for aged care services growing, the Commonwealth Government addressed the issue of a fragmented system by assuming

[^3]: *Getting it Right* 1991
[^4]: *Home But Not Alone* 1997
[^5]: *Reid Review* 2002
[^6]: *The Way Forward* 2004
responsibility for aged care services. Following the Productivity Commission’s report, *Caring for Older Australians*, the Government made major changes in the way aged care services are funded and delivered. In 2011, the Government assumed policy and funding for aged care services in most states and territories (except Victoria and Western Australia) and as of 1 July 2012, assumed full operational responsibility for home and residential care.

In 2012, the Australian Government announced the aged care reform package, *Living Longer Living Better,* with the first major changes implemented on 1 July 2013 and subsequent rounds of changes commencing on 1 July 2104 and 1 July 2015. A key emphasis of the reform continues to focus on assisting older people to stay at home with an initial $955.4 million allocated to this goal in 2012. This reform package involves a decade-long plan to reshape aged care into a more consistent system by bringing together a number of different programs into a single national program; an integrated Home Support program (including HACC, respite, day centre, housing and other assistance programs for the aged). The Commonwealth Home Support program will come into effect from 1 July 2015.

In 2013, five bills forming significant parts of the *Living Longer Living Better* package passed into law effective 1 July 2014. These were the: [Aged Care (Living Longer Living Better) Act 2013](#); [Aged Care (Bond Security) Amendment Act 2013](#); [Aged Care (Bond Security) Levy Amendment Act 2013](#); [Australian Aged Care Quality Agency Act 2013](#); and [Australian Aged Care Quality Agency (Transitional Provisions) Act 2013](#). In addition, subordinate legislation amended the Aged Care Act 1997 and created a number of Aged Care Principles and Aged Care Determinants that took effect on 1 July 2014. Concurrently in late 2013, the Productivity Commission report titled *An Ageing Australia - Preparing for the Future* was released. The report focused on documenting the changes in population and subsequent effects of aging on government budgets, infrastructure, and economic productivity. Focusing on fiscal pressures coupled with projected lower economic growth (including lower labor participation, lower average productivity and contraction of the overall labor supply along with a slowdown in income growth) the report proposed aggressive reforms.

According to the Productivity Commission’s report on Ageing, the growth in expenditures is unsustainable at current levels. It cites budget statistics noting expenses such as: in 1984-5, $78 million from the Australian Government as well as matched contributions from state and territory governments was invested in HACC; In 2012-13, the Australian Government grant funding for home support totalled close to $1.9 billion, another $500.8 million through Treasury Certified Payments to Victoria and Western Australia for the HACC Program in those states according to DoHA released figures. This represented 755,989 people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people), receiving HACC services throughout Australia in 2012-13 (48,600 through the Commonwealth HACC Program and another 269,989 in Victoria and Western Australia). On average, HACC clients in 2012-13 received a total of $2,300 in HACC services. Following July 2015, Commonwealth budget projections for aged care will utilise a population-based needs and allocation model and be linked to related sectors that service aged care (NDIS, primary care, mental health,

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8 *Living Longer Living Better 2012*
etc.) with projected funding taking into account the uptake in the national fees policy for service. The budget allocation for the new Commonwealth Home Support Programme in 2015-16 is set to remain at the current levels of just under $2 billion.

**Brief Review of Australia’s Ageing Population Statistics**

As of June 2013, the number of people aged 65 and older in Australia reached 3.34 million, increasing by nearly 20% since 2008 (ABS 2013). Overall, people aged 65 and older represented 15% of the total population in Australia (ERP as of June 2013 was 23.1 million). In Queensland, the proportion of those aged 65 and over represents 14% or 634,000 – an increase of 23% since 2008 (ABS 2013). In the Metro North Brisbane region, that proportion was 13% (approximately 115,000) with higher proportions located in Redcliffe (19%) and Caboolture (15%). In 2011, the Australian Bureau of Statistics calculated there were 578,000 Queenslanders aged 65 years and older (13% of the population) and of these 57% were aged 65-74 years, 31% were 75-84, and 12% over 85 years.

### Australian Population Aged 65 years over

**Statistical Areas Level 4, Australia - 30 June 2013**

![Map of Australia showing population distribution](image1)

### Queensland Population Aged 65 years over

**Statistical Areas Level 2, Queensland - 30 June 2013**

![Map of Queensland showing population distribution](image2)

Over the past 30 years, life expectancy for Queenslanders has increased by over 8 years for men and nearly 6 years for women with men and women expecting another 19 to 22 birthdays after age 65, respectively. The number over 85 year olds has grown over 4%, or 2,500, per year since 2000 with those in the 60-69 years category growing so rapidly (16,000 per year) that they are projected to outnumber children in Queensland within a decade.

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Profile of Commonwealth Aged Care Clients

According to the latest data from DSS, more than one million people receive aged care services nationwide from approximately 2,100 aged care providers. Over half a million receive their support at home.

Australia-wide, Number of Clients – Age Standardised Rates per 1000 Population

![Map of Australia with age-standardized rates](image)


Profile of Metro North Brisbane Aged Care Clients

The MNBML geographic area covers 4,100 square kilometres (or 0.2% of Queensland) ranging from inner metropolitan area of Brisbane through the outer northern suburbs, Moreton Bay, Redcliffe and Caboolture to rural Kilcoy, representing about 20% of the state’s population total of 4,708,500\(^{17}\).

Metro North Brisbane Medicare Local, Number of Clients – Age Standardised Rates per 1000 Population

![Map of Metro North Brisbane](image)


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Description of MNBML HACC Initiative 2013

In the Metro North Brisbane region in Queensland, a portion of the Commonwealth HACC Program was delivered by the MNHHS. The MNHHS relinquished its contract with the Commonwealth for some of the HACC services in early 2013. In April 2013, the MNBML was awarded the HACC contract. The requirement to transition the care services for the existing clients of the MNHHS over a 5-6 week period was achieved by the MNBML through the formation of a Consortium of community HACC service providers (the MNBML Consortium). The MNBML manages the allocated HACC services through a Consortium model, which includes local providers and aged care consumer and advocacy expert representatives. This new model of delivering HACC services emphasises collaboration across the members of the Consortium. The objectives were to:

- Focus on client and carer needs
- Coordinate delivery of services
- Improve practices
- Develop an evidence base to inform policy development
- Share knowledge

In July, 2013, the then federal Minister for Mental Health and Ageing, Jacinta Collins, launched this new model for the Commonwealth’s Home and Community Care (HACC) Program in North Brisbane. The HACC program was to be coordinated by the Metro North Brisbane Medicare Local (MNBML) through an innovative model that brought together established community care providers in a Consortium partnership to deliver domestic assistance services to more than 3,000 older people.

According to a quote from the MNBML Acting CEO Jeff Cheverton in the MNBML Local Link news release:

“Our primary aim is to increase access to home and community care and ensure older people get the services they want and need to stay at home and remain independent in the community. We are bringing clients, family members and services together to ensure high quality services are delivered. Additionally, the new model allows us to deliver seven per cent more services to clients. This means at least 200 more people will receive services to remain in their own homes, instead of an aged care facility.”\(^\text{18}\) (MNBML Newsletter, July 18, 2013)

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Evaluation of MNBML HACC Consortium 2013-2015

Introduction
In 2013, the MNBML commissioned AusHSI at QUT to conduct an evaluation of their new model of aged care service delivery. In September 2013, the AusHSI evaluation team began a two-year formative evaluation of the transition of HACC services from MNHHS to the MNBML newly-formed HACC Consortium. This first progress report highlights that transition and its impact on clients and providers as well as presents the economic output data related to transferring the HACC services from a state-level activity to a local community provider activity.

Evaluation Purpose & Objectives
The research approach aims to evaluate changes to the delivery of a Medicare Local Consortium model focusing on: client satisfaction, service efficiency and Consortium collaboration. The purpose is to understand important changes to the service arising from the transition from MNHHS to MNBML.

For client satisfaction we gather both quantitative and qualitative data of consumers’ experiences of services and how services have changed since the change of management to MNBML. Structured interviews and focus groups will generate insights and new hypotheses for how services can be improved. Survey data will provide quantifiable information on client satisfaction with services comparing current and past perceptions.

To quantify changes to service efficiency we provide an economic evaluation of service delivery, describe how activity changed over time and the impact on costs. Changes to fee structures, funding and value-added features are analysed as well.

We investigate the MNBML Consortium model as a means of coordinating local providers in the delivery of HACC services within the local community context. In particular, we evaluate the experience of members of the new MNBML Consortium model, particularly their perception of how this model may be a more responsive, effective, and efficient way of coordinating local providers in the delivery of HACC services. In addition, both client and provider evaluations focus on identifying value-adding characteristics, flexible service provisions, or other qualities that add to the experience and delivery of HACC services in the local context of Metro North Brisbane.
Evaluation Questions

Three research questions guide this evaluation.

1. **Does the client perceive MNBML Consortium delivered services as better/higher quality?**

   The aim is to ascertain client satisfaction with the MNBML Consortium service delivery overall and by comparing service satisfaction prior to and after the MNBML Consortium. Additionally, we capture clients’ stories - before and after histories - regarding their experiences with aged care services.

2. **Are MNBML Consortium delivered services better value for money?**

   The aim is to examine the cost-effectiveness of the MNBML Consortium by analysing the changes in outputs (e.g. services provided) and inputs (e.g. costs) over time and comparing this to the provision of these services prior to the existence of the MNBML Consortium.

3. **What opportunities/challenges does the MNBML model bestow on MNBML Consortium providers?**

   The aim is to ascertain perceived and actual provider opportunities (and challenges) through their partnership with the MNBML Consortium over time.

Evaluation Design and Project Stages

The research design includes multi-method approaches, overtime with qualitative and quantitative data collection from Service Users, Service Providers and Systems Practices. There are five stages of the project that encompasses primary, secondary and documentary type data sources (see Table 1). In addition, the evaluation project utilizes participant observation techniques through embedded researchers in field sites to capture the formative stages of the MNBML Consortium model development and the implementation of systems practices for service provision. The project incorporates stakeholder input into the various phases of the design through both formal reporting requirements and various opportunities for interim progress updates along with more informal decision-making during the course of the evaluation.
### Table 1: Project Stages

<table>
<thead>
<tr>
<th>Stage 1: Project Initiation (2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project consultancy contract finalised.</td>
</tr>
<tr>
<td>Staffing of project</td>
</tr>
<tr>
<td>Preliminary project meetings</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 2: Project Design (2013-2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Develop overall research design including aims and objectives, key questions, scope and timing, proposed data collection methodologies.</td>
</tr>
<tr>
<td>Conduct initial inquires with stakeholders</td>
</tr>
<tr>
<td>Interim project report on research design</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 3: Project Methods and Data Collection (2013-2014)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify specific project method, instrument development, data collection strategies, to include setting timeframes, targeted sample populations, indicators, instruments, piloting, potential datasets and other data reporting vehicles.</td>
</tr>
<tr>
<td>Implement phases of data collection including primary, secondary and documentary data sources within qualitative, quantitative, reporting and archival data strategies.</td>
</tr>
<tr>
<td>Interim project report on research methods.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare all data for analyses to include these tasks: clean, collate and perform preliminary population analysis for reliability and validity.</td>
</tr>
<tr>
<td>Perform quantitative analysis on economic and survey data including descriptive, correlational, statistical testing and/or modelling of outcome scenarios</td>
</tr>
<tr>
<td>Interpret qualitative data from interview and focus group sessions as well as observation, text, and field note data to determine thematic and/or logical patterning</td>
</tr>
<tr>
<td>Interim progress reports (Oct 2014 &amp; March 2015)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Stage 5: Project Final Report and Dissemination Activities (2015)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delivery of final evaluation report (Sept 2015)</td>
</tr>
<tr>
<td>Dissemination to stakeholders (presentation, forums, summary reports, etc.)</td>
</tr>
</tbody>
</table>
Sample Sources & Sample Selection

The research utilizes several samples depending on the analysis: 1) MNBML HACC clients; 2) MNBML HACC service providers; 3) MNBML HACC Consortium consumer and advocacy representatives; 4) MNBML HACC Consortium; 5) MDS secondary data on HACC clients/services. In addition, it gathers reports, financial records and the like to outline case profiles. Identifying data sources, collecting relevant data are outlined with these various sample sets in Table 2.

Table 2: Sample Sources & Selection

<table>
<thead>
<tr>
<th></th>
<th>Clients</th>
<th>Providers</th>
<th>Advocacy Groups</th>
<th>MNBML Consortium</th>
<th>Activity Data (MDS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interviews</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Focus Groups</td>
<td>✓ (via Advocacy Groups)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Questionnaire</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Participant Observation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Case Profiles: e.g. Documents-Annual Reports, Advocacy Reports</td>
<td>✓ Systems and Practices: Staffing, Services, Fees</td>
<td>✓ Aged Care Reports</td>
<td></td>
<td>✓ Meeting Minutes, Contracts, Field Notes</td>
<td></td>
</tr>
<tr>
<td>Secondary Data: MDS, ABS, HHS</td>
<td>✓ MDS: Client and Services ABS: Aged Population</td>
<td>✓ MDS: Clients and Services</td>
<td></td>
<td>✓ MNBML MDS data: Clients and Services</td>
<td>✓ MDS/NRD; PHIDU; HHS</td>
</tr>
</tbody>
</table>

The overall criteria for sample selection into qualitative and quantitative analysis of HACC client services, e.g. MDS activity and surveys of client satisfaction and interviews of provider practices include only those clients and providers who were in the originally transitioned MNHHS HACC group.

Since its inception, the Consortium has grown from seven to more than a dozen providers. Only the initial seven providers were involved in the transitioning of the MNHHS clients and, hence, included in the analyses here. The original criteria for providers to become part of the MNBML Consortium are:

- a history of providing quality HACC services and demonstrate meeting HACC standards
- viable plan to transition the MNHHS HACC clients to their service
• demonstrate company due diligence and have capacity with workforce and recruitment requirements (including policies to cover sick or annual worker leave to provide uninterrupted service to clients)
• location presence in Metro North Brisbane
• demonstrate interest in Consortium model to improve client experience.

The HACC MDS data are collected quarterly by the Commonwealth (in the National Data Repository (NDR)) to record client and carer information and service activity. Clients are assigned unique identifiers linked through the Statistical Linkage Key which then allows access to de-identified information. HACC MDS data are recorded by individual providers within the Consortium, collated and then uploaded to the NDR each quarter under the Consortium banner. HACC services delivered using Consortium funding are recorded as such and cannot be disaggregated into individual providers.

HACC MDS unit-level data have been obtained from the HACC MDS National Data Steward for the 2010-11, 2011-12, 2012-13 and 2013-14 financial years, with the permission of both the MNHHS and the MNBML. (Data for the 2014-15 financial year will follow, when they become available.) Together, these data sets will allow comparison of 2 years of provision of HACC Services prior to the MNBML Consortium, with the situation 2 years after the creation of the Consortium.

According to these datasets, 2567 Aged Care clients were transitioned from the MNHHS to the MNBML Consortium in 2012-13 and an additional 391 original MNHHS clients received services from the MNBML Consortium in 2013-14, making a total of 2958 transitioned clients. From this baseline sample, a further process delineates conditions for client inclusion into the final sample sets:

• an initial MNBML HACC transition client in MDS Quarter 2, 2013
• been assigned HACC services through an MNBML Consortium Provider
• be in active HACC service status (not packaged care nor moved to residential, nor ceased receiving services) as of MDS Quarter 2/3, 2014
• utilized care consistently over last 4 quarters (Q3/2013-Q2-3/2014)

The final sample population of MNBML Consortium HACC clients eligible to be surveyed is determined following the conditions above (by Q2/2014). A subset of eligible clients are identified for inclusion in the evaluation of client satisfaction with a targeted sample size of approximately 100 clients drawn from an identified sample of about 150 – given a probable drop-out rate of 45-55% (in order to provide some statistical evaluation of the questionnaire, these figures were calculated to meet 95% confidence level with a sampling error of ± 5%). The final sub-sample for the survey was 89 clients from seven providers; the focus group sub-sample numbered 93 participants from seven providers.

The eligible survey sample is stratified to proportionately represent the targeted providers, where providers with larger client populations are given the opportunity to be proportionately represented by electing more eligible clients, and where possible clients are targeted to represent the general profile of the Metro North Brisbane overall aged population.

The economic analysis uses HACC MDS data for all clients falling eligible for HACC Aged Care services. Transitioned clients are distinguished from new Consortium clients by the fact that they appear in both MNBML Consortium and MNHHS datasets. In addition to HACC data, a survey of Consortium...
providers was conducted to draw out any differences across populations of HACC clients, for example Consortium clients and non-Consortium clients. Costs data have been obtained from the Program Schedules for Aged Care Funding; contracts between the Commonwealth of Australia and the providers. These Schedules outline the funding given for each service type as well as the units of output to be delivered under each service type.

**Evaluation Limitations & Challenges**

Measuring the benefits of MNBML HACC Consortium objectively is a challenging task, particularly considering the short length of time for the program to translate into measurable change for the clients and providers. Change is a complex and dynamic process often with extraneous influencers that affect outcomes. As this evaluation is embedded in a newly commissioned model, the MNBML Consortium, it needs to be somewhat flexible in measuring emerging issues, foci and other potentially influential factors that may affect outcomes and even the MNBML Consortium model itself. Additionally, the potential for bias in the client population needs to be monitored. The initial client population that transitioned may be potentially biased in the direction of complex aged-care issues. This is explored within the dataset as well as benchmarked against other available information on aged-care populations, but ultimately could present biased results.

One of the important challenges for evaluation relates to attributing change (either improvement or lack thereof) to any initiative separate from other environmental attributes. In this particular case, the ability to attribute change is limited by the short time period for observing and collecting data - at this phase, the project is only half way through the full evaluation. This is particularly relevant for both the cost-effectiveness analysis for which data are still being gathered and for the effectiveness and value-adding factors of the new Consortium model on provider delivery of aged care services.
Results and Outcomes

The following is divided into the three results sections corresponding with the three main research questions: client satisfaction, service efficiency and Consortium collaboration. To begin, a profile of the relevant client samples is provided followed by the results examined to-date and the outcomes to be completed by September 2015.

Profile of MNBML HACC Clients

The MNBML Consortium HACC clients who transitioned from MNHHS in May-June 2013 numbered approximately 3000. A year later the number of clients being serviced by Consortium providers more than doubled. The ratio of males to females was in keeping with national averages or approximately a 3:1 ratio. However, the age profiles of the MNBML Consortium HACC clients showed a marked deviation from national trends with a higher proportion of clients aged 80+ years in the MNBML HACC population than would be expected (see Figure 1 below).

![Figure 1 Age Profile of Consortium Clients](image.png)

The latest available HACC MDS data (for 2013-14) shows a similar distribution of ages across both transitioned and new Consortium clients (See Figure 1). However, transitioned clients tend to be older than new clients, with 37% over 85 years compared with only 27% over 85 years, in the new clients group (see Figure 2 and Figure 3).
This trend was also seen in the selective client sub-sample participating in the focus groups and those who completed the voluntary questionnaire. Again, the ratio of men to women in these sub-samples was approximately 3:1. However a closer look at the characteristics of these groups reveals the proportion of participants aged over 80 years was nearly two-thirds of the sample. This was notably higher than the full sample of clients transitioned to the MNBML Consortium; just over 50% of those clients were over age 80 years. This is illustrated in Figure 4 below.

Profile of MNBML Sub-Sample: Participants in Interviews & Survey

This trend is also evident in Table 3, below.

Table 3: Survey Participant Age-Sex Profile

<table>
<thead>
<tr>
<th>HACC Transition Clients (Survey Sub-Sample)</th>
<th>Aged 60-69</th>
<th>Aged 70-74</th>
<th>Aged 75-79</th>
<th>Aged 80-84</th>
<th>Aged 85+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male = 27%</td>
<td>12%</td>
<td>12%</td>
<td>12%</td>
<td>23%</td>
<td>40%</td>
</tr>
<tr>
<td>Female = 78%</td>
<td>5%</td>
<td>12%</td>
<td>16%</td>
<td>36%</td>
<td>30%</td>
</tr>
<tr>
<td>Totals</td>
<td>6%</td>
<td>12%</td>
<td>15%</td>
<td>33%</td>
<td>32%</td>
</tr>
</tbody>
</table>
Other Characteristics of the MNBML Sample from MDS, Survey & Interview Data

Another important characteristic of HACC clients is their living situation. In the sub-sample, 57% reported living alone, which is about the same as those in the full transition client sample. The majority reported living in their own home with a few noting a move to a retirement-type accommodation. Of the Metro North Brisbane region serviced by the MNBML Consortium providers, the overall client base represents over 200 suburbs with this sub-sample representing 42 suburbs. However, of the ten suburbs where most of the MNBML Consortium clientele hails, only Chermside and Aspley (the two largest) were represented in this sample. A fair representation came from Kedron, Mitchelton, The Gap, Wooloowin, Stafford, Zillmere, Redcliffe and others.

Another question on the survey asked where clients were born. Of the subsample, 84% claimed birth in Australia with another 12% noting a Commonwealth country (New Zealand, the United Kingdom, Canada), and 4% “Other.” The full HACC MDS data for 2013-14 show that 71% of transitioned clients were born in Australia compared with 68% of new Consortium clients. The survey sample represents slightly more Australian-born HACC clients (see Figure 5).

![Figure 5: Clients’ Country of Birth](image)

HACC Services Received: Survey Participants

The implications of this age profile are also noted in clients’ answers regarding how long they have been receiving HACC services. Just over half of the participants had been receiving HACC services for 5 years (median value). See Figure 6. The range was from 1 year to 22 years, with the majority reporting between 3-7 years of services (mean 5.98, SD 3.81). Overall the sub-population of about 90 clients surveyed reported receiving a total of 484 years of HACC services! The MDS dataset does not contain information regarding duration of HACC services, so is not available for comparison with the full HACC transition population.
Fortnightly hours of service received ranges from as low as 1 hour to over 5 hours (see Figure 7). The majority of survey clients reported receiving about 1 ½ hours of service on average every two weeks (mean 1.61, SD .770). This is slightly more than the average hours of service for transition clients reported in the MDS: 1.24 hours fortnightly.

Profile of Client Complexity of Needs: MDS data only

The functional status and memory/behaviour elements in the HACC MDS data can be used as a proxy for determining the complexity of needs of a client. The functional status elements are based on the assessment of a client’s ability to deal with 7 basic, everyday tasks: housework, transport, shopping, medication, money, walking and bathing/showering. The client is assessed on a scale of 1-3, 3 being the highest functional level, “without help”. Therefore, the lower the overall or average score across these functional status elements, the more complex a client’s needs. In addition, the memory and behaviour elements record whether a client has been assessed as having memory problems or confusion and/or behavioural problems such as aggression, wandering or agitation. These elements are scored: 1= “No” or 2= “Yes”, therefore opposite to the functional status codes, a higher score indicates a higher level of complexity. An average score of 1 indicates no memory or behaviour problems.
Figure 8 shows that in all age groups except >85 years, transitioned clients have a lower average functional status score. The average functional status scores across the two groups are minimally different, however this difference is statistically significant at the p<0.001 level.

![Figure 8: Average Functional Status Score by Age Group](image)

Figure 9 shows a difference between the transitioned and new client groups on memory and behavioural elements. In this case, the transitioned clients appear less likely to have memory or behaviour problems. The average memory and behavioural problems scores across the two groups are minimally different, however this difference is statistically significant at the p<0.001 level.

![Figure 9: Average Memory/Behaviour Score by Age Group](image)
It is difficult to draw any particular conclusions from the available MDS data about the true functional status and memory/behaviour problems across different groups of HACC clients as functional status data were only available for around 65% of transitioned clients and 63% of new clients. Further, the MDS data available do not include the providers’ non-Consolidation HACC clients.

Contrary to what the MDS data show, there was a strong view, from the written feedback from providers in the economics survey that transitioned clients were generally much less functionally able and often required greater levels of care. It was consistently reported that the transitioned Consolidation clients were older and frailer and had poorer health and mobility. Providers also reported transitioned clients requiring more care coordination or case management.

The economics survey also asked providers to indicate the average functional status scores of clients in different groups (e.g. transitioned and non-Consolidation) and also the percentages of clients in these groups with memory or behaviour problems. Most providers were not able to separate out clients easily, however results from one provider show that around 94% of their transitioned clients had behavioural problems (using the MDS definition) while only 75% of their other clients fell into this category. Conversely, they reported that only 13% of transitioned clients had memory problems, while 65% of their other clients were reported as having these problems. Similarly, where data were available, two out of three providers reported an average functional status of transitioned clients to be slightly higher than other HACC clients. Comments from individual providers consistently state that the transitioned clients were more challenging, across the board, even though the available MDS data does not necessarily support these claims.
Client Satisfaction

Does the client perceive MNBML Consortium delivered services as better/higher quality?

Initial Results: Client Questionnaire & Group Interviews

The client focus groups and questionnaire addressed two key evaluation questions in relation to the transition from HACC services delivered from MNHHS in the past and those now delivered through the MNBML Consortium:

1. To what extent are they satisfied with the overall service and their ability to have a say in those home care options? This measure included satisfaction questions about the service, the options for and information about those services, the respect they feel they received from the provider and the financial and other arrangement’s for these services.

2. To what extent do they agree (or disagree) with various aspects of the domestic assistance services they received? This measure included how flexible and personalized clients found the care, how consistent and adequate the service, if they perceived the service as quality, and if they felt they were being treated with dignity and respect.

The following evidence is based on the client questionnaires and the client focus group discussions. These took place between May and September of 2014 during 12 sessions representing nearly 100 clients from the seven original Consortium provider groups.

Client Questionnaire Results

The survey focused on satisfaction with the overall service as well as comparing their current provider to their previous MNHHS service. It documented the clients’ ratings of their satisfaction with HACC services overall and then documented satisfaction between services now and in the past. The questions focused on quality, reliability, flexibility and consistency. In addition, clients’ rated their satisfaction with access to information and choice about the service, including awareness, timeliness and supportiveness, as well as how they rated the attitude and respect afforded to them by the provider and the service worker. Participants also had ample opportunity on the survey to provide comments, and 90% of those taking the survey provided such comments.

The survey results point to clients that are overly satisfied with the HACC assistance they receive. The reported satisfaction rate revealed that 87% were satisfied with the overall home care support received through HACC service (see Table 4, below). Importantly, the goal of the HACC services has long been to assist older persons in living independently and staying in their own home as long as possible. The questions related to the client’s own perceptions of how that goal impacts their life are also noted in Table 4. Clearly, clients see the value provided in these services to support them to continue to live independently.
Table 4: Overall Satisfaction with HACC Services & Support to Live Independently

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall are you satisfied with the home care support you receive from HACC services?</td>
<td>87%</td>
<td>13%</td>
</tr>
<tr>
<td>Do you feel that these services support you to continue living independently?</td>
<td>99%</td>
<td>1%</td>
</tr>
<tr>
<td>Do you feel that these services support you with your daily living?</td>
<td>87%</td>
<td>12%</td>
</tr>
</tbody>
</table>

Based on responses to questionnaire from HACC transition client participants

Clients also provided ample comments on both the questionnaire and in focus group discussions. Some comments are highlighted in Table 5, below.

Table 5: Comments from clients on overall importance of home care services for independent living, and their gratitude for such services that assist them in their daily tasks

- Client’s and Carers’s experience of Home Care services gave them a sense of enablement to continue to live independently in the community or at home.
  - “As a carer it is a demanding chore ... House duty help = essential without this assistance we may have to consider moving ?”
  - “I am so grateful to have them come, I can’t do much myself so it just wouldn’t get done.” (82 year old man living alone)
  - “I am grateful for the help I get. Thanks you.” (86 year old female living alone)
  - “We are grateful for whatever assistance is offered.” (80+ year old couple receiving services for 5+ years)
  - “Every little bit helps ... they help and give me a break” (male carer 64 years old)
  - A carer for her daughter noted how her current provider was very obliging “They ... even sent help another day in place of a public holiday which I was thankful for.”

- This enablement also went beyond domestic services to include the social aspect of having the care worker in the home.
  - “It is good to have a chat and for my wife to see someone else“ (male carer aged 64)
  - “...pleasant person and always takes time for a little chat and to pat my dog.” (83 year old female receiving HACC services for 5 years)
  - “We had a male some years ago and made quite a friend of him, taking an interest in his life.” (married couple in their 90’s)
  - “I’m really satisfied with the service I receive. The girls are all cheerful and say they enjoy coming as I try to make them comfortable.” (female 93 years receiving services for over 15 years)
  - “Familiarity is nice ... someone who knows what you want and has a chat” (female client)

Based on responses to questionnaire from HACC transition client participants, Questionnaire (n=88), Open Comments provided by 90% of participants as well as comments from Focus Group (n=93)
In survey comments and follow-up discussions about the transition, clients expressed concern about both the rapid pace of the local transition as well as concerns about further changes in the Commonwealth’s policies on aged care health services. Interestingly, several clients were most concerned with the impact on their former MNHHS health care worker, with a select few relieved that the new provider was able to offer employment. Despite this, most clients noted that they felt the transition went smoothly. This is highlighted in the comments in Table 6, below.

Table 6: Comments on Overall Concern with Changes to Aged Care

- Most participants expressed concern about the rapid, and sometimes, confusing pace of aged care changes in the current Australian environment. Worries expressed included future availability of service coupled with their recognition of their own ageing and growing needs
  - “Chaos with no real road map.” (male client)
  - “I’m 88 and not really thinking much more about a long future.” (female client)
  - “I do the garden, but being over 90, it is getting harder” (male client)
  - “Principally, too many changes in home care services.” (female aged 81 living alone & receiving services for 5 years)
  - “I’m in private health—no waiting lists.” (male client)
  - “I’m with private community membership organization and with my church, so I don’t have to worry.” (male client)

- Interestingly, several participants across all the discussion groups expressed sincere concern for the former staff of Queensland Health during the transition.
  - As a carer for wife “The main problem of the transition was the uncertainty for former staff. They literally did not know where their future lies, it was staff related only. Apart from that as far as we were concerned it was an excellent transition.”
  - “Queensland Health rushed to sack people and handled it poorly did not keep me informed.” (74 year old male client)

- Many noted that the transition was seamless.
  - As a carer for husband, “I thought the transition to [current provider] was very good ... the girls [at my current provider] are always courteous and helpful, and so were the girls from [previous provider].”
  - “I don’t notice any difference from the government services.” (86 year old female living alone and receiving domestic services for 6 years, currently 1 hour/fortnight with 3 different workers over last year)
  - Queensland Health provided me with quality 1st class service, [current provider] trying hard but in my opinion got too much additional work at short notice.” (couple in mid 70’s receiving services for 5.5 years)
  - “No real change as we only get limited services.” (64 year old male carer receiving services for 7 years)
  - “I know this is boring. I have had only two home care workers since beginning four years ago, one man and one woman, both were excellent.” (83 year old female living alone).

Based on responses to questionnaire from HACC transition client participants, Questionnaire (n=88), Open Comments provided by 90% of participants as well as comments from Focus Group (n=93)
Overall, clients were aware of the transition and, allowing for some adjustment to new schedules and care workers, stated that they felt the process was generally successful in providing uninterrupted service in a satisfactory way. This confirmed the effort put in by both the MNHHS and by MNBML in prioritizing a seamless process to assure continued services for clients during the transition period.

Survey results of client satisfaction with the transition in their HACC services show a clear trend in overall satisfaction (see Figure 10, below). Generally, all aspects were rated satisfactorily (on a scale of 0-4 with 4 being highest). The majority of answers for either previous or current services was between 3 “somewhat agree” to 4 “agree”. It is worthy to note that results in nearly every category show a trend towards slightly more satisfaction with their previous home care arrangements (the exception was question 17 where current workers are perceived to be in less of a rush to complete homecare tasks). However, the difference in means between their former service and their current service on a scale of 0-4 was generally tenths of a point. Only four of the items were statistically different.

Those exceptions, where satisfaction between past and current services was statistically different, showed a slight preference towards the previous service provided by the MNHHS. These included the following items: financial arrangements (clients preferred the previous no-cost arrangement); and items related to the personalization and quality of cleaning provided, “cleaning the way I want” and “cleaning properly,” as well as the service provider’s consistency in rostering care workers, “seeing the same worker.” In each instance, the previous service was deemed more satisfactory. These significant differences in perceived services, pre and post the changes in which provider delivered the services, will be further elaborated with clients own comments in the next section.
Figure 10: Consumer Satisfaction with HACC Services

Survey Questionnaire participants, n=88; Statistical significance using both parametric and nonparametric tests
*p<.05, **p<.01, †p<.1
Results of Client Comment from the Questionnaire and Focus Group Sessions

In order to gain a broader perspective on qualitative comments, the next series of figures compile thematically the comments from survey questions and the discussions from focus groups. The general themes from these comments fall into six categories: overall satisfaction, communication (mainly information from and contact with provider), quality of service (in terms of cleanliness, thoroughness, flexibility in tasks and products used, etc.), socialization between the care worker and the client (focusing on the benefits of the interaction and the ease of having a worker in the home), attitude, respect and responsiveness from both the provider and the care worker (see Figure 11 and Figure 12).

Each of the following represents a different dynamic in participants’ reporting. The first graph represents group discussions where peer pressure and other group dynamics can constrain or enlighten participants (each conversational topic is measured at the group level). The second graph represents clients’ written comments provided in an anonymous format through the questionnaire (individual comments were measured at the single participant level). In each instance, comments were coded on two levels: first as positive or negative comments; second as referring to past or current provider. The top half of the stacked bars on the graphs below represent positive comments (purple and green); the bottom half negative (red, blue). The graph has been set to 100% in order to highlight the overall proportion in types of comments.

This first graph clearly reveals a different pattern in overall satisfaction than the previous likert-style survey results provided. Here, it is evident that clients were more likely to provide verbal comments that were less positive in the current context. Nonetheless, the majority (75%) of group conversations still rated their overall services as positive and satisfying, both now and in the past.

The theme of “communication” stands out as having the most negative discussions overall. Communication covered a range of sub-topics, including communicating with the provider on service options and flexibility, communication from the provider on service changes in fortnightly care or information on other services available (personalized care). Additionally, clients provided ample examples of dissatisfaction with the rostering of current service schedules and particularly in comparison to their satisfaction with their previous provider’s handling of this task, both in terms of consistency and flexibility (as seen in the survey responses as well as written questionnaire comments).

The comments surrounding rostering had a spill-over effect on the categories of communication and socialization, where discussions were coded for both thematic topics. Socialization, which in survey responses was largely positive in the current context, becomes more negative in this group discussion context. In terms of rostering, many clients attested to the comfortable consistency they had with their previous Queensland health worker (same person, same time, same routine) and the flow-on effect of that routine into a more personalized and social experience. In both of these instances, the current experience rates more negatively than positively.

Another topic of group conversation was the quality aspect of service. Two-thirds of the conversations were favourable overall, but as the likert-scale survey results showed, there are notable differences in the perception of the quality of service the clients believed they receive. Clients’ negative comments on aspects of service mostly centred on wanting consistency in cleaning,
noting that rostering the same worker for each visit is essential in meeting that requirement. In closer examination of the responses, these requests were across types of providers, both larger and smaller.

The last category, attitude, revealed an interesting dynamic related to workforce rules when clients expressed dissatisfaction with workers. Here clients gave examples of workforce rules that made personalized and flexible service more difficult with their previously delivered services than they have found with their current service which they commented was more flexible (e.g. types of cleaning fluids, etc.).

Figure 1: Client Comments from Focus Group Sessions (n=93)

The next graph illustrates these same themes via the written comments. The written comments provided on the questionnaire reveal a slightly different pattern around these six themes. It should be pointed out that the questionnaire allowed for written comments on each item and then provided additional space for further comments. In all, 90% of those taking the survey provided written comments.

As in the survey likert-scale responses, most clients stated they were satisfied with the quality of the service, but comments provided were quite explicit in their examples of how the service could be improved. Again, rostering is seen as particularly problematic in the current context. Communication rates the second highest level of written negative comments about the current provider, but retains an equal proportion of positive comments (about 30-35%) as in the group discussions. The comments surrounding current provider quality are more negative in the written context than the discussion groups and the comments about socialization substantially more positive. With the latter, several clients took the opportunity to provide written comments on personal experiences they had with care workers, particularly in the context of how they valued the opportunity for the social interaction. Quality, which in the survey analysis was significantly different for past and current satisfaction, is here shown to be nearly equal in pro and con statements for the clients’ current
experience. Nonetheless, quality ranks third out of the six categories for number of negative comments about the current service.

Interestingly, participants in the focus groups were more likely to discuss the positive aspects of their previous service, as well as more of their displeasure with some of their previous experiences. In contrast, the written comments on the questionnaires were more likely to highlight the positive and negative aspects of the current service, almost to the exclusion of any comments on their previous service. As noted before, the dynamics of the two different types of qualitative data attest to the various foci of the clients in different settings. With the survey, a focus on the current issues was evident with an obvious attempt to show gratitude for the current home care assistance and offer constructive criticism for personalizing the service to meet their own individual needs. In the focus group setting, clients were more likely to be positive in their comparison of past and present services with obvious attempts to come to a consensus on their perceptions. The following tables illustrate the comments received.

Table 7: Overall Comments about Service

- Overall clients were satisfied, but complaints about flexible scheduling or consistency in set times or seeing the same worker were noted.
  - “Mom (currently) spends too much time explaining things to each new worker showing them where vacuum is, etc. Previously with previous service she had the same worker, same routine. Now the worker often runs out of time to take the laundry in.” (family member)
  - “With previous service, the arrival time wasn’t reliable so had to hang around waiting.” (focus group client)
  - “I would like to change the day the home care worker comes.” (couple over 75 years
receiving HACC for 3 years)
  o “With Queensland Health always same worker, [present provider] almost always someone different.” (couple in their mid-70’s receiving services for over 5 years)
  o “We appreciate prior phone contact to confirm time of arrival.” (Couple in 80’s)
  o A carer for her daughter noted how her current provider was very obliging “They ... even sent help another day in place of a public holiday which I was thankful for.”

- Most clients expressed gratitude for the work performed, but many also said they wanted more and different types of cleaning (dust in corners, splash tiles in bathroom).
  o “With previous service it was the same worker, same time, better-more proper cleaning and more opportunity to chat. Now it’s too much of a rush” “I would prefer that the home care worker do what I CAN’T DO MYSELF.” (73 year old female living alone & receiving 6+ year of HACC Services)
  o “We do most of [tasks] received because no one does things the way we do ... but help good.” (66 year old male carer)
  o “More rules of what worker can/can’t do with Queensland Health. Current provider more flexible, seems willing to do more of what I want done.” (focus group client)
  o “I think the [current] service is better service overall than Queensland Health. Can’t pinpoint why, Queensland Health was good but this provider is better-seems more aware of everything.” (female client in 70’s)
  o “I felt the change was too rushed and several of the new workers were not properly trained beforehand. None of the ones I have had had the same level of hygiene as the HH worker did, particularly in the shower and the kitchen floor.” (female)
  o “they know what NOT to do, but need more training on what to do”
  o “Whilst all the care workers are a pleasure to have helping me – on two occasions they actually only worked for 30 minutes ... I would have grateful if they offered another job to do other than vacuuming and mopping” (female in 80’s living alone)
  o “Cleaners don’t know how to ‘clean’ – e.g. move dirt to edge of floor. Cleaners don’t put ‘things’ away – e.g. empty floor bucket.” (couple in 70 years receiving service for 7 years)
  o “I have felt happier with present service overall.” (87 year old carer for her husband receiving over 5 years of service)
  o “My home care worker doesn’t always finish in the time allotted ... not necessarily bad ... the twin tub on my washing machine takes a long time and she never leaves until it is done and she hangs laundry out.” (female in 80’s living alone)

- Other clients noted a concern with options to extend or assess their services.
  o “It has been several years since we had a chance to change the tasks done. As we get older, there are perhaps other tasks we can no longer manage that we would like done.” (couple in mid-70s receiving services for 3 years)
  o “I feel it ought to be taken into consideration that there are some simple tasks I cannot do because I can’t reach, e.g., a high cupboard e.g. (I could do the lower ones & leave higher ones to my Helper.” (73 year old living alone)
  o “Am happy with what is done, but not sure what we are entitled to.” (male carer, 64 years)
  o “With Queensland Health I had perfect services that included OT, Physio, and Incontinence Nurse on a needs basis. A COMPLETE SERVICE.” (caps in original) (74 year old male).
Some interesting compliments centred on the convenience of current providers embracing modern technology; with direct debit of their co-payments touted as “very convenient” for those clients whose providers offer it. However, clients expressed concern about these newly implemented co-payment arrangements. As was noted in the survey responses, satisfaction with the newly introduced co-payment arrangement was low (statistically significant). Clients preferred the previous no-fee arrangements, but not always for the obvious reasons. The following represents the overall comments from both the questionnaire as well as focus group discussions. The overall attitude was one of being reconciled to the new fee structure, but it is worth noting that the co-payment represented a hardship for some. In the MDS data, 92% of the 2,958 clients that transitioned services reported receiving a pension. Discussions in group settings as well as comments in the surveys revealed the burden this co-payment may impose on some clients.

Table 8: Comments on Changes to Financial Arrangements of Home Care Services

- Participants and carers were both concerned with and resigned to the changes in financial arrangements
  - “I am happy to have my cleaning done for such a financial amount?” (83 year old)
  - “[It was a] really good service when didn’t have to pay” (focus group).
  - “I am so grateful to have them come, I can’t do much myself so it just wouldn’t get done” (82 year old)
  - “The quality was better when it was free” (couple in their 80’s)
  - “…the only difference between (current provider) and MNHHS is the cost, but eleven dollars per fortnight doesn’t hurt me. I am very satisfied” (79 year old male living alone and receiving services for 4 years)

Based on responses to questionnaire from HACC transition client participants, Questionnaire (n=88), and the focus group discussions (n=93)

**Follow-up for 2015 Reporting**

Client data to capture the experience of those clients who transitioned from MNHHS to MNBML Consortium providers was gathered via surveys and focus groups conducted in June-August 2014. This activity has now been concluded. These current findings provide insight into the experience of those clients who transitioned services from their previous provider to their current provider. No further data is planned to be gathered directly from the client experience.
Service Efficiency

Are MNBML Consortium-delivered services better value for money?

Initial Results: Economic Evaluation

This part of the evaluation investigates whether a Consortium structure is a cost-effective way of providing HACC services to older people in Queensland, by examining the unit cost of providing the five Service Types described earlier, as well as looking at any changes in trends across the client group as they transitioned from the MNHHS to the MNBML Consortium. This analysis is designed to complement the qualitative analysis, which takes into account client perceptions of the quality of care/service provided prior to and after transition to MNBML Consortium providers.

Due to the aggregation of MDS data, it is not possible to separate outputs by provider within the Consortium. Therefore, for the quantitative analysis, the MNBML data are compared with the MNHHS data without breaking down outputs into individual providers within the Consortium. However, this does not detract from the analysis as individual Consortium member detail is not required to compare the cost per unit of service provided by the Consortium with that of the MNHHS.

Target Unit Cost

Based on the funding and output allocations in the various Program Schedules an assumed, or target unit cost for each service can be calculated. This is done by dividing the funding for each Service Type by the expected outputs for the relevant Service Type (see Table 9, below). The performance indicators in the Program Schedules set a target of achieving at least 95% of the target across all services and delivering at least 70% of the target for each Service Type. Table 9 also shows the cost per unit if 95% of each target is met, in parentheses. There is some difference between the pre and post transition funding per unit, but it is only minimal and in most cases less than one dollar per unit.
Table 9: Target Unit Costs (Excl. GST)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Target Unit Cost – MNHHS 2012/13 (95%)</th>
<th>Target Unit Cost – MNBML Transition Period (95%)</th>
<th>Target Unit Cost – MNBML 2013/14 and 2014/15 (95%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Assistance</td>
<td>$49.11 ($51.70)</td>
<td>$49.12 ($51.70)</td>
<td>$49.95 ($52.57)</td>
</tr>
<tr>
<td>Social Support</td>
<td>$49.18 ($51.76)</td>
<td>$49.21 ($51.80)</td>
<td>$50.01 ($52.64)</td>
</tr>
<tr>
<td>Client Care Coordination</td>
<td>$74.07 ($77.97)</td>
<td>$74.07 ($77.97)</td>
<td>$75.33 ($79.29)</td>
</tr>
<tr>
<td>Counselling/Support, Information and Advocacy</td>
<td>$82.39 ($86.72)</td>
<td>$82.66 ($87.01)</td>
<td>$83.79 ($88.20)</td>
</tr>
<tr>
<td>Transport</td>
<td>$31.28 ($32.93)</td>
<td>$31.27 ($32.92)</td>
<td>$31.81 ($33.49)</td>
</tr>
<tr>
<td>Average across services</td>
<td>$49.10 ($51.68)</td>
<td>$49.12 ($51.68)</td>
<td>$49.93 ($52.56)</td>
</tr>
</tbody>
</table>

**MNBML Unit Costs**

Table 10 shows the unit costs of the MNBML Consortium, to provide services during the transition period. These have been calculated using the reported outputs in the HACC MDS Data for 2012-13. As could be expected, due to the tight time frames and difficultly in transitioning clients, these are higher than the target unit costs as not all target outputs were met. Nevertheless, the average unit cost of $54.96 is less than $4.00 more than the 95% target average unit cost of $51.68 for the transition period (see Table 9).
Table 10: MNBML Unit Costs - Transition Period

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Funded Units of Output</th>
<th>Total Funding</th>
<th>Total Units Reported</th>
<th>% of Target</th>
<th>Cost per unit reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic assistance</td>
<td>13,600</td>
<td>$668,000.00</td>
<td>12,038</td>
<td>89%</td>
<td>$55.49</td>
</tr>
<tr>
<td>Social support</td>
<td>798</td>
<td>$39,266.83</td>
<td>625</td>
<td>78%</td>
<td>$62.83</td>
</tr>
<tr>
<td>Client Care Coordination</td>
<td>180</td>
<td>$13,332.50</td>
<td>214</td>
<td>119%</td>
<td>$62.30</td>
</tr>
<tr>
<td>Counselling/Support, Information and Advocacy Transport</td>
<td>204</td>
<td>$16,862.17</td>
<td>194</td>
<td>95%</td>
<td>$86.92</td>
</tr>
<tr>
<td>Transport</td>
<td>661</td>
<td>$20,672.33</td>
<td>917</td>
<td>139%</td>
<td>$22.54</td>
</tr>
<tr>
<td><strong>YEAR TOTAL</strong></td>
<td><strong>15,443</strong></td>
<td><strong>$758,133.83</strong></td>
<td><strong>13,794</strong></td>
<td><strong>89%</strong></td>
<td><strong>$54.96</strong></td>
</tr>
</tbody>
</table>

Since the transition period, the unit cost of services provided by the MNBML Consortium has reduced. The latest MDS data for the MNBML Consortium show an increase in outputs since the transition period from delivering an average of 89% of the target outputs in the transition year (Table 10), to delivering 95% in 2013-14 (Table 11). Delivery of services was over target in all but one service type, Domestic Assistance (see Table 11). This brought the 2013-14 MNBML Consortium average unit costs to $52.10 (Table 11) much closer to the target unit cost of $49.93 and under the 95% target cost of $52.56 (see Table 9).

Table 11: MNBML Unit Costs - 2013-14

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Funded Units of Output</th>
<th>Total Funding</th>
<th>Total Units Reported</th>
<th>% of Target</th>
<th>Cost per unit reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Assistance</td>
<td>155,045</td>
<td>$7,743,790.30</td>
<td>143,325</td>
<td>92%</td>
<td>$55.14</td>
</tr>
<tr>
<td>Social Support</td>
<td>4,791</td>
<td>$239,606.00</td>
<td>6,767</td>
<td>141%</td>
<td>$36.45</td>
</tr>
<tr>
<td>Client Care Coordination</td>
<td>1,080</td>
<td>$81,355.00</td>
<td>1,797</td>
<td>166%</td>
<td>$48.08</td>
</tr>
<tr>
<td>Counselling/Support, Information and Advocacy Transport</td>
<td>1,228</td>
<td>$102,893.00</td>
<td>2,062</td>
<td>168%</td>
<td>$51.22</td>
</tr>
<tr>
<td>Transport</td>
<td>3,965</td>
<td>$126,143.00</td>
<td>4,164</td>
<td>105%</td>
<td>$30.42</td>
</tr>
<tr>
<td><strong>YEAR TOTAL</strong></td>
<td><strong>166,109</strong></td>
<td><strong>$8,293,787.30</strong></td>
<td><strong>158,115</strong></td>
<td><strong>95%</strong></td>
<td><strong>$52.10</strong></td>
</tr>
</tbody>
</table>
Further to this, Consortium members do not receive the full price per unit of service shown in Table 9. Provider members tend to receive 14%-16% less than the unit costs in Table 9 and around 8% less for Transport (see Table 12). This system is necessary to allow the Consortium to operate and to coordinate delivery of services across the providers. For example, much time and effort is put into developing systems of cross-provider referral of clients, with the ultimate aim of providing a better, more timely service to clients.

Table 12: Unit Funding to Providers

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Target Unit Cost</th>
<th>Funding per unit, transferred to Providers</th>
<th>Difference</th>
<th>Difference (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic assistance</td>
<td>$49.95</td>
<td>$42.00</td>
<td>$7.95</td>
<td>(16%)</td>
</tr>
<tr>
<td>Social Support</td>
<td>$50.01</td>
<td>$42.00</td>
<td>$8.01</td>
<td>(16%)</td>
</tr>
<tr>
<td>Client care coordination</td>
<td>$75.33</td>
<td>$64.00</td>
<td>$11.33</td>
<td>(15%)</td>
</tr>
<tr>
<td>Counselling/Support, Information and Advocacy</td>
<td>$83.79</td>
<td>$72.00</td>
<td>$11.79</td>
<td>(14%)</td>
</tr>
<tr>
<td>Transport</td>
<td>$31.81</td>
<td>$29.23</td>
<td>$2.58</td>
<td>(8%)</td>
</tr>
</tbody>
</table>

Co-payments

Co-payments now form a standard part of the costs of providing HACC services (and are not unique to the MNBML Consortium). Consortium providers generally charge co-payments of between $6.00 and $10.00 per hour (unit) for Domestic Assistance or Social Support and between $5.00 and $10.00 per trip for Transport (Table 13). Many clients receive fortnightly, 2-hour visits for Domestic Assistance and so from an individual client perspective, the co-payment may amount to $12-$20 per visit. In order to determine a client’s ability to pay, all providers surveyed stated that they have a fees policy or financial hardship assessment system to ensure clients do not have to pay a co-payment if doing so would cause them to suffer financially.

While there will always be clients with financial difficulties, most providers have reported that the vast majority of clients, 95-100%, pay some form of co-payment for Domestic Assistance, Social Support and Transport. Most providers reported that the percentage of clients contributing a co-payment was similar across different groups, for example transitioned Consortium clients and non-Consortium clients. Only one provider, reported a substantially lower level of co-payments from their non-Consortium clients (50%), but they also reported lower levels of co-payments from Consortium clients (70%). However, as this provider specialises in assisting homeless people and those at risk of homelessness, these lower levels of co-payments were to be expected.
Table 13: Co-Payments per unit (Inc. GST)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Co-payment min</th>
<th>Co-payment Max</th>
<th>Consortium Clients Paying a Co-Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic assistance</td>
<td>$6.00</td>
<td>$10.00</td>
<td>70%-100%</td>
</tr>
<tr>
<td>Social Support</td>
<td>$6.00</td>
<td>$10.00</td>
<td>70%-98.5%</td>
</tr>
<tr>
<td>Client care coordination</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Counselling/Information, Support and Advocacy</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Transport</td>
<td>$2.00</td>
<td>$10.00</td>
<td>70%-100%</td>
</tr>
</tbody>
</table>

**Overall Costs of Providing the Consortium Service**

Taking the societal view, the total unit costs of delivering HACC services should include co-payments. Including the co-payments gives a better estimate of the true cost of providing these services. Not including the co-payments gives the costs from the perspective of the Commonwealth Government only. The expected overall unit costs of providing HACC services through the Consortium are show in Table 14, below. These are calculated using the target unit costs from Table 9, above and co-payments described in Table 13. Similarly, the actual total costs, taking into account the actual levels of service provision in 2013-14, are presented in Table 15.

Table 14: Expected Total Costs of MNBML Consortium Services – 2013-14 (Excl. GST)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Target Unit Cost</th>
<th>Co-payment min</th>
<th>Co-payment Max</th>
<th>Total Min</th>
<th>Total Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic assistance</td>
<td>$49.95</td>
<td>$5.45</td>
<td>$9.09</td>
<td>$55.40</td>
<td>$59.04</td>
</tr>
<tr>
<td>Social Support</td>
<td>$50.01</td>
<td>$5.45</td>
<td>$9.09</td>
<td>$55.46</td>
<td>$59.10</td>
</tr>
<tr>
<td>Client care coordination</td>
<td>$75.33</td>
<td>N/A</td>
<td>N/A</td>
<td>$75.33</td>
<td>$75.33</td>
</tr>
<tr>
<td>Counselling/Information, Support and Advocacy</td>
<td>$83.79</td>
<td>N/A</td>
<td>N/A</td>
<td>$83.79</td>
<td>$83.79</td>
</tr>
<tr>
<td>Transport</td>
<td>$31.81</td>
<td>$1.82</td>
<td>$9.09</td>
<td>$33.63</td>
<td>$40.90</td>
</tr>
</tbody>
</table>

Table 15: Total Actual Unit Costs for MNBML Consortium – 2013-14 (Excl. GST)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>MNBML Actual Costs 2013-14</th>
<th>Co-payment min</th>
<th>Co-payment Max</th>
<th>Total Min</th>
<th>Total Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic assistance</td>
<td>$55.14</td>
<td>$5.45</td>
<td>$9.09</td>
<td>$60.59</td>
<td>$64.23</td>
</tr>
<tr>
<td>Social Support</td>
<td>$36.45</td>
<td>$5.45</td>
<td>$9.09</td>
<td>$41.90</td>
<td>$45.54</td>
</tr>
<tr>
<td>Client care coordination</td>
<td>$48.08</td>
<td>N/A</td>
<td>N/A</td>
<td>$48.08</td>
<td>$48.08</td>
</tr>
<tr>
<td>Counselling/Information, Support and Advocacy</td>
<td>$51.22</td>
<td>N/A</td>
<td>N/A</td>
<td>$51.22</td>
<td>$51.22</td>
</tr>
<tr>
<td>Transport</td>
<td>$30.42</td>
<td>$1.82</td>
<td>$9.09</td>
<td>$32.24</td>
<td>$39.51</td>
</tr>
</tbody>
</table>
Unfortunately, not all costs and target output information for the MNHHS was available at the time of writing this interim report. MDS output data were available, however and average unit costs for Domestic Assistance were able to be calculated (see Table 16 and Table 17).

### Table 16: Unit Costs of MNHHS Services 2010-11

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Funded Units of Output</th>
<th>Total Funding</th>
<th>Total Units Reported</th>
<th>% of Target</th>
<th>Cost per unit reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Assistance</td>
<td>N/A</td>
<td>$8,390,507.00</td>
<td>128,997</td>
<td>N/A</td>
<td>$65.04</td>
</tr>
</tbody>
</table>

### Table 17: Unit Costs of MNHHS Services 2011-12

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Funded Units of Output</th>
<th>Total Funding</th>
<th>Total Units Reported</th>
<th>% of Target</th>
<th>Cost per unit reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Assistance</td>
<td>N/A</td>
<td>$8,617,089.00</td>
<td>134,074</td>
<td>N/A</td>
<td>$64.27</td>
</tr>
</tbody>
</table>

During the time when the MNHHS was delivering these HACC services, no co-payments were charged. Therefore, the unit costs in Table 16 and Table 17 represent the total unit costs, from both the societal perspective and the perspective of the Commonwealth Government.

The total costs for a unit of Domestic Assistance, when delivered by the MNHHS in 2010-11 and 2011-12 were $65.04 and $64.27 respectively, making it only slightly more expensive than the current total costs of delivering these services through the MNBML Consortium. Looking at the actual costs in 2013-14 (Table 15) the Consortium delivered Domestic Assistance at a total cost of between $60.59 and $64.23 per unit. Without the co-payments and therefore from the Government perspective, in 2013-14 the Consortium unit cost for Domestic Assistance was $55.14, meaning from the Commonwealth Government’s perspective, the Consortium is providing services at a lower cost.

### Follow-up for 2015 Reporting

These analyses will be updated in the final report to include 2014-15 HACC MDS output data as well as any changes to MNBML Consortium funding from the Commonwealth Government. This will give a more complete picture of any cost savings attributable to the MNBML Consortium, in the provision of HACC Aged Care services. Depending on availability of data from MNHHS, it is hoped that the final report will also include a fuller analysis of the unit costs of providing HACC services prior to the MNBML Consortium. This will enable a better comparison of the costs of running the service under the two different models. Similarly, it is hoped that more information will be available from the MNBML Consortium providers to enable a better understanding of the differences between their client groups. With these additional data, the final report will include an updated economic analysis of two years prior to the existence of the Consortium with the position two years since it has been in operation.
Consortium Collaboration

The review of the Consortium collaboration model in this first progress report focuses on documenting the provider members’ experience of the 2013 transition process and their perceptions of their clients’ experience of this transition. It also offers some insight into their expectation and experiences of membership in this innovative model of aged care service delivery. As the Consortium model is still evolving, the full evaluation of the effectiveness of this model will not be presented until the follow-up reports in 2015.

The following evidence is based on interviews with Consortium members that took place over two time periods during the first year the Consortium began operation (2013-2014): the initial interviews were conducted in the first 6 months of operation (between Sept-Nov 2013; the follow-up interviews after the first full year of operation (Jul-Aug 2014). Overall, nine individual providers along with four state-level advocacy groups were interviewed in 20 separate sessions representing over 40 hours of recorded conversations. On average, interview sessions were two hours long and included the Consortium member and sometimes additional staff members. All interviews were held on-site at the provider or advocacy groups’ offices.

Provider Experience with Consortium Model

The following outlines general themes gathered from provider interviews and offers some relevant quotes from provider comments to illustrate their perceptions of the process of transitioning clients from MNHHS via MNBML in May-June 2013. In general, interviews revealed optimistic expectations about the Consortium partnership followed by a realization that taking on so many new clients in such a short time frame was an operational burden. Initially, the opportunity to become part of the Consortium was motivated by business model-type survival. A particularly relevant and practical motivation to join the Consortium was a concern for their organization’s survival: “staying in the game” in the ever-changing aged care policy environment where they perceived “the government is wiping out the boutique operators” in favour of larger-scale efficiencies. A particular quote is telling: “thinking beyond the micro-client level to the macro-level” of service delivery and sector needs.

Table 18: Initial Provider Comments on Expectations of Consortium Model of Aged Care Service

- Providers attested to common themes in the expectations of joining the Consortium:
  - Sector competition—“Staying competitive”
  - Funding access—“access to government funding”
  - Service flexibility --- value-add as a group versus individual provider in services
  - Client-base expansion
  - More visibility and voice in sector
- Provider noted several philosophical goals for the Consortium
  - Local provider flavor in a more global sector
  - Local community providers & personalization of community context to client
  - Provider collaboration to provide array of client services (versus competition for service types and funding)
  - Value adding smaller context, volunteers, extra services like translators

Based on Interviews with all original Consortium members in 2013-2014
Moving beyond expectations to relevant experience, Consortium members noted both a realization of several of their expectations as well as several challenges that arose over the course of the last year. The Consortium has afforded members the opportunity to expand not only their client base and service flexibility - “not one provider at the table could do it all alone,” but to enhance their own organization’s business model by providing new examples and educating Consortium members on innovative ways of delivering service. A sub-set of MNBML Consortium members even began another Consortium to meet the growing transportation needs across their client-base. In the words of two providers, it began as a process of “building trust with providers and ended up having them collaborate and even start another consortia, “and it “encouraged more things to be tried and developed that wouldn’t have been before.”

Others noted the personal satisfaction in being a part of the Consortium through networking with colleagues and participating in professional opportunities, “Networking is great! news, language, nuances, policy information, opinions, new debates, positive sharing, progressive thinking, mini-teaching on professional development issues and on business topics like budgeting and forecasting.” Several providers listed the multiple opportunities organized by MNBML on behalf of the Consortium to attend forums, seminars, training sessions, discussions and round tables in the greater Brisbane community and inter-state as very beneficial.

Concerns were also noted in their experience of the Consortium. Initially to do with adjusting to the collective model, “short time from doing everything ourselves to doing things through a partnership” followed by the operational challenges of growing their client base, “inspired us to not sit still and take our fates as it is dished out,” but to be pro-active rather than reactive.

Providers noted challenges with Consortium obligations; namely increased administrative burden including more and different types of reporting, paperwork and tracking. This required staff training in different systems and thus introduced the potential for this activity to not be cost-ineffective for provider. Providers noted the already existing base of non-MNBML HACC clients and requisite requirements they already adhered to for Commonwealth MDS reporting and other HACC related audits, funding applications, etc. In essence, the Consortium added a layer of complexity to their administrative systems. On the other hand, other providers noted that having MNBML handle the Commonwealth contracts, reporting requirements and funding allocations meant “someone else’s headache – ML manages the outputs as the lead agency.” And although not a consistent comment across all members interviewed, the prevailing feeling at the time of interviews was, “the benefits of the Consortium far outweigh any limitations” being good for the organizations and good for the clients with more ability to deliver more services to more clients.

In the words of one provider in answer to what is the biggest challenge over the last 12 months, “we’ve created a tiger—new services, new properties, lots of new clients, new hiring needs, new grant development. Managing all these processes – alongside our existing business base—is the challenge.”
Table 19: Provider Comments on Current Experience in Consortium Model of Aged Care Service Delivery

- Providers noted several positive aspects for themselves and their organizations of Consortium membership:
  - Buying power
  - Information sharing
  - Access to MNBML’s data on service mapping
  - Networking
  - Collaboration – opportunity to work together on meeting area service needs
  - Educational opportunities
  - Feedback on best practice
  - Expansion into different client demographics (needs, locales, etc.)
  - Collaboration versus competition
  - Building on existing organizations rather than starting a new one

- Providers also noted several challenges to Consortium memberships
  - Competition versus collaboration among members (for funds, clients, service types)
  - MNBML reporting requirements, invoicing, contracting, tracking, records
  - Consistency across all regions, services, providers in service delivery & quality
  - Risk issues related to Commonwealth regulations (quality assurance, audits, etc.)
  - Assuring quality across providers
  - Burden of substantiating “success” “value” “effectiveness”
  - Consortium collaboration gave a strategic advantage to some members
  - Keeping unique local identity in a more “global” Consortium identity
  - Balancing the regional reach of mid-size providers with the local community organizational identities

Based on Interviews with all original Consortium members in 2013-2014

Provider Experience with Transition Process

The experience of transitioning a large group of clients in a short period of time had many challenges, and providers reported continuing operational concerns persisted. In terms of the actual handover of clients, one provider’s comment sums up the overall experience as reported by all, “the transition process was atrocious” noting the handover involved “car boots full of boxes of paper client records” (no electronic versions). All data had to be hand-inputted in a matter of a few weeks expending “over 1800 hours of our own staff time to enter hundreds of records to our systems.”

In particular, providers reported workforce development efforts in both recruitment of new staff to meet higher service demands and well as workforce training for both frontline workers and back office staff to meet expanding client needs and new reporting requirements of the Consortium. In this environment of expanding services and up-skilling staff, providers consistently noted the organizational “risk involved in expanding too quickly” and the hazards associated with handling increased activity in such a regulated environment.

In the case of client co-contribution fees, some providers noted complications with administering the payment structures including: reconciling unit costs, means testing clients, applying different fees to different service types and administrative accounting procedures, and importantly, the reluctance of staff to ask for money. Given the previously reported concern of clients about the co-payment
requirement (in client survey and focus groups), this continues to be a challenge for both providers and clients.

Providers’ perceptions of their own experience of the transition of services focused on the operational challenges of service delivery, whereas their perception of the clients’ experience of this event focused more on making the event “seamless,” “business as usual,” “wrap-around care.” This later focus attested to their commitment to the Consortium goal of providing consistent service to clients during the transition. In reality, the providers attested to both positive and negative experiences for clients during this process. In particular, they reported that clients were “in an uproar about co-payment fees,” and providers struggled to meet increased client base demands that often resulted in a period of inconsistent service delivery (including client frustration with changing times and changing workers).

Table 20: Provider Perceptions of Client Experience of the Transition of Services

- **Providers noted the following expected benefits for clients in keeping with general philosophy of the Consortium:**
  - Seamless transition & consistency in service
  - More personalized service “large organization to a small community provider
  - More choice from Consortium, including service types and referrals
  - More flexibility in services, less restrictions than HHS
  - More social contact than with government provider

- **Providers noted the following difficulties for clients in actually delivering these services:**
  - Client “uproar over copayment fees”
  - Client complaints about service consistency, availability, flexibility, etc
  - Client concern about change and conflicting information from past and current providers
  - “No line of sight to MNBML for clients—just know local provider”

- **Providers also experienced some unexpected impacts from the transition experience**
  - Lost some clients to “choice”
  - More competition for clients and services from collaboration
  - Had to re-educate the client about what HACC program can do and what provider could offer.

Based on Interviews with all original Consortium members in 2013-2014

Providers consistently focused on the delivery of service as their main objective to meet the transition period goals of providing uninterrupted services to a large group of clients with a short amount of notice. In this, all providers expressed satisfaction with meeting that objective. Their definition of “consistent” in the provision of services to a client-base is in contrast to the clients’ experience of consistently satisfactory service.

In comparing the client experience of change to that of the provider, both transitioning services and managing new models of service delivery, the providers generally reported that the clients’ perceptions were of a more seamless process, “No line of sight to MNBML for clients—[they] just know the local provider,” or that the clients were generally satisfied after the initial adjustment
period once the scheduling was put into place. On the other hand, the providers’ own perception of that transition process revealed a very rushed attempt to gather client records, transfer clients and find capacity to deliver additional services.

Throughout the first year of providing services to Consortium clients, providers attested to a continuing focus on meeting service unit targets, securing funding allocations and a “mad dash” to meet Commonwealth deadlines coordinated through the Consortium. A clear task is balancing the dual focus of the Consortium on client inputs (service needs as well as complexity) and provider outputs (quality assurances & cost-effectiveness).

**Follow-up for 2015 Reporting**

Consortium member data was collected in 2013-2014 capturing the experience of those providers and advocacy groups who initially joined the Consortium. It focused on their motivations, expectations and challenges in providing aged care services vis a vis this new model of delivery. The data were gathered in interviews (both in 2013 and follow-up interviews in 2014) and in participant observation of Consortium meetings from September 2013 through September 2014. The current report highlights the experience of the service providers during the 2013 client transition process. The 2015 report will provide more information on the Consortium members’ experience of Consortium membership as reported in interviews in 2013-2014.
Summary of preliminary findings

These initial results reveal a pattern of overall client satisfaction with aged care services in general and a slight trend towards service cost efficiencies. However, in both instances the differences between the current and the past service delivery models were minimal.

The initial cost analysis of the MNBML Consortium’s provision of HACC services shows a trend towards cost savings since the transition period. The average MNBML Consortium unit cost has been decreased by $2.86, since the transition period, a trend that will hopefully continue. From the Commonwealth Government’s perspective, the costs of providing Domestic Assistance have been reduced by around $9 per unit. However, from the societal perspective, when co-payments are included, the cost savings are reduced to between $3.68 and $0.04, depending on the co-payment amount charged to the client. It is important to note that co-payments are not unique to the MNBML Consortium and are now charged by most providers of HACC services. Therefore the effect on total costs, seen because of the introduction of co-payments, will be the same for other, non-Consortium providers of HACC services who also charge co-payments. The overall costs will be even higher for providers who do not meet target outputs and similarly, will be lower for providers go beyond their targets. The current trend for the MNBML Consortium is an increase in service delivery over time and if this trend continues, under the current funding arrangements, a larger reduction in unit costs will be seen over time.

The overall purpose of the client, provider and economic evaluation activities was to assess the effectiveness of delivering HACC services through the MNBML Consortium model and to capture the lived experiences of the clients and service providers in that context as well as show value for money. A consistent theme from client participants emerged throughout the group discussions and survey items; they were grateful for and satisfied with the HACC services they received. The client-satisfaction survey results show that clients were already quite satisfied with the services they were receiving and since the transition, remain so. Survey results show that on almost all items, clients had a slight preference for the previous services, with MNHHS. However, the differences are minimal (both in the past and now, the mean scores were well over "3" on a 4-point scale) and only statistically significant on a few items. On the other hand, clients went through a huge transition phase and changed providers, and through this transition process the MNBML Consortium providers were still able to maintain client satisfaction.

For providers, the expectations of delivering services through a Consortium model were mostly realized although somewhat thwarted by the administrative challenges of the transition process and the overwhelming burden of policy change in the aged care sector. At this point in the evaluation, it has been demonstrated that the providers can work together collaboratively, openly and supportively in a traditionally competitive sector. It remains to be proved that the smaller, local providers working collectively results in better outcomes for clients and more efficiencies in service delivery costs.