THE UNIVERSITY OF NEW SOUTH WALES

ATTENDANT CARE PROGRAM DIRECT FUNDING PILOT EVALUATION

FINAL REPORT

FOR THE NSW DEPARTMENT OF AGEING, DISABILITY AND HOME CARE

SPRC Report 11/08

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Many people with experience of the ACP employer model spoke of problems relating to the quality and organisation of support. ACP employer model service providers could investigate how to change care arrangements so that clients are more likely to achieve their goals for quality of care.

Relationships with attendant carers improved because they have trust, commitment, a direct personal relationship and they can negotiate and resolve problems directly. They are more satisfied with their support, although some said they need more hours of care, which can be reassessed.

Management of attendant carers has improved in terms of conditions and satisfaction. Recruitment and retention has improved because they can offer better work conditions. Recruitment has been easier outside the cities. Some people still use back-up from agencies. Unlike the ACP employer and cooperative models, they have the flexibility to improve pay rates and conditions and offer variable rates for shifts, tasks and bonuses for good service. They offer support, training and OH&S that is personalised to their support needs and the experience of the attendant carers. Some participants pay experienced carers to train others. The participants have a greater commitment to training and OH&S because of the consequences for their own care and employment responsibilities. Attendant carer satisfaction has increased because they have better pay and conditions and a direct relationship. Problem solving is more direct and immediate.

Cost effectiveness

The cost to DADHC of ACP direct funding is similar to other ACP employer and cooperative models. All participants managed their funds close to budget, some returning a surplus, which on average was similar to that of the main program (surplus 5 per cent of total grants). Participants who were highly cost efficient in managing their funds paid mid-range attendant carer pay rates (average over $28 per hour) and mid-range other costs (12-16 per cent of total costs) (Table 5.3). The measured outcomes were comparative improvements in health and wellbeing, confidence and self-esteem, family relationships and community, social and economic participation.

Implications for policy

The evaluation has implications for the development of possible ACP direct funding models and ways to improve service delivery quality within ACP employer and

Cost and accountability

Direct funding is cost effective in terms of improving relative outcomes for the same or lower costs. The participants managed their financial obligations responsibly and within the intention of the pilot. Implications for policy options include:

- continuing allocation of an experienced policy official to support program implementation, including responding to queries from the participants and managing financial accountability;
- maintaining management systems to monitor and protect against financial and support risks to clients and government. The experience of monthly and annual reporting for new participants contributed to this risk management. The Department could review reducing the frequency of reporting for clients who successfully manage care hours and finances within budget after an initial period; and
- examining the financial implications of allowing participants to apply the cost savings to purchase additional care, expenses or management improvements.

ACP Employer and Cooperative Models

Direct funding complements the ACP employer and cooperative models. Many of the results about quality of care could be transferable to all the ACP options. Implications for policy options include replicating the direct funding approach to the following aspects of organising ACP in the other models:

- care arrangements – responsive to client's needs; flexible (time, travel and tasks); client focused in management and arrangements (care fitting the person's needs); tailored to meet individual needs; and maximising independence and control.
- attendant carer conditions – training, OH&S, pay and conditions, direct relationship between attendant carers and clients, hours and tasks; and
- financial management and accountability – managing hours and clients' incidental management costs.

Conclusion

The evaluation shows an overwhelmingly positive response to the direct funding pilot from the initial participants. The elements reported as contributing to improved care arrangements are:

- attendant carer quality – because of improved pay and conditions, so they are more likely to be skilled, knowledgeable and compatible;
- less turnover – because of the pay and conditions, rapport and satisfaction;
- better training – more attuned to the person's specific needs and preferences;
- committed attendant carers – because of rapport with the participant; and
- the process is more efficient – because direct relationship with attendant carer and fewer overheads.

As a result of the better care arrangements, the quality of their care has improved in terms of consistency, reliability and flexibility. With improved quality of care they report that they have experienced improved outcomes in terms of health and wellbeing; confidence and self esteem; and community, social, economic participation.

1 Background

1.1 Attendant Care Program Direct Funding Pilot Description

The Department of Ageing, Disability and Home Care (DADHC) is piloting a direct funding project in conjunction with the Attendant Care Program (ACP). The direct funding pilot aims to complement the objectives of the ACP, which provides support to individuals with physical disabilities with a range of tasks and activities to allow them to live and participate in their communities. ACP is funded under the Commonwealth State/Territory Disability Agreement and administered by DADHC.

The report compares three ACP funding options, which differ in who employs the attendant carers, who receives the funding from DADHC and who is responsible for management and reporting:

- Employer model – the service provider is the attendant carers' employer; in some organisations, clients can chose to participate in some attendant carer management decisions, such as recruitment. DADHC pays the funds to the service provider and the service provider is accountable to DADHC for the management of funds and reporting. Thirty two service providers are registered with DADHC to provide this model.
- Cooperative model – the client is the attendant carers' employer; the service provider supplies administrative and management support. DADHC pays the funds to the service provider and the service provider is accountable to DADHC for the management of funds and reporting. One provider offers this model.
- Direct funding – the client is responsible for all attendant carer employment and management. DADHC pays the funds directly to the client, who is accountable to DADHC for the management of funds and reporting.

The pilot project is providing funds directly to ten current ACP clients for the direct purchase of personal care services. This is intended to provide clients with greater control over the choice and management of the support they receive as well as to promote more flexible and responsive services for clients.

ACP direct funding is aimed at people with physical disability with high personal support needs, who have the capacity to manage administration of funding directly. People in receipt of direct funding are responsible for all legal, financial and accountability requirements as well as managing or contracting out employer responsibilities for attendant carers including recruitment, training and support; and financial management including wages, superannuation and insurance.

The pilot project builds on the development of similar programs in Australia and internationally and related research on the significance of client control for social inclusion and independence rTJ0.0002 Tc 0.0748 Tw -l

2 Participant Outcomes

Does the direct funding pilot lead to increased participants' wellbeing and enable them to maximise their participation in the community? Does the pilot lead to increased participant satisfaction levels?

The first purpose of the evaluation is to review the outcomes for the people in the direct funding pilot. This section presents information

comparison). The youngest person in the comparison group is most similar to the direct funding participants in terms of his expectations about the care needed and participation. He uses the ACP cooperative model. Some comparison participants were unaware that they can continue to access ACP after they turn 65 years.

Only two direct funding participants are women, compared to 69 per cent of the

average across all domains, although some participants score below the mean. The comparison group means are mainly below the Australian average except in safety, feeling part of the community and future security.

Between the baseline and follow-up PWI measure for the direct funding participants, only satisfaction with personal relationships significantly changed.[1] It had improved or remained the same for all direct funding participants except one. Reasons for this improvement are discussed below.

The differences between the groups discussed in this section are probably at least partly due to the difference in their profiles (Table 2.1), rather than the affect of direct funding, ACP cooperative model or ACP employer model. That is, some people have chosen their ACP model because of the characteristics in their profile, rather than the model directly influencing some of these outcomes.

Attendant carer satisfaction is discussed in Section 3.4.

Health and wellbeing

Most of the direct funding participants stated that their health and wellbeing is very good or excellent (60-80 per cent; Table 2.3). In contrast, most of the comparison group participants felt their health is good or worse (73 per cent). The direct funding group are similar to the Australian population average (56 per cent very good or excellent; ABS 2006).

Table 2.3: Health and Wellbeing

	Direct funding (10)		Comparison (26)
	Baseline	Follow-up	
Poor	-	1	1
Fair	1	-	6
Good	3	1	12
Very good	3	3	4
Excellent	3	5	3

Similarly, people in the direct funding group reported higher average satisfaction with their physical and mental health than the comparison group (on a scale of 0-100, 81 and 90 for physical and mental health direct funding, compared to 67 and 77 for the comparison group; Table 2.4). The greatest difference is their level of satisfaction with their mental health, which is consistent with differences in confidence and self-esteem discussed below. From their comments, the comparison group participants' quality of health and wellbeing can be grouped in to generally well, some problems and many problems, discussed below. The participants' comments about their health

[1] This observation is based on a Chi-Square test using a 10% confidence interval. If stricter 5% confidence interval is applied, no significant change is found. A t-test on the mean scores showed no significant change using a 5% and a 10% confidence interval.

and wellbeing are consistent with these scores. Attendant carers and families also agreed. The measures of health and wellbeing did not change significantly between the baseline and follow-up for direct funding participants.

Table 2.4: Satisfaction with Physical and Mental Health

	Direct funding (10)				Comparison (26)	
	Baseline		Follow-up			
	mean	range	mean	range	mean	range
Physical health	76	50-100	81	50-100	67	20-100
Mental health	93	80-100	90	60-100	77	30-100

Note: Scale 0-100 where 0=completely unsatisfied, 100=completely satisfied (IWG 2005)

This difference between the groups may have been present before direct funding. However, the direct funding group comments below about the impact of improved quality of care from the direct funding pilot on their health and wellbeing supports the assumption that these higher average scores are at least partly due to the control they have from direct funding.

All direct funding participants noted decreased levels of stress. Reasons they discussed were they are not dealing with inflexible service providers. In addition, they reported that they have less conflict with the attendant carers and providers; better attendant carers and quality of care, control of OH&S management; and direct management of attendant carers concerns about pay, conditions and relationships between the attendant carer and the provider. The attendant carers are more reliable, providing better continuity of care. The participants are less likely to use agency

agreed that pain management is improved when they have a small number of attendant carers providing consistent care.

Positive changes for direct funding participants included regular meals and being supported by attendant carers to medical procedures. Similarly, a comparison participant said attendant care facilitated her access to dental care. However, other ACP employer model comparison participants commented on the negative impact that restrictions in their ACP arrangements has on their physical and mental health, such as attendant carers not permitted to do stoma care; patronising attitudes from attendant carers; and fear of retribution if they raise problems with the ACP provider.

Participants in both the pilot and comparison groups spoke of their experiences of abuse (financial, verbal and physical threats) when they received ACP in the employer model because of poor quality attendant carers. One direct funding participant had also experienced financial abuse when he first entered the pilot, when an attendant carer stole money from his direct funding operating account. The bank replaced the money. Another direct funding participant had experienced mild verbal abuse.

Confidence and self-esteem

All ten direct funding participants expressed a feeling of empowerment and self reliance, knowing that full control and management is in their own hands, therefore they have a vested interest in getting things right. For example they discussed ensuring attendant carers are paid correctly, and feeling an equal and respected partner in the care arrangements. One participant noted that, 'Having had a catastrophic injury, being able to manage your own care increases your confidence and life skills.' In contrast, a comparison person wanted to re-enter the workforce but did not have the confidence to do so yet after her injury.

Direct funding participants said they have more control over their care and therefore over their own lives. Attendant carers and family members commented on this too. One participant said,

> … direct funding gives control, flexibility and independence, which in turn creates something in yourself … hope … I know my care arrangements are ok and I am not afraid to accept jobs. This has enabled me to build my own consultancy business.

Another reported, 'I am able to manage my own life, not be a passive recipient without any choice. I can satisfy my own lifestyle. I feel empowered and that I have a sense of control.' It has given some participants the opportunity to learn new management, business and communication skills, for example dealing with the Australian Taxation Office and using bookkeeping software.

It has resulted in participants enhancing their confidence and ability to manage and communicate with attendant carers. An attendant carer had noticed, 'He is more motivated, positive. He says, "Get me up, we have lots to do." He has purpose and control.' A family member commented that having an active role in administering the direct funding has given the participant a new focus, which is appropriate to his background in financial management. Another person concluded, 'Don't stop the

program. It would be a tragedy. It's empowering me and letting me really live my life.'

Comparison participants also commented that having attendant care maximises their independence, choice and gives them an option away from institutional care or less flexible personal care services. They have the confidence to take on more activities and make more social and work arrangements. However, one ACP employer model participant said,

> I feel I should be in control of my own care … I feel very disempowered by the service provider. I feel kept in the dark to make my own decisions because there is no information. It is not clear what I can use the service on.

Family relationships

All direct funding participants have family and friends active in their lives, compared to 77 per cent of the comparison group (Table 2.1). Their satisfaction with their personal relationships is also higher on average (average satisfaction score of 88 compared to 69 in the comparison group; Table 2.2). Even from a high baseline, the direct funding participants' satisfaction improved between baseline and follow-up. Comparison group people who have active relationships tend to be the ones who reported satisfaction with their level of control and flexibility.

Direct funding participants reported that family relationships improved since entering the pilot. Benefits they reported including greater control over their home environment; less stress on family members; and more flexibility to make social arrangements with family and friends, each described below.

Control in the family home

Attendant carers are in the home of the whole family. Having consistent attendant carers has enhanced the relationship with family members. This is both between the attendant carers and the family and also between the participant and their family members. Family members spoke of the importance of knowing and trusting the attendant carers as they enter the family home and have a significant impact on all family members.

Family members said they had better relationships with the attendant carers under direct funding, which increased security and safety especially for the three participants with children. One direct funding participant commented that his four-year old son has been positively affected by improved consistency of attendant carers. He had previously used a HACC provider and said, 'My son was scared not knowing who would come into our home. Now my son knows the carers better.' This also means his wife is less stressed.

Other family members said, 'It gives him peace of mind, so I have peace of mind.' 'It takes the pressure off the whole family.' 'I feel better knowing that the carers are trustworthy and reliable, and reassured that they will do their best.' 'We feel really settled. Everything is going really well. It's so great to have a proactive role in your own life and control over who is in your home.' A direct funding participant said,

the care at a friend's home or at later hours of the night. Another family member said that direct funding meant being able to negotiate changes in times allowed them to have a more active social life, 'It's not normal to have your husband put to bed at 6:30pm.' This participant previously used a HACC provider. Impact on friendships and social participation is discussed further in the next section.

Most direct funding participants live with family me

One person who had previously not gone out often increased his social participation from the beginning to end of the evaluation, 'I go out lots of times now if I have an invitation, or to the local shops. Having a carer to go with me gives me peace of mind for safety when I wheel around.'

Some comparison participants said they are restricted in their ability to travel with their attendant carer nationally and internationally. Other people are clearer about their entitlements and their provider is responsive. Some direct funding participants wanted greater portability interstate and internationally so that they could travel and live outside the state for longer periods.

Economic participation

All the direct funding participants are in paid employment, study or active retirement. Occupations include solicitors, doctor, business owners, artist, IT consultant, university study and government. They were in these positions when they entered the program, however at least half the participants have increased their roles and work capacity since accessing direct funding. Examples of direct funding enabling them to increase their capacity to participate include travelling nationally for their business; attending university lectures; and working more hours. One person is gradually increasing his work, 'Since being on the direct finding pilot, I have contacted Spinal Cord Injuries [Australia] looking for further employment options.' He is building up his consultancy work by working from home. Another participated added, 'My art is going really well. I am starting to look for part-time research work.'

Occupations of comparison group participants are similarly skilled, such as business owners, active retirement, government, graphic design, counsellor and studying. Attendant care had facilitated one comparison person to start university. One comparison participant who had used ACP since he was a teenager said, 'Attendant care has allowed me to have a life, not be in an institution and go from studying, to employment, to being self-employed.' Another person said, 'I wouldn't give it up for anything; it is unbelievably unique. If I didn't have AC, I wouldn't have achieved what I have in my life.' In fact, he had moved states to retain access to the program. Some ACP cooperative participants experience benefits similar to the direct funding participants. One employs an attendant carer who also has office duties said,

> I feel I have more control over my day-to-day life. I think having my own staff who know me is important because of my communication issues. I am able to have personal care at work when I need it and I can chose the times I have support so I can get to work on time. Furthermore, I have the confidence in undertaking my Masters.

However, in contrast with the direct funding participants, 38 per cent of the comparison group were not engaged in active economic participation. The direct funding group on average are younger (41 years) compared to the comparison group (51 years), which may also affect their participation in paid employment and study.

The two groups are also in different socio-economic circumstances (Table 2.1), which probably affects these outcomes more than the impact of the direct funding pilot. This difference is also reflected in their satisfaction with future security scores (84

- active social networks; improved family relationships; control in home – impact on partner and children; less pressure on family; more quality social time with family; improved friendships because of greater flexibility;
- increased participation in paid work, study or community life for some people; in addition, some comparison group clients thought direct funding could help them improve their participation through better control of care; and
- higher average satisfaction with feeling part of community than some other ACP clients and the general population.

3 Care Arrangements

Does the pilot offer greater choice and flexibility of services compared to existing funding arrangements? Does the pilot lead to increased attendant carer satisfaction levels?

The second goal of the evaluation is to understand the impact of direct funding on the quality of the care arrangements. Participants in the direct funding pilot concluded that the model offers greater choice and flexibility of services compared to funding arrangements in either the existing ACP cooperative or employer models. This section discusses the findings from the participants, family members, attendant carers, officials and service provider managers. The analysis contrasts thei

pensions and the scope of the program. They agreed that the program needed to be piloted to sort out the accountability and parameters of the program.

Reasons for changing to direct funding

All the direct funding participants said the primary reason for entering the pilot was that they saw it as a way to enhance their independence, flexibility and control over their life, hours, money and attendant carers' conditions. Two people previously used the cooperative model (Table 3.1). Their intention was to keep the same attendant carers and extend the control and flexibility available to them (eg. training, flexible contracts, freedom of choice of when and where care is provided and more direct relationship with attendant carers). They have experienced these benefits.

The direct funding participants who previously used the ACP employer model felt that before the pilot they were not getting the service they wanted from their service providers. They did not like the rigid methods of managing care arrangements and felt they were not getting individualised support. They said they did not want to rely on a 'bureaucratic service provider', by which they meant problems such as communication, poor support and attendant carers pay and conditions; described in more detail in Section 3.3). One participant described her previous experience as 'hell'. People spoke of their disappointment with the provider, such as lack of assistance with recruitment, as a reason for changing to an alternative model, more suited to their expectations and preferences. Some people said they had a high level of

needs and improving pay and work conditions. Some people felt they are doing all the management of the care arrangements anyway (eg. rosters, timesheets, negotiation and on the job training) and the service provider creates difficulties by fulfilling management obligations in rigid and unr

comments about the care management experiences are most similar to the direct funding participants' experiences.

Types of assistance

All evaluation participants receive personal care depending on their support needs. In addition, some people receive domestic assistance e.g. cleaning, meal preparation, shopping; transport assistance; and administration/organisation services. Generally the types of assistance received are similar in both groups. The direct funding participants tend to have more flexibility to change the care arrangements and to respond to specific needs such as, employing the attendant carer to help them access education. Direct funding has allowed some participants to employ someone to drive them to work or study, do errands and shopping. All direct funding participants have family or friends who provide additional support (Table 2.1).

People in direct funding, employer and cooperative models commented that they were unclear about the degree to which they can be flexible in defining which tasks are included in the categories of types of assistance. For example, some people are unclear about the guidelines on domestic assistance. Purchasing equipment is still a problem for three direct funding participants, despite the allocation of set-up funds. They had interpreted that they must still wait on PADP to purchase a hoist or more suitable wheelchair, or pay with their own savings if it did not fit within the guidelines for the set-up funds.

Choosing the provider

Comparison group participants chose their service provider based on their disability or their preference for control. For example, some people chose an ACP employer model provider because of the allied health knowledge of particular organisations. Some people chose the ACP cooperative model because it allows greatest choice and control for the participant. People who had used ACP for a long time did not discuss choosing the provider because fewer providers existed when they began.

Some people had changed service providers, which is offered as part of the flexibility of the ACP to better meet their needs. Managers and officials reported that people usually change providers due to an unresolved conflict or to move to a provider or ACP funding model that allows them to have greater or less involvement in managing their attendant carers. Some comparison group people had changed away from a HACC provider as their ACP provider. The reasons were control, flexibility of service and choice and involvement in staff selection. One comparison participant complained about their current ACP employer model provider, 'If I had a good agency, it would make me a hell of a lot happier.'

ACP support compared to prior support

The evaluation participants sought ACP support when they heard about it from professionals or other people with disability. Before receiving ACP, most people in the comparison group received HACC services. They changed from HACC providers because of the quality of care; the maximum hours available in the HACC program were insufficient for their needs; the program was inflexible; they had no choice in staff and times or input into staff management; untrained staff; poor professionalism; lack of confidentiality; and they experienced a lack of responsiveness to need for

people spoke about already having this arrangement through their provider. The cooperative model providers are currently investigating these difficulties.

Some comparison participants commented that they need processes to share attendant care experiences with other clients. In addition, they could learn from each other about access to community activities and support.

3.4 Management and Satisfaction of Attendant Carers

The final aspect of care arrangements is the management of carers. Direct funding participants report having more stable attendant carers, and therefore enhanced consistency of care. They can offer better pay and conditions, which results in better quality of attendant carers, more stability, and better relationships. A participant summarised why the financial arrangements had such an impact on the management of attendant carers, which improved her quality of care,

> Probably the most crucial benefit is that it adequately responds to the inherent necessity for flexibility that is part of providing personal care. Given that the work I can offer my carers is limited to personal care work and that my personal needs change and will continue to change over time, I need a structure for paying my carers that is as flexible as possible so that I can attract them to work for me and retain them into the future.

Case study of management of attendant carers

Carlos previously used the ACP employer model. He had many problems with communication with the service, rostering carers and the payroll system. The attendant carers were not previously getting superannuation. He has kept quality carers that were going to leave the service provider that previously provided his care. He has used his skills in financial management and business to manage his direct funding responsibilities, has become more focused during his days and is developing new skills and experience. Direct funding has allowed him to improve his social networks, as he is able to go out late at night and still get to bed, because he has a better relationship with his attendant carers and they are being remunerated much better. His reputation as the town's party animal remains intact.

Recruitment and retention of attendant carers

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small amount of hours each week, often ACP is their second job or they are studying or parenting and juggling ACP around other commitments. In ACP it is important to retain a pool of carers even though you cannot guarantee them much work.

To secure quality attendant carers, being able to offer better rates and conditions, enables them to compete with providers and other employers. One direct funding participant said, 'If you are going to pay somebody $19 for only 15 hours a week, they're not going to stick around long.' With the flexibility of direct funding, the participants can choose how to pay attendant carers to enhance the commitment and availability of staff. This is largely due to better pay and conditions.

Recruitment

Most of the direct funding participants have kept at least some, if not all, of their previous attendant carers. Other attendant carers they have recruited through advertisement (eg. university, newspaper and local hostels) and word of mouth. None had problems recruiting and some have not had to recruit. Some attendant carers resigned from their previous service provider because the conditions under direct funding are better and they wanted a direct relationship with the participant. Some of these attendant carers were looking for work elsewhere because they were dissatisfied with the conditions with the provider. One participant said, 'I never found recruiting staff a problem because [the pay for] my 3-hour morning service is equivalent to an 8-hour shift in a nursing home.'

Direct funding ensures that participants have primary responsibility for recruiting suitable staff, thereby increasing compatibility and retention. The participants and family members felt that it was appropriate that the person receiving the care is the one determining the required skills, experience and qualifications of carers rather than the service provider. One family member said,

> Non-nursing trained staff often have a better attitude to enabling independence and many tasks are not nursing, such as washing, cooking, and errands. For example, uni students are suitable as carers as they have flexible hours and provide a peer network.

Interestingly, people in regional areas did not find it difficult to recruit staff. In fact, both participants and providers said it is easier to recruit outside the large cities. Participants living in regional areas report greater support, because they are able to use innovative methods to recruit the attendant carers they need, for example through social, community and business networks. They also report that the job can be packaged to be more attractive both through increased pay, flexible work arrangements and training. However, people in small towns do have difficulties recruiting staff, particularly for some shifts.

Retention

Participants have improved the retention of their attendant carers because the pay, conditions and relationships are better under direct funding. At the end of the evaluation, most participants had retained the same carers. When asked about job security, one attendant carer felt she 'had a safe, good relationship.' Some participants had employed additional carers to cover sick leave.

One family member said that the 'best thing about direct funding was being able to attract and retain better carers so that his [participant] needs are better met'. An attendant carer agreed, saying, 'When you get a good carer you want to look after them, so you can hold onto them for quality and consistency of care.' For example, one participant said his attendant carers are now receiving superannuation for the first time.

Retention is a problem for some participants because of the small number of hours they can offer. Two participants are using agencies to fill in some regular shifts, odd hours and emergencies. Participants are reporting better control and more choice when using agencies as back-up. One person has familiar carers when he uses the agency, which is important for managing his physical health risks. People who are using agencies for back-up care are reporting a positive response from agencies and more direct communication.

ACP employer and cooperative models

The direct funding participants previously expended considerable effort in managing the care relationship under the other ACP models. They are relieved that this option is less paperwork and administration for them, as well as the attendant carers, because a third party is no longer involved. For this reason they report being able to resolve problems promptly and directly.

Some comparison group participants do not have problems recruiting attendant carers. They do it through word of mouth (eg. people known to existing attendant carers), networks and advertising. Other ACP employer model participants commented that their providers had difficulty recruiting attendant carers. One said, 'The agency has had a lot of problems attracting workers … The pay rate needs to be increased, need penalty rates and a proper car allowance.' They said that one impact of poor recruitment and retention is they must use casual staff, who are not familiar or trained to deal with their needs. Some casual staff are accessed through agencies. They commented that sometimes agency staff do not turn up.

Another impact of poor recruitment and retention reported by comparison group participants is that some ACP employer model providers are arranging times for the attendant carers to attend to their needs at the convenience of the service provider rather than the participants' preference. For example, if more than one person lives in the same suburb, providing care for them sequentially in a run, irrespective of the person's work and social needs.

Many direct funding and comparison participants and family members suggested that family members should be eligible to be back-up paid attendant carers. They explained that if the attendant carer is not available, their family members do this role. They recognised that it was most feasible if it was for

organise training specific to their physical needs and preferences. An example is attendant carers attending the Cerebral Palsy Conference with the participant. Participants reported that training costs are also less than before the pilot because they are able to recruit experienced and qualified attendant carers and lower the staff turnover.

who have vast relevant experience, and have no flexible approach in delivering training.

Comparison group participants commented that ACP training should have a broader content than just OH&S, such as mental health, referral to other services and career development. Another issue raised was the lack of training on conditions other than spinal injury.

Attendant carer satisfaction

All direct funding participants report an increase in attendant carer satisfaction. They state that attendant carers are happier for reasons discussed above, including pay and conditions and the quality of the relationship. The arrangements remove the extra relationship with service provider so that communication is more direct. This has improved their relationship with the person for whom they care. It has meant that problems are easier and quicker to resolve, and processes are less complicated.

Interviews with attendant carers supported the participants' perceptions of their improved satisfaction now that their pay and conditions are settled. Many of the attendant carers have experienced increased pay and conditions in their new care arrangements. A participant quoted one of his attendant carers as saying, 'The only reason I'm working with you now is that you are on direct funding.' An attendant carer said her pay had increased and the employment relationship had substantially improved. In contrast, in her former relationship with the service provider, she had experienced poor rostering, low pay and a disrespectful attitude to her needs.

Another attendant carer who switched from a provider to direct funding expressed her frustration about the former employer, remarking that, 'They had been doing "bugger all" – not supporting the client or the carers … the government was paying a middleman to do an insufficient job.' In contrast, she said under the direct funding arrangements she feels well looked after and able to enhance the give-and-take type relationship with the participant. Another attendant carer said that the direct funding has had a positive impact on the client 'amazingly and improved everything' including enhancing flexibility of care so that work and social life is made easier. She said, '[I think] he feels in control of his life – why shouldn't he be the boss!' Another attendant carer said, 'It's an excellent program it would be mad to stop it'. An attendant carer acknowledged that the direct funding participant can feel more confident expecting his attendant carers to be committed and reliable, which is especially important when they are required to work from 5:30-7:30am each weekday to get him ready for work.

In relation to the management of the direct funding option, attendant carers reported

Problem solving

Problems between participants and attendant carers solved during the pilot included communication about pay rates, number of hours and pay periods. The attendant carers thought the participants should consult and decide the conditions prior to the direct funding employment relationship. They did not raise problems about tax, superannuation, insurance or OH&S.

Direct funding participants report that it is easier to sort out problems when less people are involved. One participant said, 'If there are problems, it is more direct, you are in control.' Another said, 'If I do the best by them [staff], they will in turn come to work with a smile and do their best for me, so its win-win.'

Some comparison participants in both ACP cooperative and employer models commented that they already have the benefits from good relations with their attendant carers without needing direct funding. Similarly, the service provider managers noted that helping clients and attendant carers to manage their relationship is one of the biggest reasons for clients changing between ACP service providers.

Some direct funding participants have a grievance procedure in the contracts with staff. One person has stated in the contract that, 'If our relationship breaks down then it may not be possible to continue the employment, given the extremely personal nature of the role.' Participants did not report any instances of dismissal.

3.5 Summary of Care Arrangements

In summary, the reasons the participants chose to be in the pilot were to achieve the following goals:

- enhance independence, flexibility, reliability, customised training;
- improve control over life, hours, money and attendant carer conditions;
- achieve a direct relationship with attendant carers;
- avoid the complexity of the ACP employer model experienced by some people, such as rigid methods of managing care arrangements, recruitment, limited flexibility and control and cost inefficiencies; and
- extend the control and flexibility of the ACP cooperative model already experienced by participants who were using it.

Most ACP clients had not heard of direct funding. Before participating in the pilot, direct funding participants and other comparison ACP clients thought the risks might be in relation to liability, insurance, tax, OH&S, pensions and the scope of support; and financial and management responsibility.

The support received through ACP is similar in both groups. The direct funding participants experienced improved flexibility to change the content of the support and respond to specific needs eg. access to education, work and shopping. Like other ACP clients, they supplement the ACP formal care with support from family or friends and HACC.

They experience better quality of care than they had previously had because of the additional control they have over their choices of attendant carers, training, support

and conditions. In relation to reliability, flexibility and choice, they experienced improvements relative to their past experience and relative other ACP clients (except people who had previously used the cooperative model). Examples are ability to change arrangements and receive short episodes of care. This control has a positive impact on informal care and participation arrangements. Most ACP cooperative model clients and some ACP employer model clients experience most of these benefits already. Many people with experience of the ACP employer model spoke of problems relating to quality and organisation. ACP employer model service providers could investigate how to change care arrangements so that other people can also achieve their quality of care goals.

Relationships with attendant carers improved because they have trust, commitment, a direct personal relationship and they can negotiate and resolve problems directly. They are more satisfied with their support, although some need more hours of care, which can be reassessed through ACP.

Management of attendant carers has improved in terms of conditions and satisfaction. Recruitment and retention has improved because they can offer better work conditions. Recruitment has been easier outside the cities. Some people still use back-up from agencies. Unlike the ACP employer and cooperative models, they have the flexibility to increase pay rates and conditions and offer variable rates for shifts, tasks and bonuses for good service. The offer support, training and OH&S that is personalised to their support needs and the experience of the attendant carers. Some participants pay experienced carers to train others. The participants have a greater commitment to training and OH&S because of the consequences for their own care and employment responsibilities. Attendant carer satisfaction has increased because they have better pay and conditions and a direct relationship. Problem solving is more direct and immediate.

4 Governance

Are appropriate and effective governance arrangements in place to support the establishment and ongoing development of the pilot?

The third aspect of the evaluation is to review whether appropriate and effective governance arrangements are in place to support the establishment, implementation and development of the direct funding option. Direct funding participants, attendant carers and government officials are satisfied with the governance arrangements. ACP service providers said the arrangements have not had an impact on their normal operations.

4.1 DADHC Support

A DADHC senior policy official is responsible for establishing and implementing the pilot (approximately 10 hours per week). She is responsible for financial management monitoring and reporting. The policy official arranges teleconferences with all the participants to share information and is available to respond to questions as they arise.

The position is supported by DADHC managers and informed by the Department's Physical Disability Expert Advisory Group. Other parts of the Department were also consulted in the establishment process, such as for legal, human resource and taxation advice. Payment is managed through Businesslink, a NSW government agency responsible for financial payments.

All participants are satisfied with the support provided by DADHC, both with the communication with the policy official and the system support to respond to new questions. They noted improvements in the support process as the pilot has progressed, such as initial late payments to some participants. They find the internet forum and teleconferences useful. The internet forum might be improved through using a moderator, one participant noted. They suggested that these methods of communication could be supplemented with informal face to face meetings to share ideas and systems, perhaps in geographical areas.

4.2 Transition to Direct Funding

Most participants experienced a smooth transition from the main ACP to the direct funding pilot. Some people had problems retrieving and transferring payment for accrued hours before they entered the pilot, where their ACP provider had not kept full records. DADHC is following this up more generally for all ACP models because some providers were failing in their record keeping. It was a reason some of the participants reported joining the pilot. They commented that if the pilot ends, questions about accrued funds will need to be similarly resolved.

Direct funding participants suggested exploring whether new participants needed an option for training and development on administrative responsibilities and managing attendant carers. They see this as a way for other people to take advantage of the lessons from direct funding pilot. One person suggested that DADHC could arrange mentors to help new participants transition from ACP to direct funding. Another suggested a training manual, templates of spreadsheets and examples of software used by participants.

All direct funding participants offered support for further development of the direct funding of Attendant Care. They commented that DADHC will need to refine the process if the pilot or rollout continues. They are all willing to be involved in that feedback. For example, a teleconference could be arranged to review and share their experiences. They suggested that their contribution could include providing information to the Department, other participants and service providers, one person said, ‘We need to be kept in the loop … to develop the program … it’s a brand new

4.4 Accountability Requirements

Participants signed a funding agreement with the Department, equivalent to agreements with ACP service providers.

5 Effective Use of Resources

Does direct funding provide an effective and efficient use of resources compared to existing arrangements?

The final evaluation question is whether direct funding provides an effective and efficient use of resources compared to existing arrangements. From the perspective of the ten participants, attendant carers and government officials it is cost effective because quality of care and participant outcomes are better within the same cost or less cost for most participants. In this section, the financial arrangements and the participants' experiences are analysed against the financial management data and discussed relative to the other ACP models. The cost and outcomes are summarised using cost effectiveness analysis.

5.1 Participants' Financial Arrangements

Participants are responsible for managing both the attendant carer employment costs and all other financial costs associated with employment, caring and accountability to government for how they use the funds. During the pilot, they managed their financial obligations responsibly and within the intention of the program. These arrangements are discussed below in terms of funding, administrative arrangements, attendant carer pay rates and managing support hours.

Funding

The annual grant is calculated and managed in the same way as payments to ACP service providers in terms of assessed number of hours by cost per hour:

- the number of approved ACP hours, up to 34 hours plus one emergency hour per week, annualised. Hours are calculated based on a DADHC assessment when they enter ACP and reassessed as required; by
- $37.92 per hour in 2006/07 ($39.17 in 2007/08).

Funding from the Department is paid prospectively into the participant's bank account each calendar month (1/12 of the annual grant). In addition, some participants received establishment funds on an as needs basis for software and office related expenses, as available in all ACP options (maximum $968 for 4/10 participants). Some people already had business and care equipment so they did not have additional set up costs. They reported that the establishment funding was an important consideration for the people who used it.

Participants are satisfied with the funding arrangements from DADHC, after the delay in the first payments was resolved. They did not experience any payment problems in the second half of the pilot. Initially, they raised questions about what the funding could cover, for example hiring a hoist for travel, repairing a hoist, ironing, gardening and carers expenses when travelling. They said specific questions like this are sorted

administrative cost average is similar to DADHC expectations for other programs (10 per cent), however two people had an administrative cost 15 per cent or more.

Table 5.3: Attendant Carer Gross Pay Compared to Total Costs and Funding, per Participant

	Per cent of total costs		Average hourly cost ($)			
	Carer gross pay*	Other costs	Attendant carer pay rate	Attendant carer & agency pay rate*	Total cost	Balance from funding ($37.92)
	87.04	12.96	27.81	28.55	32.80	5.12
	87.25	12.75	28.78	28.78	32.98	4.94
	83.74	16.26	22.43	29.20	34.87	3.05
	73.40	26.60	26.07	26.07	35.52	2.40
	84.80	15.20	28.32	30.54	36.02	1.90
	71.80	28.20	26.79	26.79	37.31	0.61
	73.31	26.69	25.66	27.36	37.33	0.59
	95.63	4.37	28.00	36.26	37.92	0.00
	94.15	5.85	25.28	36.82	39.11	-1.19
	79.54	20.46	31.60	31.60	39.73	-1.81
Average	83.07	16.93	27.07	30.20	36.36	1.56

Note: * includes agency and contractors

When calculated as total annualised hourly rates, costs were less than funding for most participants (8/10) but slightly greater for two participants (Table 5.3). People with the highest cost surplus had high attendant carer pay rates (average over $28 per hour) and mid-range other costs (12-16 per cent of total costs). People with deficits or breakeven costs had either high pay rates (over $30 per hour) or high other costs (20-28 per cent). For two of these participants, the very high pay rates were due to high use of agency staff. DADHC budget management is not affected by participants' different hourly pay rates and other costs because the annual grant is fixed on basis of assessed hours needed and reconciled against hours used at the end of the financial year.

Participants identified that they are experiencing more efficient use of resources. For example, they are able to pay differential rates for less convenient hours; shift hours to meet their changing needs; and minimise administrative costs. Most participants report that usual monthly costs for attendant carers and expenses are less than payments, which they can then save for unexpected costs or care. They have flexibility to use additional resources to improve the quality of care, such as specific training, staff bonuses, infrastructure and consumable equipment, such as slip-on wet shoe covers.

Managing support hours

DADHC's end of financial year reconciliation of hours and funds in the direct funding pilot is the same as grants management with ACP service providers. DADHC reconciles hours funded and used against funds granted and expended. Most people (8/10) were in surplus or broke even in the cost of the number of hours used at the end of the financial year (Table 5.4).

Table 5.4: Reconciliation of Total Funding, Costs and Hours, per Participant

	Funding ($)	Total expenditure & commitments ($)	Balance of hours in pilot	Saved hours*	Surplus/deficit ($)
	41,712	33,554	53	50	6,199
	40,638	32,931	73	50	5,748
	44,947	40,531	224	50	2,457
	40,369	36,723	85	50	1,687
	45,157	42,226	33	33	1,638
	44,818	43,362	-15	0	1,455
	39,334	37,550	-24	46	0
	27,902	27,901	-6	0	0
	31,497	31,517	-9	0	-20
	45,128	45,519	21	0	-390
Average	$40,150	$37,182	44	28	$1878

Note: *Balance in pilot reconciled against saved hours from pre-pilot

Surplus funds from unused funds and excess hours (50 hours can be carried forward) are deducted from the participants' grant in the following financial year. All participants had managed their accounts sufficiently to absorb the reconciliation and did not have negative feedback about the process. The proportion of recouped surplus funds (5 per cent of total grants – $19,189) is similar to the other ACP models (4 per

equipment; or management expenses to improve quality such as professional assessments, specialist training for attendant carers and other employee benefits.

5.2 Cost Effectiveness

Cost effectiveness analysis provides information about the value added by ACP direct funding. It examines the cost to government of direct funding compared to ACP existing arrangements. The cost of the program per participant is calculated and the change in outcomes per participant is examined. The purpose of the analysis is to derive implications and recommendations for future funding options.

Costs of ACP direct funding

Annual costs to DADHC of the direct funding pilot are presented in Table 5.5. Other costs to participants, attendant carers and family members were not available. The estimate of recurrent program costs per participant per year is approximately $70,000 plus any future Businesslink charge for grant payments to clients (not charged during the pilot). The cost includes the policy official time plus the funding grant.

Table 5.5: Annual Costs of Pilot ($)

		Pilot cost	Ongoing cost	Per person (10)
Program manager		N/A	N/A	N/A
Program officer	10 hours per week	21,679	21,679	2,168
Annual grant	Assessed hours x hourly rate	678,200	678,200	67,820
Participant establishment costs	As required	22,119	-	-
Costs specific to direct funding pilot				
Establishment costs		Advice from DADHC staff and external advisory group	-	-
Businesslink	Mechanism to pay grants to participants	No charge	N/A	N/A
Evaluation cost	Commissioned	77,000	-	-
Total				$69,988

Source: DADHC financial records
Note: N/A – not available

Comparison costs to the other ACP models are not available. The costs are likely to be similar because the cost components are the same: program manager and program officers to support the program; internal and external advice; annual grants for each ACP client based on assessed hours by hourly rate; one-off payments to clients as required; process to pay grants internal to DADHC for payment to service providers or external to DADHC (Businesslink) for payment to clients under direct funding.

Benefits of ACP direct funding

Outcomes discussed in Section 2.2 were assessed with three comparisons: people in the ACP direct funding pilot with other ACP clients; change over time for the ACP

direct funding participants; and direct funding participants compared to the general population. Qualitative and quantitative measures were used. On average, improvements were measured in all outcomes – health and wellbeing, confidence and

The data have several limitations to be considered when interpreting the results: the sample is very small (10); the first measure was collected up to 6 months after the participants had started in the pilot, so direct funding could already have improved the

- develop direct funding options in other DADHC programs for people with similar capacity or support.

Administrative support for this capacity is discussed in Section 6.2.

6.2 Administrative Support

Implications for policy options include:

- continuing allocation of an experienced policy official to support program implementation, including responding to queries from the participants and managing financial accountability;
- maintaining management systems to monitor and protect against financial and support risks to clients and government. The experience of monthly and annual reporting for new participants contributed to this risk management. The Department could review reducing the frequency of reporting for clients who successfully manage care hours and finances within budget after an initial period; and
- examining the financial implications of allowing participants to apply the cost savings to purchase additional care.

6.5

7 Conclusion

The evaluation shows an overwhelmingly positive response to the direct funding pilot from the initial participants. Their quality, control and flexibility of their care has improved. This has had a positive impact on their quality of life outcomes. The participants are all keen to assist in developing the model and expressed strong support for it to continue. Many comparison participants are also eager to know about its progress and when they can reconsider joining the direct funding option.

Governance

- Are appropriate and effective governance arrangements in place to support the establishment and ongoing development of the pilot?

Service systems

- Does the pilot offer greater choice and flexibility of services compared to existing funding arrangements?

- Does the pilot provide a more effective and efficient use of resources compared to existing arrangements?

Longitudinal data collection

The evaluation uses primary data collection methods with the participants in the pilot program, other clients in existing ACP arrangements and other participants, particularly from DADHC and service providers. Research instruments measure the range of outcomes and process experiences described in the design section above.