

Evaluating the Transferability of Innovative Models of Care

Prof Fang Lee Cooke

Dr Richard Cooney

Prof Ian McLoughlin

Dr Karthyeni Sridaran

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This publication may not involve an exhaustive analysis of all existing evidence. Therefore, it may not provide comprehensive answers to the research question(s) it addresses. The information in this publication was current at time of completion. It may not be current at time of publication due to emerging evidence.

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Abbreviations

ABI	Acquired Brain Injury
AUSLAN	Australian Sign Language
BoC	Behaviour of Concern
DSPO	Disability Service Provider Organisation
DSW	Disability Support Worker
ICP	Individual Care Package
ICT	Information and Communications Technology
ISCRR	Institute for Safety, Compensation and Recovery Research
MVP	Minimum Viable Products
NDIS	National Disability Insurance Scheme
NDS	National Disability Services
OHS	Occupational Health and Safety
PACE	Program for All-Inclusive Care of the Elderly
SCI	Spinal Cord Injury
SMF	Service Modularity Function
TAC	Transport Accident Commission
VIG	Video Interaction Guidance

Executive Summary

This study builds upon a previous study of new models of care in the disability sector. The initial pilot study was designed to scope the work necessary to develop a better co-ordinated, high quality system of care for people with disabilities – a system that is client-centred, flexible, responsive, cost-effective and makes the best use of digital and assistive technologies. This study examines innovations in the sector and organizational barriers to embracing new practices.

The aim of the current study is to identify good practices and innovations in service delivery models locally and internationally; in disability and related care sectors. The study identifies issues around the transferability of innovative models of care to enhance client experience and support more independent living of clients living with Acquired Brain Injury and Spinal Cord Injury (ABI-SCI). The study aims to provide the Transport Accident Commission (TAC) and Disability Services Providing Organisations (DSPOs) with a better understanding of the gaps that exist between current practice and best practice in comparable contexts elsewhere, and provide opportunities for the TAC and DSPOs to consider the implementation of new care models, or elements of them.

The research was undertaken by means of case studies in selected Victorian DSPOs. The research included phases of:

- i. An extensive literature search to identify new models of care and good practices.
- ii. Case study research involving 7 Victorian DSPOs based upon interviews with 32 senior managers, middle managers, supervisors and care workers.
- iii. analysis of the interview data to identify the issues in the transfer of new models of care, and;
- iv. The dissemination of research findings through workshops and similar forums.

The research identified several new models of disability service delivery with potential to be transferred to Victoria. These include:

Integrated Disability Support Service Teams that bring together care workers, support workers with specialised skills and also specialists with specific clinical skills. Internationally, much evidence has highlighted the need for interdisciplinary and multi-skilled care teams in human service delivery.

Disability Support Modules that bring together all related activities involved in achieving a specific goal for the client. The standardisation of a set of activities enables DSPOs to improve the way in which the modules are delivered to continuously improve efficiency and effectiveness.

Case Managers/Case Coordinators to tailor the delivery of disability support services to client needs and deliver a higher quality of services. They are the interface between the client and the DSPOs.

Disability Support Services Brokerage to bundle up specialised support services on behalf of clients and to source providers that can best meet client needs. We understand that this is already occurring within TAC and the NDIA Barwon Trial site as well as in the broader disability sector, but may need to be adopted more widely.

The research found a low uptake of such innovations, however. There was little focus on service model innovation amongst DSPOs and innovation efforts that were being undertaken were often fragmented and led by individual champions, rather than being systematic. The start-up of the National Disability Insurance Scheme (NDIS) is driving change in the disability care sector. There is growing recognition that change is needed in the sector, but change efforts are currently focussed on organizational restructuring and improvements to back-of-house administrative systems to scale up for the NDIS. Little attention is being paid to service model innovation, although a small number of larger DSPOs are in the early stage of embarking on an organizational overhaul to reposition themselves in the market.

Such attention as is paid to service change is focussed upon the development of new categories of service (e.g. transportation services or gardening services) rather than new models of service delivery for core care services. DSPOs are concerned about apparent skill gaps between the workforce available to them and the workforce required to improve service and adopt new models. DSPOs are concerned about the cost of skill upgrading to implement new service models and are currently focussing upon new human resource management strategies - in recruitment, training and work organization - to deal with workforce development issues.

1. Key messages

The key findings of the research are:

- I. The start-up of the NDIS is driving change in the disability care sector. There is growing recognition that change is needed in the disability services sector but change efforts are currently focussed on organizational restructuring and improvements to back-of-house administrative systems to scale up for the NDIS.
- II. Current innovation efforts within DSPOs are fragmented, rather than systematic, and there is little focus upon service model innovation. Innovation efforts are driven by committed individuals and are rarely disseminated across the organization or the sector at large. TAC may consider selecting a number of core provider organisations and work with them to develop a process to drive innovations beneficial to achieving its goals, as NDIA is unlikely to play a part in practice stewardship.
- III. Attention to changes in service delivery is focussed upon the development of new categories of service (e.g. transportation services or gardening services) rather than new models of service delivery for core care services.
- IV. There was awareness amongst the managers of changes to some job roles as DSPOs restructure, but little awareness of systematic occupational change to innovate in

service delivery. Systematic occupational change includes, for example, modernising the skill sets of the care workers, e.g. ICT skills, a client facilitation orientation, and an innovation mindset.

- V. There is a considerable skill gap between the carer workforce available to DSPOs and what may be needed to provide innovative forms of service delivery to clients, e.g. older workforce may not be IT savvy to use the IT equipment to help make life easy for clients. DSPOs are concerned about the cost of skill upgrading to implement new service models.
- VI. DSPOs are implementing new human resource management strategies - in recruitment, training and work organization - to deal with workforce development issues.

Our study has a number of strategic and operational implications for the TAC:

- I. TAC can more actively shape the emerging market for the provision of disability support services. This should be done to avoid quality of care and supply issues in the future, and thus avoid TAC being constrained by market incompetence.
- II. TAC can develop activities that are simple and relatively inexpensive to promote innovation in service delivery. DSPOs are looking to bodies such as TAC for guidance in their change activities and would be receptive to promotional activities, small grant programs for innovative demonstration projects or the brokering of network improvement activities by TAC. As the lead player in the care service supply chain, playing an active role in shaping the behaviour and competence of those at the lower end of the supply chain, namely, the DSPOs, will enable TAC to have a bigger control in the quality of the services provided, hence contributing to its strategic goals. We have already seen leading and upmarket retail giants playing this kind of role in their value chain.

- III. The TAC could give DSPOs more guidance/feedback on the quality-of-care that it expects and this may involve consideration of price signals.
- IV. The TAC needs to stay abreast of workforce development issues in the sector, as these are another potential source of quality failure leading to market failure.

2. Purpose

The purpose of this research is to examine innovative models of care that have been implemented within and outside the disability sector in different parts of the world. Our overall aim is to identify good practices and innovations in service delivery models evident among service provider organisations in Victoria and to consider transferability of innovative models of care from elsewhere nationally and internationally to enhance client experience to support more independent living of ABI-SCI clients. Our findings and recommendations also aim at improving the cost-effectiveness of service delivery in the disability service sector.

As a **working definition** for this study, 'innovation' is referred to as any organisational policy and procedure, initiative and work practice new to the organisation itself and not necessarily new to the rest of the world. We focus on three types of innovation: administrative, managerial and technological innovations.

2.1 Research Objectives

The project has the following objectives:

- To identify and evaluate innovative models of care within and outside the disability sector in order to identify practices suitable for transfer to the TAC-compensable sector in Victoria;
- To pilot innovative models in selected care organisations;
- To develop an assessment framework through which the potential transferability of innovative models and specific practices, approaches to implementation and methods and criteria for measuring outcomes can be evaluated;
- To promote and disseminate innovations within the TAC-compensable sector in Victoria.

2.2 Key Research Questions

The key research questions of this research are as follows:

- 1) What are the key elements of innovative models of care in relation to the co-ordination of care delivery to meet client needs in the medium to long-term?
- 2) How have these innovations been effectively implemented and sustained and what problems, issues and challenges have been addressed and overcome?
- 3) How have the outcomes of these changes been measured and evaluated?
- 4) To what extent and by what means can the key elements of innovative models, the approaches to implementation and frameworks for evaluation, be transferred to the TAC context?

3. Rationale

The delivery of a total package of disability care services involves the co-ordination of numerous care professionals, support workers and many others through the independence plan cycle i.e. from the acute/rehabilitation phase, through transition to community and to maximising independence. Our Phase One pilot projectⁱ undertaken in 2013 highlighted shortcomings in current care models, in particular in implementing independence plans in the delivery of attendant care by disability service provider organisations (DSPOs), are having an adverse impact on client experience, client outcomes and overall scheme viability.

The TAC has identified the need for, i) a fuller understanding of how innovative care models used in other contexts have achieved cost effectiveness (e.g. the cost of attendant care) and increased client independence whilst improving the quality of client experience and outcomes; and ii) an assessment of what innovations might be transferable to the TAC context and how this might be achieved.

Our Phase One pilot research suggests that such change requires a high level of collaboration from all parties to enhance communication, align goals, and take advantage of

what has been learned through translating such knowledge into practice and sharing it. This has implications for coordinating responsibilities, developing flexibility, and establishing new ways of integrating knowledge and sharing information among groups of professionals, support workers and others. In a TAC context, this may present considerable challenges to DSPOs and care workers, based on our case study information (see below and our report which is available from ISCRR for more detail).

The pilot study in 2013 highlighted service delivery issues prevalent among DSPOs as follows:

- Current models of care are not client-focussed, with limited attention to client preferences and choice;
- Current models of care address immediate care needs, rather than future long term goal-setting of clients;
- Current models of care do not provide emotional support for clients and their families, potentially posing further psychological trauma and leading to behavioural problems downstream for both client and their carers;
- Current models of care do not sufficiently utilise the untapped resources of family and friends (the unpaid carers), in tailoring care plans that are holistic and truly client-centred;
- Current models of care provided independently in client's homes are difficult to audit for service delivery quality.

The pilot report concluded that service provider organisations in the disability sector were generally operating with provider-centric models that made it difficult for clients and/or their families to navigate through the multiple layers of services to find services that might be relevant or suitable to the needs of a specific client. This supply-driven provision is disempowering for clients and their families, who often lack the relevant knowledge and skills

to navigate through cumbersome and confusing systems and processes. This often caused frustration and greater angst, at a period when clients and their families were already coping with great difficulties brought on by the trauma of facing life-altering circumstances. The provider-centric models of service delivery compounded frustration as clients and their families largely felt unsupported in a system that often felt cold and uncaring.

The pilot report also highlighted that, despite expressions of enthusiasm to adopt client-centred care in their operations, there was some confusion amongst senior level managers in DSPOs as to what client-centred care actually means. The pilot also indicated that clients (or their champions) have little say and are not always informed, consulted or included in the decision-making concerning treatment or rehabilitation. Often, services are not well-tailored to the unique needs of individual clients for post- trauma recovery. The pilot also indicated that DSPOs were faced with extreme challenges in the areas of internal funding and manpower, which limited their capacity for service delivery innovation. These shortages often left clients dissatisfied, as resource issues negatively impacted upon quality standards. A key finding of the pilot was that the insufficient monitoring and audit of service delivery in the individual homes of clients was disconcerting. Care provision seemed to largely centre around short-term immediate care concerns, rather than on long-term plans for independence of a client. Given these insights from the pilot phase, learning more about how such issues have been addressed in other contexts would provide valuable prospects for the transferability of care models and practices new to the organisation.

It was envisaged that, by answering the key research questions, the TAC and DSPOs would come to a better understanding of the gaps that exist between current practice and best practice in comparable contexts elsewhere. The project also presented opportunities for the research partners to consider the implementation of new care models, or elements of these models, in DSPOs. The research also raised the possibility of forming proactive partnerships between the TAC and DSPOs to more effectively manage potential issues and challenges that need to be addressed to deliver change in the service delivery and practices of the disability

service sector. Establishing effective means of overcoming such issues/challenges might be best explored through trials or demonstration projects to establish effective ways of implementing innovations in a manner suitable for the TAC context.

In light of these challenges, the overarching rationale of this project is to identify good practices and innovations in service delivery that enhance clients' independence and wellbeing, and to share with the TAC and Institute for Safety, Compensation and Recovery Research (ISCRR) insights into how the diffusion of good practices and innovations might be facilitated amongst service providers that support the TAC- compensable clients within Victoria. Whilst the report to ISCRR on the pilot study identified the sector-wide barriers and constraints to achieving a client-centred approach to care, the current report presents findings from case studies in selected DSPOs, with a focus on how these organisations engage in innovative practices, despite the constraints highlighted in the pilot report. The research begins the process of drilling down into organisations to understand some of the realities of innovating, and what DSPOs are doing to better align their practices with the principle of client-centred care, which is fundamental element of the organisation of the National Disability Insurance Scheme (NDIS). Accordingly, this project contributes to understanding the organisational practices and approaches that support innovation, so that any particular models or practices that DSPOs might wish to implement have a greater chance of success and are more likely to be sustainable. Several selected innovative models of care are examined to identify how such practices and models have been implemented and sustained in similar sectors - e.g., aged care or healthcare - to deliver measurable improvements in independent living for clients.

4. Methods

4.1. Research Design

This study adopts a qualitative method with case study as the main approach for data collection. A multiple-case design is employed for the purpose of gaining an in-depth view of how DSPOs are dealing with the question of innovation within their operations. The project proceeded in four stages as follows.

Stage 1:

In Stage One, an extensive literature search was conducted on models of care to identify good practices and innovative models, and to develop a draft framework for the evaluation of the transferability of innovations to the TAC-compensable sector in Victoria. Secondary data was gathered from the extensive policy, grey and academic literature covering both national and international perspectives. Innovative or best practices from within the disability sector and outside of this sector were identified, along with their potential transferability to Victoria. Several meetings were held with the TAC and ISCRR to understand the expectations of the funding bodies and align research output accordingly.

Stage 2:

Stage Two involved the fieldwork to collect interview data for two in-depth case studies. Initially, 30 Victorian DSPOs were identified. This number was reduced to include only those DPSOs operating within a 15km to 30km radius of Monash University Caulfield campus. From this preliminary list, initial interviews were conducted with senior managers of ten DSPOs, to establish their suitability and interest to participate in this research project. Then, from this list, seven DSPOs were short-listed, on which two in-depth case studies were completed. These studies involved semi-structured interviews with senior managers, middle managers, supervisors and care workers in the participating organizations. In total, 32 interviews were conducted with respondents in seven DSPO's.

Stage 3:

Stage 3 involved the preparation of draft case studies and the analysis of the key emerging issues. The drivers of change within the DSPO's were identified and comparative analysis of approaches to innovations in care was undertaken. This work informed the preparation of the final research report. The models and best practices identified were assessed using an overall framework to evaluate the transferability of innovative approaches for implementation in the disability sector providing methods and criteria for measuring outcomes.

Stage 4:

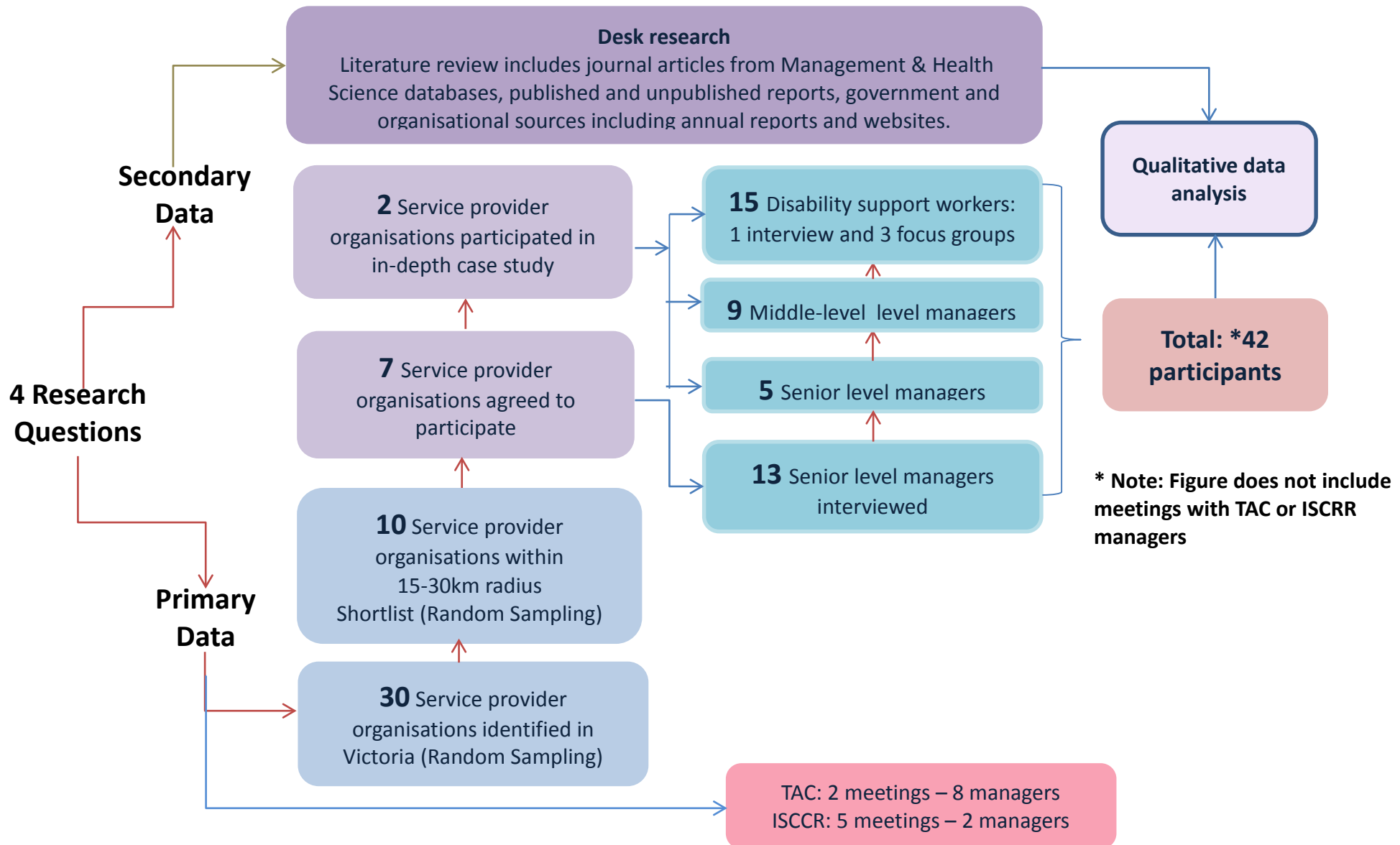
This final stage involved the dissemination of research findings which might involve the delivery through workshops, with an aim to share good practices and innovations.

An overview of the research design is provided in Table 1 and Figure 1. The fieldwork commenced in November 2014 and was completed in May 2015. At Stage 4, the innovative practices from findings in Stages 1 and 2 may be trialled or consulted for suitability with a small number of participating organisations. We note the relatively small scope of our study as limitation of our project. For example, we have not been able to gain full access to a larger number of case study organisations, nor could we gain access to speak with the clients. This is because a number of organisations which initially agreed to participate in the study have pulled out due to (major) organisational change or unwillingness to share information/good practices in the industry, despite the research team's guarantee of confidentiality.

Table 1. Number of research participants interviewed

Organisation	Senior Level Managers	Middle Level Managers	Disability Support Workers
DSPO 1	3	1	1
DSPO 2	6	8	14
DSPO 3	2	0	0
DSPO 4	1	0	0
DSPO 5	1	0	0
DSPO 6	3	0	0
DSPO 7	1	0	0
Other	1	0	0
TOTAL	18	9	15

Figure 1. Overall research design



5. Research Findings & Implications

5.1 NDIS-driven change in the disability sector

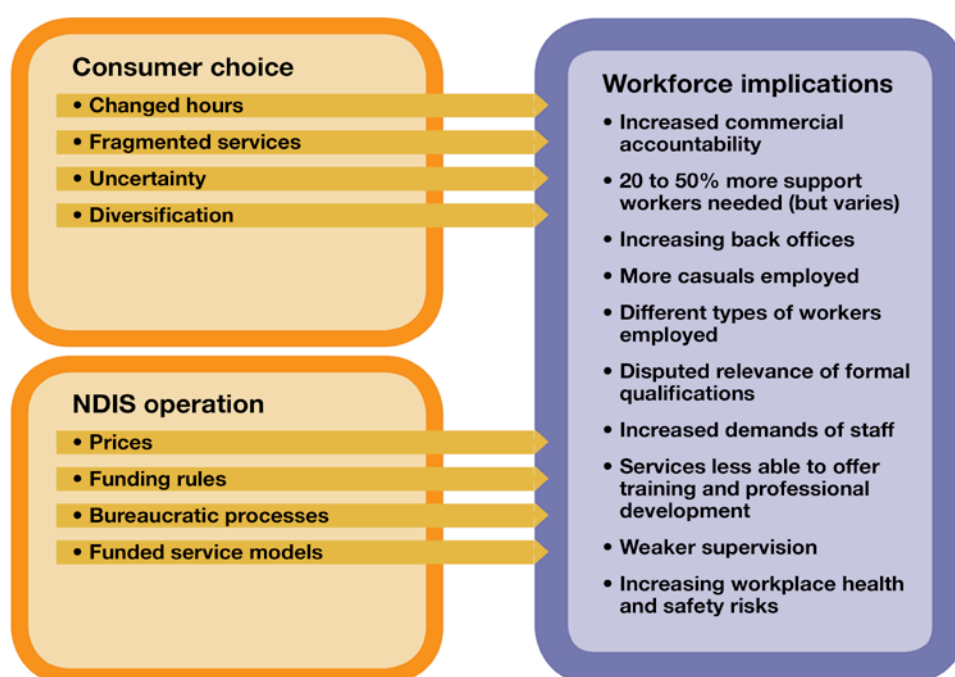
Amidst great expectations and uncertainty about the impact of the NDIS, there is, however, wide recognition and acceptance that change is needed in the sector. The policy developments of the NDIS were addressed in the Pilot study. Although, in principle, the NDIS promises to dramatically improve the lives of people with disability and their families by personalising and expanding the support available, questions remain about the readiness of DSPOs for such a transformation as they confront the reality of transferring control of funding to clients, or to their families or guardians. Some two years on from the release of the Pilot Study report to ISCRR, the research underpinning the present report reveals that there is still a great deal of uncertainty within the sector as to how the NDIS will unfold. In this current project, the fundamental shift in social policy that is the NDIS was felt more urgently by the DSPOs, as they dealt with the necessary parallel transformation of their internal operational structures and the re-alignment of their workforce to keep pace with the demands of the NDIS policy.

As the early roll-out stages drew close, the DSPOs faced the daunting task of restructuring and repositioning themselves, given that a considerable amount of their old funding model was changing. Our findings indicate that many DSPOs are under pressure on this front as, from among ten short-listed DSPOs, seven exhibited keenness to participate, but ultimately, five dropped out of the case study phase of the current research project. The majority of DSPOs that dropped out cited urgent internal affairs that took precedence and superseded their ability to commit time and focus to this research. Almost all the participants that dropped out cited massive internal restructuring taking place, and a lot of movement of personnel, particularly at the senior and mid-levels of the organisational hierarchy, was noted. This, to some extent, delayed the fieldwork on this project, but more importantly, it indicates the general state of flux in the sector.

Our observation: Little guidance seems to be available on sectoral change from the funding bodies. DSPOs are predicting sectoral change in ways similar to that experienced in the aged care and child care sectors.

National Disability Services (NDS), in its discussion paper on forming a National Disability Workforce Strategyⁱⁱ draw on the early transition experiences of the NDIS trial sites, to outline challenges arising from expanded consumer choice and control, as shown in Figure 2, below. Consistent with the NDS discussion paper, our research indicated that one key concern of DSPOs is that costs will increase during the transition to a full NDIS, and there is some anxiety about who will foot the bill/share the cost of, for example, the salaries of more support workers, the cost of training for the disability sector workforce, and increasing back-office costs. It is important to note that the NDIA research suggests inflated back-office and corporate costs for most providers, e.g. sitting at over 40%.

Figure 2. Workforce implications from NDIS trial sites
Workforce implications in the trial sites



Source: National Disability Service (April 2014)

Apart from these cost concerns, readiness for change among the service providers also varies. While one of our case study participants who took part in the trial claimed to be NDIS-ready, our research findings told a different story, with most DSPOs appearing to be in a haphazard state of readiness. There were particular concerns about the coordination of their services with new service organisations, their efforts at community integration, their back-of-house improvements and their repertoire of developing new services or new occupational categories, for example, “boundary spanning managers” for service brokerage, such as in-sourcing for gardening services. Table 2, below, summarises the paradigm shift that is needed to achieve the level of readiness that would be ideal for the full NDIS roll-out. Our research findings show that the reality on the ground for most of the DSPOs is far from the ideal. Most DSPOs we encountered are still operating as described in the ‘Before’ mode outlined in left-column of Table 2. At best, some are making incremental innovations and struggling to reinvent themselves, with old models crumbling and new players all competing to remain viable and on the lookout for more sophisticated models of care.

Table 2. Before and after: the NDIS paradigm shift

BEFORE	AFTER
Provider-centric services	Client-centric services
Secure “block-mode” funding	Competitive individualised funding
Lack of brand awareness	Heightened brand awareness
Passive marketing	(Pro-)active marketing
Inefficient back-office functions	Modernised (more-efficient) back-office functions
Reliant on external contractors for training and certification	Developing in-house training, orientation programs and structured training programs
Casualised workforce	Professionalising workforce
Low level of attention to innovation	Increased interest/pressure for innovation , research, organisational improvement
Fragmented best practice	Scalable and system-wide improvements

5.2. Innovative Models of Care in the Disability Sector

One of the key drivers of change anticipated from the introduction of the NDIS policy in the disability sector is the increased commercial accountability that is being demanded of the service providers in a sector which, for a long-time, had operated on 'block-mode' funding, where eligible clients received the services that a funded DSPO was contracted to provide. This resulted in a provider-centric service delivery system that impeded the choice and participation of people with disabilities in their own care. Under the new, client-centred, client-empowered paradigm of the NDIS, clients will be granted control over their Individual Care Package (ICP), thus shifting the balance of control from the DSPOs to the client. What this means for DSPOs is that their operations need to be redesigned to reflect business-like innovations within an NDIS-driven landscape that is becoming intensely competitive. However, the challenge for DSPOs is to achieve an innovation model which adds value to the service provider, without compromising the social and welfare service intended for those they serve. Thus, the search for an innovative model of care, both nationally and internationally, was undertaken by our research team to identify innovations from within the disability sector and other related sectors, such as health and aged care, to methodically address the challenges faced in the disability sector. Ultimately, the models we propose should question, challenge and transform outmoded practices and lead to new approaches that deliver the highest value to the DSPOs and the clients whom they ultimately serve.

5.3 Framework for Evaluation of Innovative Models and Best Practices

The main objective of our study is to identify innovative models that may be useful to the disability service sector and recommend them to those that have not adopted these models in full or in part but are keen to improve their organisational effectiveness. Evaluating innovative models of care on their transferability into the disability sector requires a shared understanding of what constitutes an innovative model of care. From the pilot study phase preceding this

current project, it was clear that, despite an extensive literature search, a single exquisite model of care does not exist to be transplanted in a wholesale manner into the disability sector.

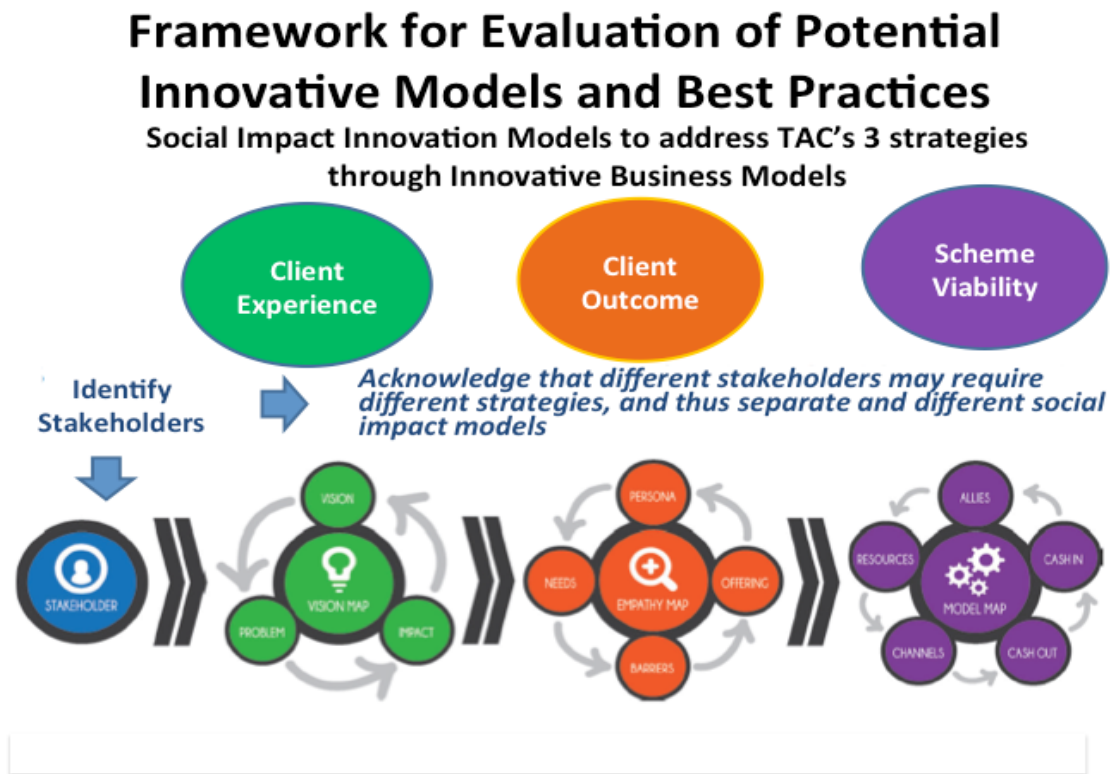
What this means is that any proposed model of care must be adapted to ensure that it is simple, yet relevant, while also capturing the complexities that surround disability service providers in the State of Victoria. Therefore, we use both primary and secondary data to identify model alternatives which include any strategic improvements and best practices, in part or in whole, in a variety of care sectors nationally and internationally. The researchers were guided by the TAC's Provider Strategyⁱⁱⁱ document, which enumerates three main goals, to: i) achieve client outcomes, ii) improve client experience, and iii) maintain scheme viability, in order to maximise the independence of severely injured TAC clients.

5.3.1 Overarching framework: Social Impact Model

An overarching framework for the evaluation of innovation and best practices was used to ensure a systematic consideration of the viability of the various models we encountered in the literature, and the living exemplary models in practice within the service providers that we investigated. For this purpose, we found the *Social Impact Innovation Model* (see Figure 3) proposed by Ortega, Furr, Liman and Flint (2014) to be a useful evaluation framework. The Model recommends that innovative ventures be placed in their context. In other words, one needs to understand under what situations these ventures are most needed and useful.^{iv} Given that the context of the disability sector has an underlying social and welfare agenda, the quest for more impactful efforts, strategies, and ventures requires DSPOs to carefully identify their key stakeholders, and then to create, map and iteratively test each of the stakeholders' social impact models and their respective assumptions (see Figure 3). For each model, the authors suggest the use of three maps: the vision map, the empathy map, and the model map (see Figure 4).

Figure 3. Social Impact Model

Source: Adapted from Ortega, S., Furr, N., Liman, E., & Flint, C. (2014).



5.3.2. Service providers in disability sector context – the changing landscape

Our findings indicate that on largely exogenous counts (NDIS and new person-centred reforms in the disability sector), service provider organisations need to make progressive and innovative changes to their institutional frameworks to meet competitive demands in the changing disability landscape. There is a need for tailoring products and services using co-design/co-creation principles to create new niche offerings whereby flexible services or products can be customised for individual clients or groups of client (key stakeholder) segments. As clients achieve greater independence over how and where to spend their Individual Care Package funding under the NDIS, only the highly effective and efficient service providers will secure new independent clients or client groups through funding bodies like the TAC and other insuring agents.

5.3.3. The Vision Map

The Social Impact Innovation Model begins by identifying key stakeholders within an organisation, as well as those external to the organisation, to ensure that there is a clear vision of each and every stakeholder it engages with in the running of the organisation, including clients, employees, suppliers, governing agencies and any other stakeholders. This is followed by considering the Vision map. In using the Vision map, DSPOs are guided in their decision-making and problem-solving process to ensure the core values of each of their different stakeholders are addressed (Figure 4).

Figure 4. Vision Map



Source: Adapted from Ortega, S., Furr, N., Liman, E., & Flint, C. (2014).

The benefit of the Vision map is that it allows for an overall view of the sector to identify all key stakeholders and identify the key problems associated with each stakeholder and to develop a vision for achieving positive outcomes and experiences for all key stakeholders. An example of such a Vision map for the disability sector in general is provided in Table 3, below. The broad vision map serves as a way to clarify and explicitly express the desires, as well as to define what success looks like before diving into the details. Like the mission, vision, and core values of a for-profit company, these sections become the guiding principles for future decisions (Ortega et al., 2014).

Table 3. Example Vision Map for the Disability Sector (tabular form)

Stakeholders	Big Problem	Vision	Impact
Clients /Client segments with varying degrees of Disability	<ul style="list-style-type: none"> • Poor Client Experience • Poor Quality of Life 	Client Centred Care Services & Products	<ul style="list-style-type: none"> • Improved Client Experience • Improved Quality of Life • Independence
Disability Support Workers	<ul style="list-style-type: none"> • Lack of career path • Limited training • Social isolation • OHS issues 	Highly trained and motivated workers	<ul style="list-style-type: none"> • Skilled workforce • Effective care delivery • Low turnover • Satisfied workers
Care Provider Organisations	<ul style="list-style-type: none"> • Poor services • Recruitment issues • Retention problems • Mismatch of skills with client needs 	Alternative Model of Disability support services Shared Best Practice Adoption Integrated Services	<ul style="list-style-type: none"> • Improved Administrative Services • Integrated Services • Efficient & Effective support services • Organisational innovations • Technologically-enabled innovations
TAC	<ul style="list-style-type: none"> • Escalating Cost of Disability care support 	<ul style="list-style-type: none"> • Scheme Viability • Client Outcome • Client Experience 	<ul style="list-style-type: none"> • Reduced claims duration • Reduced cost • Satisfied clients

The Vision Map can be presented in tabular form as above, or in pictorial form as in Figure 5, below. The application of elements of the Map may be constrained by institutional context, notably the regulatory framework that governs the sector in service provision and employment practices.

Figure 5. Example of Vision Map for the Disability Sector (Pictorial form)



5.3.4. The Empathy Map

Ortega et al. (2014) reiterate that all too often products, services, or organisations end up having little impact for the end user. This view matched our findings among DSPOs, particularly among disability support workers (DSWs), who represent a critical stakeholder segment, as they are in direct contact with clients, delivering products and services on the ground to this key segment of stakeholders. Many DSWs recorded feelings of disengagement with the overall aspirations of the DSPOs and did not feel that the policies devised by senior personnel of the organisation had significant value to their day-to-day work with clients. In the focus groups we conducted with DSWs, it was commonplace for this stakeholder segment to feel their needs and voices were not being considered by their superiors and that good innovative ideas were only shared amongst themselves or in the individual homes where these workers worked. Thus, innovative are often not scaled up to benefit the overall organisation.

Many innovations on the ground, although small and incremental, may have the potential to make a big change in the long run, and at the aggregate level. Thus, the DSPOs

are failing to capture such small innovations from within their own ranks, where there is a prevailing climate of mistrust between senior and lower level staff. This lack of trust was illustrated when some DSWs chose to opt out of the Focus Group sessions, despite being explained the confidentiality clauses of the research. Other more vocal DSWs appeared cynical about the policy changes driven by the top management. Thus, a key barrier among DSWs is their pessimistic view about innovations driven from the top. At the same time, their own innovative capacities are limited to a small level of impact and not often not shared with others, and consequently, do not add significant value to the overall organisation. In this way, DSPOs fail to capture their creative offerings.

The Social Impact model is designed to address these common failings in organisations. It works to identify the stakeholder's needs and to design creative offerings that address those needs. The model digs deep to understand each stakeholder, their needs and aspirations, to identify the barriers in front of them and to capture their unique offering or service. The Empathy Map (see Figure 6) provides a structured way to map assumptions in these areas and to test them using many of the tools of design thinking.

Figure 6. Example of an Empathy Map for the Disability Sector



The Empathy map firstly defines the stakeholder segment and creates its '*persona*'. According to Ortega et al. (2014, p.77):

A persona is a more personal representation of the stakeholder's segment. It provides answers to the questions: who is this stakeholder? And, what are the distinguishing characteristics (demographics, behaviors, thoughts and feelings, etc.)? How you define your persona should be based on sound qualitative and quantitative research and should be described in a narrative form, using first names and follow a user story or behavior.

Many organisations, both within and outside the disability sector, fail to clearly know their stakeholders. The Empathy map is an effective way to comprehensively understand the stakeholder one is serving. This is perhaps most important when dealing with the complex needs of a vulnerable group of clients in the disability sector who experience varying degrees of physical, emotional and socio-spiritual need. While quantitative data is great for situations of great familiarity, understanding the complex situations of people whose needs differ from

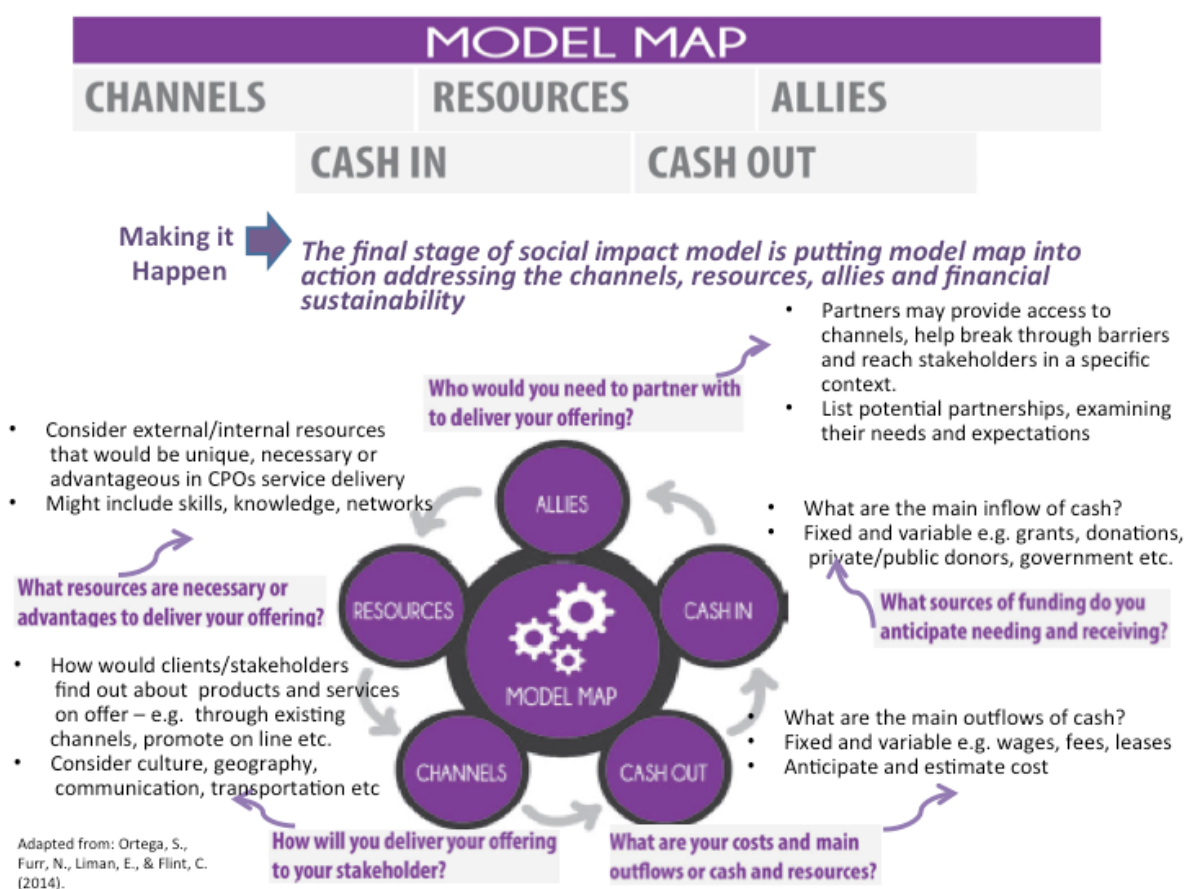
one to the next requires an upfront as well as a continuing investment in careful, qualitative observation. In the words of the authors, “you have to go there, be there, and experience it before you can really understand” (Ortega et al., 2014 p.78). They explain that what one person may assume to be a major pain might hardly even bother those whom we observe and serve. Ortega et al. (2014) call this phenomenon the *Theory of Needs Relativity*. The authors reiterate that a need or a job-to-be-done is relative to the current needs a stakeholder faces, rather than that of the observer. This is why it is so important to deeply understand the stakeholder, their context and circumstances, and what they perceive to be a big problem, a problem worth solving and an opportunity for stakeholders to impact their lives.

The Empathy Map in Figure 6 provides an example of how DSPOs can map the needs, barriers and offerings to be made to multiple segments of stakeholders. The map can be adapted to focus on each stakeholder segment, drilling down further to truly establish the needs of a single segment at a time.

5.3.5. The Model Map

The final stage of the Social Impact model looks into how a service or product is delivered to the unique needs of the identified stakeholders, as established by use of the Empathy Map previously described. For DSPOs, this is an important step to ensure their commercial viability under the new NDIS funding system, where they now need to be far more mindful of their in-house cost efficiencies and effectiveness in a competitive client-centric landscape. The model map is an important step in addressing the channels, resources available, and allies to be partnered with, as well as monitoring the financial sustainability of their operations by closely monitoring their cash-in and cash-out flows. An example of a model map is presented in Figure 7.

Figure 7. Example of Model Map



In using the overarching Social Impact Model, the researchers consider it useful for comprehensively mapping a delivery of service to any segment of stakeholders in the disability sector. It is also a useful framework for evaluating the various forms of innovations that were identified in the secondary and primary data of this research project. The next section presents the findings and discussion of forms of innovation and new support and business models in disability care services.

5.4. Forms of innovations in disability care services

As the disability sector is driven to become more client-centred, DSPOs need to realign their operations from the traditional provider-centric models to reflect the different needs of the diversified range of client segments they serve. Clients comprise the heart of any business model and as such, once a conscious decision is made about which segments to serve, a

business model can be designed incorporating a strong understanding of specific customer needs by using the Empathy map to plot the persona of the identified client groups.

While our research within disability service provider organisations in the disability sector focussed mainly on administrative, managerial and technological innovation, our findings reveal that the workforce in the sector is often comprised of passionate, caring individuals who, more often than not, have personal experience with disability, either themselves or via family members or close friends. Such encounters in their own lives tend to bring highly driven and committed individuals to work in a sector that is well known for its low wages and demanding work. Although the sector also suffers from a low-skilled workforce and other related issues, which will be addressed later in this report, our research also revealed incidences where passionate individuals have driven innovations within DSPOs and have been instrumental in developing new innovative services or practices. Examples of this phenomenon include the creative use of assistive information and communications technology (ICT) to improve the quality of care and consequently improve the living experience of the client (e.g., Video Interaction Guidance (VIG), discussed in Case Study A, was pioneered by a speech therapist on her own initiative). Other examples small innovative work practices that can make a big impact on the client's experience also exist on the ground.

However, more often than not, these grassroots level innovations or new ways of working are not shared across the entire organisation. Even if they are shared, dissemination tends to happen in an *ad hoc* manner rather than being systematic. Part of the problem lies in the fact that there is no systematic organisational mechanism for knowledge sharing (organisational learning). The absence of such a management mechanism to capture service innovation means that DSPOs miss out on the opportunity for interaction between different types of innovations, which would support and serve further creative ideas between organisational segments within the DSPOs. There is a need to examine how different types of innovations might build on each other, and observe whether one type of innovation may affect and lead to improvements in other sections.

For example, innovations in administrative procedures may lead to knock-on quality improvement in the delivery of service by a DSW to a client. This can occur due to improved information flow or better understanding of service information which, prior to the administrative innovation, may have been prevented by information bottle-necks and inefficiencies that impact upon supply chain. The ultimate effect of these bottle-necks and inefficiencies is upon the experience of clients with their support workers down-stream, so innovations that overcome these problems have an important part to play in improving client outcomes.

In the following sections, we will discuss evidence of innovations that we have uncovered from our case study organisations. These can be summarised as encompassing the following dimensions:

1. Administrative Innovations and New Models of Disability Support Services/New Business Models
2. Disability Support Services Brokerage
3. Technological Innovations, e.g.:
 - a. Technologically Assisted Disability Support Services
 - b. Technologically Co-ordinated Disability Support Services

5.4.1. Administrative Innovations

Administrative innovations are innovations in the processes of service delivery and/or the structure of DSPOs. Changes may be seen in the organisation of work (affecting skills, knowledge and training of disability support workers), the delivery process (the sequencing of activities) and the organisational structure (work roles of employees).

In the wider healthcare sector, those seeking delivery reforms or innovative care models in order to achieve service improvements and financial sustainability lament the lack of integration and financial incentives for these initiatives. In their 2012 work, Bazinsky, Herrera and Sharfstein^v discuss innovative models in Maryland, USA, that reward clinicians,

practices and hospitals, for keeping their patients healthier and incentivize strategies that reduce the need for expensive acute care services. The article discusses state-driven resources such as a public domain website to encourage sharing of good practices and to facilitate connection of those with innovative ideas with the goal of developing integrated programs that achieve better outcomes at lower cost. Parallels can be drawn with the state-driven NDIS in Australia providing policy and resources to encourage a central resource website^{vi} for all stakeholders, including providers, to register and align with the overall social and economic reform of the NDIS.

Our findings suggest that the new innovations being introduced into the DSPOs by the external pressures of the NDIS are two-pronged, one set of improvements at the strategic top-down organisation-wide level, and the second, less well-known, smaller-scale practice improvements that occur within organisational pockets. These latter innovations are seldom shared, although they are of equally important value to the organisations if they are systematically scaled-up organisation-wide, to accrue aggregate benefits from effective innovations. The first is a more structured, logic-driven approach and the second, a practical, incremental, often unintegrated and uncoordinated approach which is based on the shared values of organisational members.

Our findings show that some innovations are large-scale, expensive, motivated by exogenous pressures that threaten the survival of the organisation, highly formalised (i.e. centrally governed by project management principles and reporting processes, built into organisational units' business plans, and formally incorporated into workers' daily routines), and driven through the organisation by senior management. These are 'top-down' innovations and they include the introduction of organisation-wide IT systems, and the restructuring of the organisation, both of which are discussed in more detail in the case studies. An example of structural innovation is an IT system called CareLink Plus, which is used by DSPOs to digitise critical information which was previously manually logged. The integrated electronic system means greater efficiencies are accrued through better access and flow of critical information

to and about clients on a reliable platform. CareLink Plus is especially useful given that the workforce is spread across diverse geographical locations and without a central system, crucial information is easily lost in transition.

Our findings highlight that on the ground, DSPOs' responses to the new demands on them are still in flux. The level of chaos and uncertainty experienced within these DSPOs is possibly quite disruptive, particularly at the senior management level. It does seem that, as the pressures of the NDIS loom, the keen level of competition throughout the sector is being felt more strongly, not just in the form of stronger business competition but among staff at higher levels who are seeking career opportunities in the disability market place. Staff turnover at senior management levels suggests that organisations like Case Study B are in the midst of organisational transition and new systems and changing structures which, overall, present difficult challenges to administration.

At the critical client-staff interfaces, the message is quite different, with a typical "business as usual" attitude adopted by support workers. These employees appear to communicate among themselves and resolve issues among themselves as far as possible, because at that ground level, the concern is quite simply getting on with fulfilling whatever the client needs of the day may be. This phenomenon highlights the level of disconnect between higher and lower organisational layers within the organisational hierarchies of DSPOs.

5.4.2. Practitioner-led Unintegrated Practice Innovations

In contrast with the more radical type of innovations discussed above, practice innovation tends to bubble up from the ground. Practice or service-delivery innovation is practitioner-led, endogenous, incremental, and typically, informal. Practice innovation tends to be largely driven by individuals within the organisation who are highly skilled, committed to the disability sector and their clients, and who are connected to domestic and international research networks. Presently, this form of innovation within DSPOs is "*personality-driven*" and "*personality dependent*". In other words, it depends on the innovation orientation of individual

carers at the front line of services, their attitude and competence. We are not referring to the dedicated roles in disability organisations such as Practice Leader (Vista, Ermha, Annecto, Independence Australia).

Our observation: Disability service practice innovation tends to occur within pockets of the organisation, but not across the organisation. This form of innovation is fragmented, and depends upon the intrinsic motivation, work ethic, informal authority, and resilience of the worker endeavouring to innovate.

As a consequence, care practice innovation tends to occur in pockets of the organisation, but not across the organisation; this form of innovation is fragmented and depends upon the intrinsic motivation, work ethic, informal authority, and resilience of the worker endeavouring to innovate. Should this key worker leave the organisation, the continuation of the innovative practice is unlikely. For example, in Case Study A, the innovation with VIG technology (see Case Study A, Participant A2) to assist DSWs to re-evaluate and improve their care skills with clients with multiple disabilities such as deaf-blindness, was championed by a manager who, having a similar disability herself, had shown a committed passion in leading her small team to investigate the options for improving the lives of clients with such disabilities. She indicated that she had even pursued post-doctoral study to gain further insights into this particular area of disability, because she had been unable to find help herself, or found the services on offer severely lacking. She also observed that DSWs rarely have the professional skills to deal with complex disabilities.

This is because disability care consists not only in the activity of assisting clients with day-to-day tasks, but also in the quality of a DSW's interaction with the clients, a factor that affects the mental and emotional wellbeing of clients. High quality interaction helps to shift the often depressed mindset of clients, and can contribute to a more optimistic, hopeful and motivated existence. Providing this high quality interaction requires significant emotional labour and humane skills from the DSW. While most DSWs may be efficient and caring

individuals, they do not necessarily have the subtle social-emotional skills necessary to see how their interactions with their clients are deeply affecting the clients. The VIG innovation was a simple technology employed to allow DSWs to see for themselves where they do well and to utilise that information to achieve improvements in their interactions with clients. However, the risk of such unintegrated innovations is that, if the manager were to leave the organisation, this creative innovation which she had championed is likely to be lost to the organisation.

Another practice innovation concerns the push within Case Study organisation A to reduce or eliminate restrictive practices by seeking the input and advice of highly specialised medical practitioners. One mid-level manager, who firmly opposed the use of restrictive practices to deal with clients who exhibited Behaviours of Concern (BoC) was upset that he was reprimanded for his approach to these issues, which challenged some occupational health and safety (OHS) regulations because, in his opinion, the regulations conflicted with what he felt to be a better method of handling difficult clients. Thus, some committed staff feel unsupported by their management in experimenting with what works on the ground with clients, because there is a strong culture of compliance that had to be adhered to that takes precedence over what may or may not work when dealing with a client. Sometimes, workers may experience situations with a client which conflict with the belief systems of those workers *“who are of most value to the organisation”*, these workers being the *“good quality staff”* who have *“passion”* and *“the right mind-set”* (Participant A9, Coordinator, Family and Community Services) – precisely those staff members who are *“really difficult to find”* (Participant A9) and important for the organisation to retain.

The lack of diffusion and structural integration of innovation within the organisation which results from their origin with crusading individual staff members is referred to by Strang and Meyer ^{vii} relational, rather than structural diffusion of innovation. This means that innovation occurs through force of character and personal networking within the organisation;

it is proximity-dependent and carried through personal interactions between the individual who is endeavouring to diffuse the innovation, and the potential adopters of the innovation.

This phenomenon appears more common as the *ad hoc* approach of relying on single individuals to drive innovation was reflected by others who find creative ways to work around a less than supportive system to trial efforts that were deemed effective for providing clients opportunities for independence and well-being. Hence, Participant A3 (state operations manager) and Participant A4 (HR manager) characterised the process of practice or service delivery administration within Case Study A as expanding via occasional, local, undocumented and informal 'wins' across the organisation "*one step at a time*".

The idea is that a "*tipping point*" will be reached, at which the improved practice, which could be considered as an incremental innovation, will survive and spread throughout the organisation without explicit management effort (Participant A4, HR manager). That is, the innovation will be what Jepperson refers to as 'self-activating'.^{viii} In other words, at such a point the innovation would have become institutionalised.

A curious aspect of this form of innovation is that the logic impelling the change may have substantial cultural support throughout the organisation (e.g. the reduction or elimination of chemical restraints) by appealing to pre-existing, widely-shared, 'proper' ideals of disability support that have acquired legitimacy throughout the sector. By contrast, this may *not* be the case for the more radical, 'top-down' innovations discussed above, which are informed by logics imported from the corporate sector. Rather than being in accord with workers' values and belief systems, these logics sometimes jar with workers' values and belief systems.

5.5. New Models of Administrative and Practice Innovations in Disability Support Services

In this section, we review literature on innovations in disability and other care services around the world, in order to identify models and practices that may be beneficial to DSPOs that

provide services to TAC clients. It should be noted that some of the models found internationally may also exist in a similar form in TAC, but may not be widely adopted in DSPOs.

5.5.1 Integrated Disability Support Service Teams

Disability support service teams, which may be a variant of the TAC's Independence Plan, bring together support workers with specialised skills or workers who may undertake specific tasks. These teams may also integrate specialists with clinical skills. Internationally, much evidence highlights the need for an interdisciplinary and multi-skilled care team in healthcare delivery, with a shift towards programs that expand on the successful in-home medical care models, which are equally relevant to the disability sector and create responsible financing methods that control overall costs while rewarding providers appropriately.

In their 2013 work, Boling et al.^{ix} cite the advanced home-care models of the Program for All-Inclusive Care of the Elderly (PACE) which have been tested and became a defined (US) federal benefit in 1997, and now have now nearly 100 PACE centres nationwide in the USA. Drawing on elderly and palliative care research, Boling and colleagues suggest that in their advanced home-care models, home visits reveal more accurately than office appointments the nature of patient goals, true rehabilitative potential, and family capacity for caregiving. Although home visits take longer than office encounters, they make the provider's job easier. By observing the patient at home, providers can better assess barriers to comfort and devise strategies to improve function. Consequently, the authors argue for broadening the application of portable and information technologies and developing an interdisciplinary workforce, claiming that these approaches lead towards the overall goals of optimal care at minimal cost.

Rowley, Morriss, Currie and Schneider's 2012 study^x in the British context highlights the need for "diffusion fellows" to actively bridge the knowledge gap between research and

clinical practice. This model addresses the barriers to implementation of innovation in healthcare sectors ranging from mental health to stroke rehabilitation. Their approach, founded on the principles of organisational learning theory, recognises that change is a social and political phenomenon, and that barriers to innovation can be overcome if knowledge is co-produced by academic and clinical service staff, taking account of the organisational context in which it is to be applied. These international findings make the case for further collaborations with academic research institutes to co-design solutions for innovation in the disability sphere.

In their 2004 work, Anderson-Butcher and Ashton^{xi} discuss the complexities of serving a child or youth who has a complex family background or socio-economic stressors that can lead to mental health and behaviour of challenge. This US-based research discusses innovative strategies for developing wrap-around services and supports for students with schools, accomplishing this by collaborating with other agencies, stakeholders, and invested parties. The authors explore models of intra-organisational, inter-agency, inter-professional, family-centred, and community collaborations in addressing the co-occurring needs of children, youths, and their families.

These collaborative models provide valid frameworks for support networks. The collaborative model between teachers, school social workers, other school personnel, health and mental health providers, human services agencies, city governments, families, and others discussed in this article indicate that a similar need exists for wrap-around services developed via stakeholder partnerships in the disability sector to better meet the needs of clients towards mutually responsible outcomes. There is also clear evidence that there is no single organisational model or approach that best supports integrated care^{xii}, as shown in the 2014 King's Fund study of seven countries comparing UK, USA, Canada, Sweden, New Zealand, Australia and the Netherlands, which highlights the complexities of providing integrated care of older people with complex needs.

Closer to home, there are various initiatives by healthcare professionals that look into the benefits of team structures such as the Team Structure in Community Model of Care^{xiii} by Monash Health, employing Design and Systems Thinking. These initiatives are aimed to drive innovation in healthcare that are applied to diverse healthcare delivery areas, such as Acute General Medicine, Community Medicine, Chronic Disease Management, Refugee Health and Mental Health Care.

The lessons to be learned from the literature on integrated disability support are as follows. No perfect model exists that can be transplanted wholesale into the disability sector. Instead, the solution lies in incremental innovations, developed for the specific clients located within unique socio-economic, community and cultural structures, all of which play a key role in addressing needs of various client segments located in various geographical areas. For this task, the Social Impact Model, discussed in Section 5.3.1, provides a useful framework for the DSPOs to start to map where they are at with the issues they are currently facing.

Our findings from two in-depth case studies indicate that the DSPOs are making incremental improvements, such as placing a client's individual personal plan on the CareLink Plus system, to record all historical data as well as log future learnings about the client's needs and goals. This innovation is a huge advance on the use of manual logs, which depend on the capacity of DSWs to record accurately and sensibly small, but potentially highly significant events in a client's progress. In the electronic record, this information can be edited and incrementally built and analysed for patterns or themes, to provide more cohesive and comprehensive data on a client, focusing on a client's ability rather than on their disability. The electronic system also allows for continuity of information, and its provision to different parties involved in the integrated care of a client, from DSWs to case managers, funding agents, allied health personnel, clinicians and a range of others. This access to information allows the client and their team to move, united, towards achieving independent living or assistive independent care. The current climate in DSPOs appears to be a cautious movement towards partnerships with research bodies, as illustrated by the current research project, in which most DSPOs

contacted were keen to participate for the sharing of knowledge, but at the same time, quite wary about sharing their trade secrets about what they do well, to protect their competitive edge over other providers in the sector. Indeed, the sentiment is that the weaker players in the system will not survive in the current competitive environment. Both case studies also indicate that there is barely any collaboration between DSPOs, except on the occasion when a client may have several packages with different service providers. In which case there is contact between providers, but this is for reasons of coordination of service, rather than collaboration.

5.5.2 Benefits of Integrated Disability Support Service Teams

Disability support service teams bring together support workers with specialised skills or workers who undertake specific tasks. Such teams may also integrate specialists with clinical skills. In line with the Social Impact framework, in his recent work, Wodarski^{xiv} discusses procedures by defining the problems to be addressed, applying research and studies for support, and presenting an innovative model for cost-effective and integrated managed health care.

Client Benefits:

- Greater continuity of disability support services – turnover of one team member does not disrupt relationships
- Higher quality of disability support services – access to specialists within the team

Workforce Benefits:

- Task specialisation – multiple tasks can be undertaken at the same time
- Variety of work – team members can rotate tasks or deliver preferred tasks
- Informal training and social support among team members

TAC Benefits:

- More effective delivery of clinical and allied health services - improved quality/reduced cost
- More effective delivery of disability support services - reduced cost

5.5.3 Benefits of Disability Support Modules

Modular support services bring together all related activities involved in achieving a specific goal. So a module entitled 'Shopping' would combine activities including, but not limited to preparation for going out, arranging transportation, and organising access to money or credit cards. Modules can also be designed to develop client skills, e.g., a 'Technology' module. This standardisation of a set of activities then enables DSPOs to improve the way in which the modules are delivered to continuously increase efficiency and effectiveness. For instance, research on modular support services in aged care^{xv} shows that an in-depth understanding of the complex and multi-faceted specification in elderly care helps both care and service providers to make well-considered decisions. These decisions include what level of client involvement is required to establish the type of modularity to for optimal customization of support services according to differing client needs. It is worth noting that TAC's Independence Plan and the Care Plan share some similarities with this module.

Others scholars, such as Voss and Hsuan,^{xvi} discuss a service modularity function (SMF), a mathematical model indicating the degree of modularity deriving from unique services and the degree to which the modules can be replicated across a variety of services systemically. They highlight that their SMF enhances three areas of competitiveness for the organisation: i) the possession of unique service modules or elements not easily copied in the short term by competitors; 2) the ability to exploit these through replication across multiple services and/or multiple sites; and 3) the presence of a degree of modularity, which in turn supports both customization and rapid new product development. In the mental health sphere^{xvii} the modularity concept has been successfully applied at the Centre for Psychosis in

the Netherlands, where the majority of the residential care can be disaggregated into modules, and grouped into service bundles and sub-bundles.

Client Benefits:

- Greater client choice of modules
- Integration of specialist support in modules – e.g. dealing with challenging behaviours
- Modules can be adapted to reflect changing client needs during recovery and rehabilitation

Workforce Benefits:

- Variety of work – deliver different modules
- Specialisation in tasks – improved training
- Disability support workers can continuously improve delivery

TAC Benefits:

- More flexible delivery of services - quickly adapt to changing client needs/goals
- Improvements in service quality and client satisfaction
- Continuous improvement - reduced cost

5.5.4 Benefits of Case Managers/Case Coordinators

Case Managers/Coordinators tailor the delivery of disability support services to client needs. They are the interface between the client and the DSPOs. They may also deliver a higher quality of services. It is reported by TAC key personnel that Case Coordination, known as 'Support Coordination' in TAC and the NDIA, is already utilised in many DSPOs.

Client Benefits:

- Greater customisation of service delivery to client needs
- Improved client advocacy

Workforce Benefits:

- Case Managers/Coordinators have greater responsibilities - require specialised skills and training
- Restructuring of work roles within CPOs

TAC Benefits:

- Single point of contact at CPO regarding client - better information flow
- Improvements in client satisfaction
- Greater professional oversight of service delivery

5.5.5. Disability Support Services Brokerage

With the introduction of the NDIS and the shift of power towards clients to make their own service decisions, support service brokerage may be needed more than ever in the Australian context, as our study indicates. Brokers can bundle up specialised support services on behalf of clients. They source providers that can best meet client needs. It is reported by TAC key personnel that Disability Brokerage is already adopted within the Australian disability sector.

Client Benefits:

- Higher quality of disability support services – use the best provider or mix of providers

Workforce Benefits:

- Variety of work – deliver different services
- Specialisation in tasks – improved training

TAC Benefits:

- Improvements in client satisfaction
- Improvements in quality of support services

6. Use of the Research

In this section, instead of prescribing a set of advice on how our research may be used by the TAC and other stakeholders in the disability service sector, we summarise our key findings and highlight strategic, policy and practical implications relevant to the TAC and other stakeholders.

6.1. Characteristics of Innovations in DSPOs

In summary, we found that innovations on the ground contain a number of characteristics. Many innovations on the ground are small and incremental, but have the potential make significant changes. Lack of dissemination of these innovations is the main obstacle to their wider effectiveness. Examples of innovations that we found include teaching people with limited vision to use an iPad for communication, and providing video feedback to carers to improve their interactions with clients.

In addition, we found the following forms of HRM innovations:

- Innovations in workforce recruitment (e.g. Induction Day as a recruitment screening);
- Employee training (e.g. training in small groups more often, instead of bulk training for bulk recruitment); and
- Work organization (e.g. team-based work in residential houses leading to the development of a Team Leader work role).

The lack of dissemination of innovation could be addressed through mechanisms such as best practice promotional activities, recognition awards, small grants for innovative demonstration projects, or the brokering of network improvement activities that DSPOs could participate in voluntarily. Through these means, the relatively small and incremental innovations found at the larger and better performing DSPOs in the Australian disability service sector could be promoted to other (smaller) organisations and a culture of innovation and improvement developed in the sector.

6.2. Workforce Issues

Our research identified a number of human resource management/workforce issues, as indicated below:

1. There is a considerable skill gap between what may be needed to provide high quality services to the client and the skills that are available in DSPOs and their workforces.
2. Specialised skill gaps are evident in some areas (e.g. AUSLAN), whilst emerging skill needs are not being addressed (e.g. behaviour of concern training is seen as highly beneficial to the workforce but quality provision is lacking)
3. While DSPOs recognise that a higher wage level will be needed in the future in exchange for greater responsibility and better service quality from the workforce, the current pricing system precludes such a consideration.
4. Relatedly, while both the workforce and employers seek skill upgrading, such a desire is severely constrained by cost concerns.
5. The DSPOs we have come into contact with have reported a high level of turnover at the senior leadership level. The frequent change of senior leadership undermines morale and disengages the workforce. Change fatigue is evident amongst the workforce as consecutive new leadership teams develop new initiatives and abandon those of their predecessors.
6. Workforce disengagement is reflected in a “business as usual” sentiment amongst carers who focus exclusively upon the day-to-day relationship with their clients.

The above findings point to the need for the TAC to consider the trade-off between cost and quality when subcontracting disability services to DSPOs. While efficiency gains can be achieved through more effective management of DSPOs, the tight budget of service procurement does not allow much room for further efficiency gain without squeezing the resources required for workforce development.

6.3. Organisational and Sectoral Implications

We highlight a number of organisational and sectoral implications of our findings:

1. Service providers are experiencing a significant amount of organisational change and upheaval in anticipation of the stage-by-stage roll-out of the NDIS in Victoria.
2. Several keen or would-be participants pulled out of this research due to internal organisational re-structuring priorities, highlighting the state of flux in the sector.
3. Service providers appear to be grappling with new roles, relationships and distributions of resources as exogenous factors (NDIS policy implications) bear down.
4. Restructuring, characterised by institutional changes and rapid and frequent movement of senior level staff into new roles - or toward redundancy - is observed by direct employees with cynical interest or complete apathy. This undermines prospects for innovation and improvement in the sector.
5. Administrative innovations are focused on the back-of-house, such as the introduction of integrated operational software/hardware to move to “paperless” operations, but even this relatively standard protocol appears fairly rudimentary and new to the sector.
6. Managers’ competence and experience/knowledge gained elsewhere in other care sectors is important for their leadership and innovation in a new DSPO, but is undermined by change fatigue amongst front-line workers.
7. Many DSPOs are seeking to expand and go national in order to be bigger and gain economies of scale, but this is preventing them from focussing upon innovation in service delivery models.

In short, sectoral restructuring appears inevitable to DSPOs because of the introduction of NDIS, but their response thus far has been to focus upon developing the scale of their operations rather than innovating in service delivery. Key institutions in the sector are focused upon the extent of supply with little attention paid to quality issues or innovation in service models that could deliver cost and quality improvements.

6.4. Strategic and Practical Implications for the TAC

Our study has a number of strategic and operational implications for TAC:

1. The TAC could, as many large business organizations do, actively shape the quality of supply in the disability sector through promotional activities and support for targeted improvement programs.
2. The TAC could be more pro-active in shaping providers' business models to avoid quality failure leading to market failure in the future.
3. The TAC could give more guidance/feedback on the quality-of-care that it expects and this may involve consideration of price signals.
4. The TAC should monitor DSPO movement into new areas of services, to ensure that the goals of the TAC are still being met.
5. The TAC should continue to monitor the response of DSPOs to the NDIS to stay on top of care quality and supply issues.

7. Potential Impact of the Research

1. The TAC can more actively shape the emerging market for the provision of disability support services. This should be done to avoid quality of care and supply issues in the future, lest the current turbulence lead to widespread failure or poor performance of DSPOs.
2. The activities required to do this are simple and relatively inexpensive but have a long-term positive impact to lead the sector forward. DSPOs are looking to bodies such as the TAC for guidance in their change activities and would be receptive to promotional activities, small grant programs for innovative demonstration projects or the brokering of network improvement activities by the TAC.

3. The TAC may need to more actively assist selected DSPOs to meet their quality and service standards, i.e. develop preferred provider organizations.
4. The TAC needs to stay abreast of workforce development issues in the sector as these are another potential source of quality failure leading to market failure.

Notes

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