



Community Options case-management and brokerage model - evidence of success, system benefits and policy options



Contacts

For more information, please contact:

Brian Corley

Chief Executive Officer

Brian.Corley@communityoptions.com.au

Brendan Taber

Deputy Chief Executive Officer

Brendan.Taber@communityoptions.com.au

Natalie Wilkins

Executive Manager – Corporate Services

Natalie.Wilkins@communityoptions.com.au

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Acknowledgement of Country

Community Options respectfully acknowledges the Ngunnawal and Ngambri peoples as the Traditional Custodians of the land on which our organisation stands. We pay our respects to their Elders past, present and emerging, and recognise their continuing connection to land, waters, and community. We also acknowledge and honour the contributions of all Aboriginal and Torres Strait Islander peoples to the life and culture of this nation.

Executive Summary

Community Options is a not-for-profit organisation with over 30 years' experience supporting older Australians, people with disabilities, and those with complex health and social needs to live safely and with dignity at home. Our model combines intensive case management with flexible brokerage, enabling rapid, tailored responses that prevent unnecessary hospitalisation and reduce system costs.

Independent evaluations and client feedback confirm the model's success: high satisfaction, improved wellbeing, and strong engagement with culturally diverse and high-risk cohorts. Case studies show how we deliver timely, person-centred solutions that sustain independence and avoid crisis.

However, the Aged Care Act (Nov 2024) and Support at Home reforms threaten the viability of this model. Funding caps, removal of package management income, and increased compliance obligations create an estimated \$1.2M annual gap risking the integrator role that turns funding into real outcomes for complex clients.

We urge the Senate to recommend targeted policy adjustments:

1. Fund case management for complex clients.
2. Retain flexible brokerage for timely, tailored care.
3. Introduce complexity loadings and rapid micro-packages.
4. Embed transitional and palliative care streams.

These measures will ensure reforms deliver on their promise of quality, sustainability, and equity keeping older Australians at home, by choice, for as long as possible.

About Community Options

Guided by our vision for all people to live good and full lives as valued members of their community, we work to maintain relationships, roles, and connections that enhance opportunities for people to enjoy life.

Our mission is to provide excellence in case management and support services that enable individuals to achieve greater independence and continue living quality lives in their own homes and communities. We do this through a model built on intensive case management, flexible brokerage, and a wellness and reablement approach. This model ensures timely, tailored responses that respect individual choices, promote dignity, and deliver meaningful outcomes.

Our work is underpinned by our core values:

- Commitment – delivering high-quality support that respects choice and promotes self-determination.
- Integrity – acting with honesty, transparency, and accountability in all we do.
- Respect – valuing diversity and treating every person with dignity.
- Collaboration – working in partnership with clients, families, and providers to achieve the best outcomes.
- Innovation – embracing new ideas and approaches to improve services and respond to changing needs.

Values

- Commitment
- Integrity
- Respect
- Collaboration
- Innovation



Vision  **Community Options**

All people living good and full lives as valued members of their community

- Enable people to live safely and with dignity at home and in the community
- Translate funding into outcomes through rapid, tailored services
- Reduce pressure on hospitals and residential care

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Through these principles, Community Options has consistently delivered proven outcomes: helping thousands of people to remain at home, avoid unnecessary hospitalisation, and receive care aligned with their preferences. Our approach reduces pressure on hospitals and aged care systems, aligns with the Royal Commission’s recommendations for person-centred care, and ensures that those we serve can live safely, with dignity, and by choice.

Brokerage as a Component of a Flexible Responsive Service System

The potential of brokerage in the aged care system to address a range of service access and response issues has been undervalued. Brokerage, if done effectively can;

- Increase clients' choice and control over their services
- Provide flexible support to people with complex support needs
- Provide targeted support to clients who cannot access traditional aged care service providers
- Provide a quick response service in emergency situations
- Develop highly personalised support arrangements, accessing services from a range of providers, where this is in the interest of the client or the aged care system in general

Brokerage has recently been associated with labour hire and outsourcing practices of some providers as a mechanism of reducing their costs.

In reality, community-based service brokerage supported by skilled case managers, as seen in the Community Options service model should be seen as filling an important role in a complex and dynamic service system.

Evidence of Success

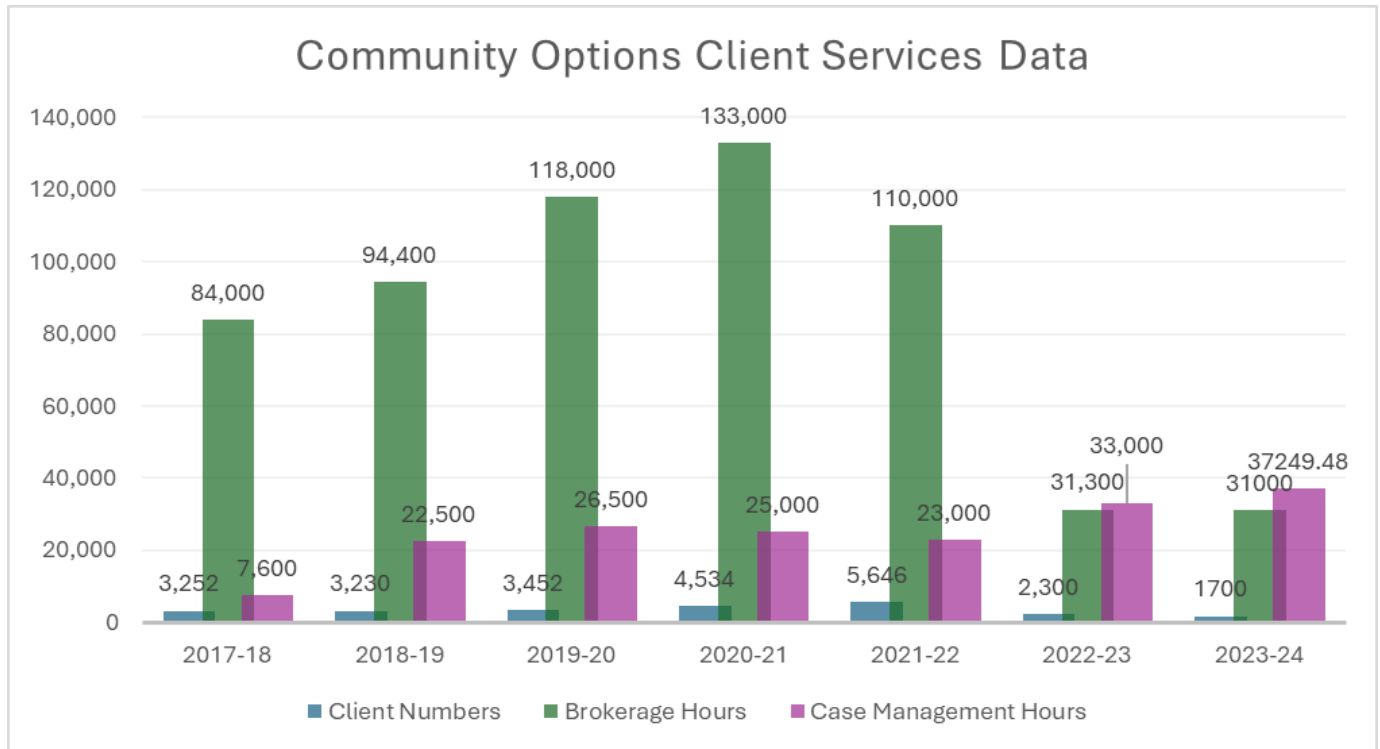
Community Options' service model has been rigorously evaluated across diverse programs, including aged care, hospital-to-home transitions, palliative care, and targeted maternal and newborn support.

Independent evaluations and government submissions consistently highlight the following:

- **Client outcomes:** Programs have demonstrated measurable improvements in health, wellbeing, and social connectedness, particularly among vulnerable populations.
- **Data-driven impact:** Quantitative and qualitative data collected across service streams confirm high levels of client satisfaction, reduced hospital readmissions, and improved continuity of care.
- **Cultural responsiveness:** Evaluations show strong engagement with Culturally and Linguistically Diverse (CALD) communities and individuals with complex needs, reflecting the model's adaptability and inclusivity.
- **System integration:** The model supports seamless transitions between health and community services, backed by evidence of effective collaboration with hospitals, primary care, and specialist providers.

The data highlights the model's success in delivering more targeted, high-value support to the community. While overall client numbers have reduced from their 2021–22 peak, the proportion of clients receiving intensive, case-managed assistance has grown substantially. Case management hours have increased nearly fivefold since 2017–18, enabling deeper engagement, tailored care planning, and improved outcomes for those with complex needs. This shift reflects a deliberate strategy to prioritise quality and impact over volume, ensuring resources are directed where they

achieve the greatest benefit. The model’s adaptability and focus on high-intensity support demonstrate its effectiveness in meeting evolving community needs and funder expectations.



Client Experience with Community Options: What the Data Tells Us

The chart below presents aggregated data from over 200 client responses to Community Options’ satisfaction survey. It reflects the organisation’s consistent delivery of high-quality, person-centred care across aged care and transitional support programs. The model’s success is evident in the overwhelmingly positive ratings for overall experience, service coordination, and responsiveness with the majority of clients reporting they were very satisfied.

This feedback is not just statistical it’s deeply personal. Clients described Community Options as a lifeline during vulnerable moments, praising the professionalism, empathy, and reliability of both case managers, coordinators and support workers.

Some excerpts of feedback we have received:

- *“I never expected that I would get all the help that I needed. I feel far more confident now... I was really spoiled by everything.”*
- *“The whole of these services has been exceptionally good. We were very grateful for the personal, sensitive and kind responses of both workers who came at a much-needed time.”*
- *“The support workers are efficient and supportive in a cheerful and timely manner.”*

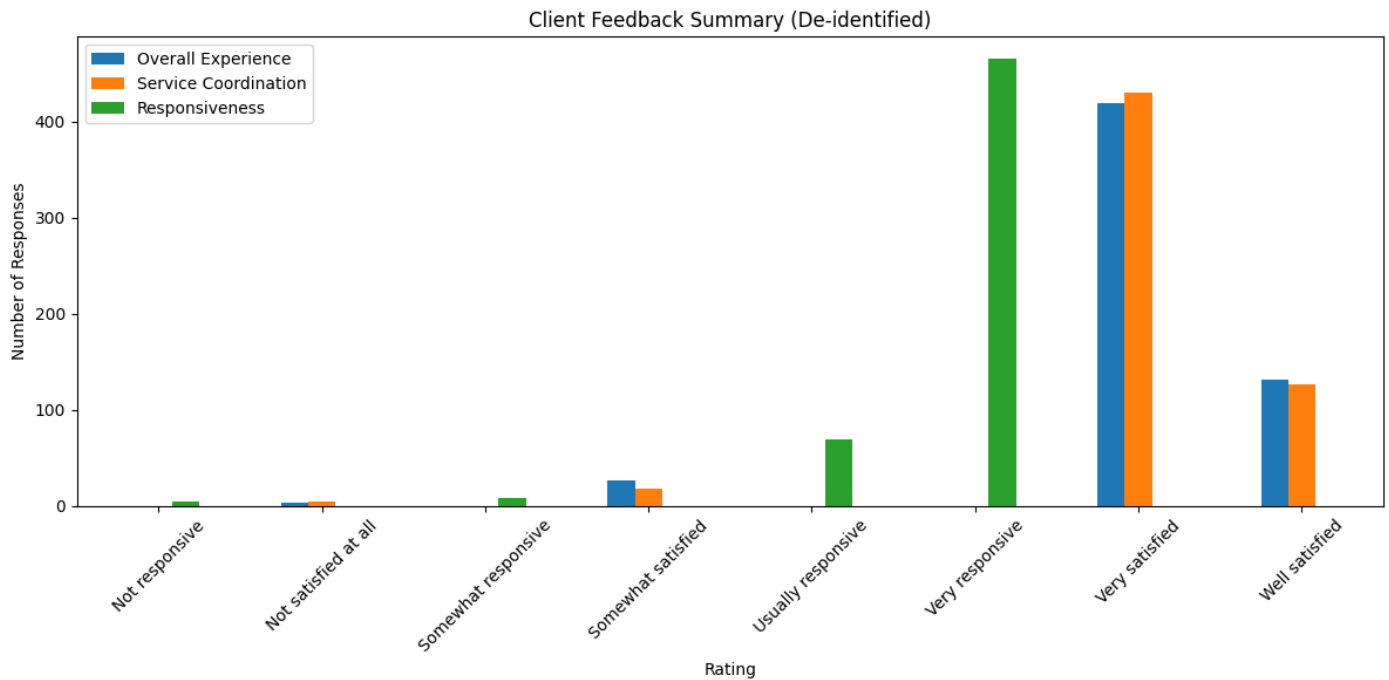
The model also demonstrates agility and responsiveness, with services often mobilised within hours of referral. Clients noted that coordinators were accessible, proactive, and solution-focused a critical factor in maintaining independence and dignity at home.

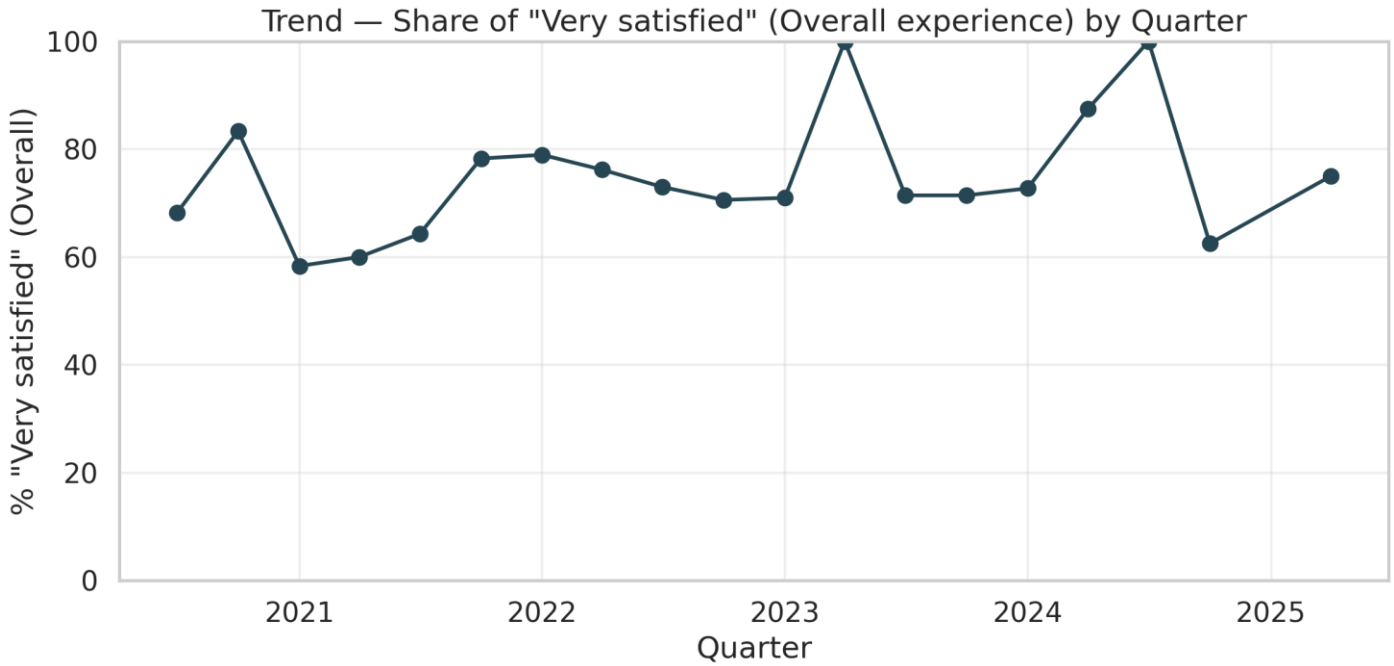
However, the feedback also highlights areas for system-wide improvement, particularly in workforce consistency and communication:

- *“Some jobs were not cleaned properly... It’s good to see they follow up their staff performance.”*
- *“A support worker who is able to communicate with the client and arrives on time... Let them know the client is entitled to the full allocated time.”*
- *“I understand that not all the specs I wanted to have could be supplied by your limited choice.”*

These insights reinforce the value of the Community Options model as a trusted intermediary between clients, families, and service providers one that not only delivers care but advocates for quality, continuity, and cultural safety.

As aged care reforms continue, this data provides compelling evidence that locally embedded, relationship-based models like Community Options are essential to achieving the goals of the Aged Care Quality Standards and supporting older Australians to live and die well in their communities.





Real Stories Behind the Numbers

Case Study 1

At 90 years old, Mrs J faced the challenges of aging with dignity. Living with poor eyesight, incontinence, and limited mobility, she relied on a wheelie walker or manual wheelchair to move around. Originally from India, Mrs J and her family identified as coming from a Culturally and Linguistically Diverse (CALD) background, a factor that shaped their values and preferences around care.

Mrs J's two sons, Mr SJ (62) and Mr BJ (60), both worked full-time and had families of their own. Despite their busy lives, they shared the responsibility of caring for their mother, with Mrs J alternating between their homes. While this arrangement reflected deep familial commitment, it also placed increasing strain on the family. Mr SJ, the primary carer and main point of contact with services, reached out to Community Options in November 2013, seeking support.

The family was at a crossroads. They were determined to keep Mrs J at home and avoid residential aged care, but the emotional and physical toll of caregiving was becoming unsustainable. They also lacked knowledge of available in-home support services.

This is where the Community Options model made a critical difference.

Through the Flexible Respite for Carers Program (FRP), Community Options responded swiftly. A short-term in-home respite service was arranged to provide immediate relief. This included daily personal care (showering), dressing, and toileting giving the family much-needed breathing space.

But Community Options didn't stop at short-term fixes. Our holistic, culturally sensitive case management approach ensured that Mrs J and her family were supported in planning for the future.

The FRP Coordinator facilitated:

- A referral to the Continence Clinic and access to the Continence Aids Payment Scheme (CAPS) to manage incontinence.
- A referral to the Falls Assessment Clinic to reduce fall risks.
- Connection to the Red Cross Emergency Home Alarm Service to enhance safety at home.

Recognising the family's long-term goal of keeping Mrs J at home, Community Options guided them through the process of accessing a Level 4 Home Care Package. With support from the Coordinator, Mrs J was assessed by the Aged Care Assessment Team (ACAT) and successfully transitioned to a sustainable, high-level care package by December 2013.

Case Study 2

Mrs A, an 81-year-old Khmer-speaking woman, was referred to Community Options following discharge from The Canberra Hospital. She had recently been diagnosed with cancer and multiple cerebral metastases, alongside existing conditions including rheumatoid arthritis and lymphedema. Her family, already caring for her elderly husband, was overwhelmed.

Community Options provided immediate short-term in-home support and intensive case management. The team navigated language barriers by working through her daughter, coordinated referrals to My Aged Care, and advocated for long-term support. As Mrs A's condition deteriorated, services were scaled up to daily visits, including personal care and domestic assistance.

Case management was critical in liaising with Clare Holland House for palliative care, arranging equipment, and supporting the family emotionally and practically. The daughter reported that without Community Options, they would not have coped. The grab rail installed in the bathroom, coordinated by Community Options, significantly improved Mrs A's mobility and safety.

This case demonstrates how Community Options' culturally responsive, flexible model and skilled case management enabled Mrs A to remain at home with dignity, while reducing carer stress and preventing hospital readmissions.

Case Study 3

Mr A is a 65-year-old man living with epilepsy, chronic back pain, Hepatitis C, and substance abuse issues. He resides in public housing and receives the Disability Support Pension. With no active family support (his wife and daughters are estranged) and only the Public Advocate of the ACT listed as his emergency contact, Mr A lives in isolation. His relationships with the few people around him are often exploitative or abusive, adding to his vulnerability.

When Mr A was referred to Community Options, he was in a precarious state. He had little insight into his health conditions, was non-compliant with medication, and frequently missed medical appointments. He was prone to falls and had been found unconscious, bleeding, and covered in faeces and urine in his home. His substance abuse contributed to incontinence and erratic behaviour, including refusing medical help even in emergencies.

Community Options stepped in with a comprehensive and compassionate case management approach. Recognising the complexity of Mr A's situation, the team developed a detailed emergency plan, shared with support staff, his guardian, and relevant agencies. In one critical instance, Community Options coordinated with the Australian Federal Police and Mr A's guardian to arrange an involuntary hospitalisation, ensuring he received urgent medical care.

Beyond crisis response, Community Options provided consistent, structured support. They offered transport and accompaniment to medical appointments, knowing Mr A needed encouragement and supervision to attend. They arranged personal care, domestic assistance, shopping, and meal preparation tasks Mr A often resisted but desperately needed. Support workers were carefully selected for their experience and sensitivity, respecting Mr A's lifestyle while maintaining his dignity.

Housing stability was another major concern. Mr A's tenancy was at risk due to the condition of his accommodation. Community Options advocated on his behalf with Housing ACT, successfully negotiating for the replacement of carpets that had been soiled with blood and faeces. Their ongoing liaison helped preserve his housing and prevent eviction.

Throughout this journey, the Community Options model proved essential. It wasn't just about delivering services, it was about building trust, responding rapidly to unpredictable crises, and navigating complex systems on behalf of a vulnerable individual. The case manager's ability to establish rapport with Mr A was key to sustaining support and improving his safety and independence.

Mr A's story is a powerful example of how Community Options provides more than care. Community Options offers stability, advocacy, and a lifeline to those who might otherwise fall through the cracks. Our model of intensive, person-centred case management made it possible for Mr A to remain in the community with a degree of safety and dignity, despite the many challenges he faced.

Case Study 4

Mrs C, a 78-year-old woman, was referred to Community Options in July 2016 for domestic assistance under the Commonwealth Home Support Program (CHSP). At the time, she lived with her husband, Mr C, in their family home. Mrs C had been diagnosed with dementia and epilepsy and was awaiting hip replacement surgery. She also exhibited paranoid, violent, and compulsive hoarding behaviours. Mr C, her husband, was living with Parkinson's disease.

Both Mr and Mrs C were deeply distrustful of medical and community support services. They feared that any formal involvement might lead to forced entry into residential care. Despite these concerns,

Community Options began providing domestic support and attempted to introduce social support to ease their isolation and build trust.

Following her initial referral, Mrs C was assessed by the Aged Care Assessment Team (ACAT) in November 2016 and approved for a Level 3–4 Home Care Package, residential respite, and permanent residential care due to her high care needs. However, despite this approval, no Home Care Package was offered until September 2018—two years later.

During this time, Community Options continued to support Mrs C under CHSP, but the program did not include funded case management services and had limitations of care services. This gap became increasingly problematic. Mrs C stopped taking her medication, and her daughter discovered over twenty-six untouched Webster packs in the home. She also began refusing food and lost a significant amount of weight. Meanwhile, Mr C's condition deteriorated rapidly, and he was eventually hospitalised and admitted to residential care, where he later passed away.

After Mr C's admission, Mrs C became fearful of being alone and began wandering outside. Community Options, recognising the escalating risks, contacted her GP to request a referral to the ACT Health RADAR Team a multidisciplinary team designed to respond to deteriorating and at-risk older adults. Unfortunately, the referral was never organised. Mrs C's health continued to decline; she contracted pneumonia, was hospitalised, and suffered a fall that resulted in a broken hip and femur. Following this, she entered residential care.

In residential care, Mrs C began taking her medication regularly, and her dementia symptoms improved. She was eventually moved from a dementia-specific unit to a mainstream unit, and her violent behaviours decreased.

Mrs C's story is a clear example of how the Community Options model can provide vital support—but also how systemic limitations can undermine its effectiveness. For more than two years, Mrs C was supported under CHSP, which did not offer the funding for the case management she clearly needed. The delay in accessing a Home Care Package meant that by the time it was offered, it was too late to prevent her entry into residential care.

Community Options played a critical role in maintaining Mrs C's safety and wellbeing for as long as possible, offering consistent support and advocating for additional services. However, without access to appropriately funded case management and timely transitions to higher levels of care, the system failed to meet the complexity of her needs. Her story underscores the importance of integrated, responsive care models—like Community Options—being properly resourced and empowered to act early, especially for clients with high and evolving needs.

Why the Community Options Model Works: The Central Role of Case Management

The success of the Community Options model lies in its ability to respond to complexity not just with services, but with skilled case management. At the heart of this model is case management, which enables trust, safety, sustainability, and meaningful outcomes for clients with high needs.

Complexity Requires Coordination

Clients referred to Community Options particularly those with complex social needs such as mental health, substance use, squalor and hoarding often present with multiple, intersecting challenges: medical, social, cultural, and emotional. In these cohorts, case management accounts for most of the service effort. For example, in our palliative care pilot, 62% of total hours delivered were case management, not direct care tasks.

This reflects the reality that achieving safe and sustainable outcomes depends on:

- **Planning:** Assessing needs holistically and anticipating risks.
- **Navigation:** Guiding clients through fragmented systems (e.g., My Aged Care, health services).
- **Brokerage:** Sourcing and coordinating appropriate services quickly less than 12 hours.
- **Review:** Monitoring progress and adjusting supports as needs evolve.

Without this scaffolding, task-based service delivery alone is insufficient, especially for clients with complex or changing conditions.

Preventing Avoidable Hospitalisation

Community Options consistently prevents what clinicians call “social admissions”, hospital stays driven not by medical need, but by the absence of safe support at home. Referrers and families report that rapid, brokered in-home support, often arranged within hours, is the difference between coping at home and unnecessary hospitalisation.

This model also enables earlier discharge, reducing length of stay and freeing up hospital capacity. By ensuring supports are in place before discharge, Community Options helps clients return home safely and recover in familiar surroundings.

Respecting People’s Preferences

Most Australians prefer to receive care at home. The Community Options model makes this possible not by replacing clinical care, but by building the practical infrastructure around it. This includes personal care, domestic support, equipment coordination, and emotional support for families.

The result is documented improvements in:

- **Quality of life** for clients.
- **Reduced distress** and burnout for carers.
- **Preservation of dignity** in care needs.

Our 2018 submission to the Royal Commission collated peer-reviewed evidence showing that home-based palliative care leads to better symptom control and lower costs compared to inpatient settings. Community Options operationalises this evidence in practice.

Implications of current reforms

Our detailed analysis of the Aged Care Act (Nov 2024) and Support at Home implementation indicates the following material impacts on the Community Options model:

- **Revenue removal & capping:** Package Management income ceases (~\$65k/month currently) and Care Management is capped at 10% of package value regardless of complexity—this is incompatible with the high coordination load in complex cohorts.
- **Compliance shift to providers:** Introduction of “Associated Provider” concept makes the registered provider responsible for the compliance of subcontracted services (our 160+ brokered providers), requiring new internal audit capacity and increasing risk exposure.
- **Participant contributions & cash-flow risk:** Mandatory co-payments per service, provider responsibility for invoicing/collection, higher bad-debt provisions, and potential cash-flow lags.
- **Net viability effect:** Modelled expense increase ~\$440k p.a. with income reduction ~\$750k p.a., before price-cap granularity—rendering a pure brokerage model unsustainable without policy adjustments. We assessed alternatives (direct-employment, private-pay service line) and found significant risk and mission drift with no guaranteed sustainability against large national providers. These impacts risk removing precisely the integrator function that Commonwealth and Territory systems depend on to turn funding into outcomes for complex cohorts.

Risk-Impact Matrix: Community Options Model under Aged Care Reforms

Impact	Low			
	Med		Cash-flow risk from Co-payments	
	High		Compliance Burden (Associated provider rules)	Funding caps and income removal. Loss of intergrator function
		Low	Med	High
		Likelihood		

Recommendations to Government

- **Funded Case Management for Complex Clients:** Reinstate and fund the traditional Community Options model to support high-risk clients with complex needs. This includes dedicated case management funding to coordinate care, navigate systems, and ensure continuity during critical transition periods.
- **Rapid, Flexible Micro-Packages:** Fund short-term, responsive supports to bridge gaps while clients await longer-term services.
- **Expand Care Finder Services:** Extend funding to include initial service delivery for high-risk clients, not just navigation.
- **Introduce complexity loadings** to reflect the true cost of supporting clients with multifaceted needs.
- **Enable quality-assured brokerage** so providers can confidently accept non-standard cases and tailor supports.
- **Provide one-off discharge bundles** to reduce avoidable hospital days and support safe, timely transitions home.

- Pair predictable package releases with provider readiness funding.
- Set a 14-day service start goal to ensure timely access to care.
- Co-design usability and interoperability standards with providers.
- Ensure vendor accountability and offer shared back-office supports for smaller providers to reduce administrative burden.

Sustain Diversity

- Commission with a focus on retaining community-led providers.
- Measure relationship-based outcomes to reflect the value of trust, cultural safety, and continuity.

Single Assessment System with Nuance

- Implement hybrid assessments that combine clinical and social perspectives.
- Create transparent escalation pathways and warm handovers to community supports.

Conclusion

The Community Options model demonstrates that effective aged care is not just about funding services it is about translating that funding into real outcomes for people with complex needs. By providing the critical “in-between” functions assessment, navigation, brokerage, monitoring, and rapid problem-solving we ensure that older Australians can live safely and with dignity in their own homes.

Our evidence shows that this approach delivers measurable benefits: improved client experience, alignment with personal preferences, and significant health-system efficiencies through avoided hospital admissions and faster discharges. These outcomes are not theoretical they are proven through decades of practice and independent evaluation.

As the aged care landscape undergoes major reform, the risk is clear: without deliberate policy adjustments, the integrator role that makes these outcomes possible will disappear just as complexity increases.

The solutions we propose are practical, evidence-based, and proportionate:

- Fund case management properly for clients with high and evolving needs.
- Retain flexible brokerage to enable timely, tailored responses.
- Support the transition to new models without losing local expertise.
- Embed proven transitional and palliative care streams to prevent gaps in care.

With these adjustments, the Support at Home program can achieve its promise delivering quality, sustainability, and equity, and ensuring that older Australians remain at home, by choice, for as long as possible.