Care finder policy guidance

Contents

1   Introduction

Primary Health Networks (PHNs) will establish and maintain a network of care finders to provide specialist and intensive assistance to help people within the care finder target population to understand and access aged care and connect with other relevant supports in the community. PHNs will:

- commission care finder services based on local needs in relation to care finder support

- support a transition of the Assistance with Care and Housing (ACH) program (with the exception of hoarding and squalor services) to the care finder program

- develop, implement and maintain processes to meet data collection and reporting requirements

- support the integration of the care finder network into the local aged care system

- support continuous improvement of the care finder program

- identify and address opportunities to enhance integration between the health, aged care and other systems at the local level.

2   Context

The aged care system is complex and some people find it more difficult than others to navigate and access the services they need.

While My Aged Care is the single entry point for people to find out about and access aged care services, there have been long-standing calls for more localised and face-to-face support to help people to navigate and access aged care.

The Legislated Review of Aged Care 2017 (Legislated Review) identified that a common recommendation from stakeholders was to provide a face-to-face presence in the community for people who require extra support to access My Aged Care and the aged care system generally.

In response to recommendations made in the Legislated Review, the aged care system navigator trials were announced in the 2018-19 Budget. The trials have been testing different ways of helping people to understand and engage with the aged care system. Findings from the trials will inform design of the care finder program.

The Royal Commission into Aged Care Quality and Safety (Royal Commission) heard throughout its inquiry that aged care needs to have a much greater face-to-face presence. It recommended a workforce of care finders be funded to provide face-to-face support to help people navigate and access aged care.

The care finder program was announced in the 2021-22 Budget as part of the *Connecting Senior Australians to Aged Care Services* measure and will be delivered through PHNs. Care finders will:

- provide specialist and intensive assistance to help people to understand and access aged care and connect with other relevant supports in the community

- specifically target people who have one or more reasons for requiring intensive support to interact with My Aged Care (either through the website, contact centre or face-to-face in Services Australia service centres), access aged care services and/or access other relevant supports in the community.

Further information about access and navigation supports is at **Appendix A**. Information about how care finders will complement existing supports is at *section 9.5* of this guidance.

The care finder program forms part of a significant investment in aged care reform in response to the recommendations of the Royal Commission and is one of the first aged care programs to be delivered through PHNs. This document therefore includes a sufficient level of detail and clarity to enable PHNs to deliver a nationally consistent program, operating within a complex and rapidly changing system and which is expected to receive a high degree of scrutiny.

3   Care finder program objectives and outcomes

3.1   What are the objectives of the care finder program?

The objectives of the care finder program, as relevant to the activities being undertaken by PHNs, are to:

- establish and maintain a national care finder network that:
  - o   provides specialist and intensive assistance to help people in the care finder target population to understand and access aged care and connect with other relevant supports in the community
  - o   addresses the specific local needs of their region in relation to care finder support
  - o   includes a transition of the ACH program (with the exception of hoarding and squalor services) to the care finder program
  - o   is supported to build their knowledge and skills
  - o   is an integrated part of the local aged care system
  - o   collects data and information to support an evaluation of the care finder program
- support and promote continuous improvement of the care finder program
- support improved integration between the health, aged care and other systems at the local level within the context of the care finder program.

3.2   What are the intended outcomes of the care finder program?

The intended outcomes of the care finder program, as relevant to the activities being undertaken by PHNs, are to:

- improve outcomes for people in the care finder target population, including:
  - o   improved coordination of support when seeking to access aged care
  - o   improved understanding of aged care services and how to access them
  - o   improved openness to engage with the aged care system
  - o   increased care finder workforce capability to meet client needs
  - o   increased rates of access to aged care services and connections with other relevant supports
  - o   increased rates of staying connected to the services they need post service commencement
- improve integration between the health, aged care and other systems at the local level within the context of the care finder program.

4   Care finder target population

4.1   Who is care finders targeted at?

Care finders will complement, and should not duplicate, the My Aged Care channels that provide access support to people who are able to proactively navigate the system for themselves. Care finders will therefore specifically target senior Australians who need intensive support who could otherwise fall through the cracks. This will include people who are not yet receiving aged care services, as well as those who are.

The care finder target population is people who are eligible for aged care services and have one or more reasons for requiring intensive support to:

- interact with My Aged Care (either through the website, contact centre or face-to-face in Services Australia service centres) and access aged care services and/or

- access other relevant supports in the community.

Reasons for requiring intensive support may include:

- isolation or no support person (e.g. carer, family or representative) who they are comfortable to act on their behalf and/or who is willing and able to support them to access aged care services via My Aged Care

- communication barriers, including limited literacy skills

- difficulty processing information to make decisions

- resistance to engage with aged care for any reason and their safety is at immediate risk or they may end up in a crisis situation within (approximately) the next year

- past experiences that mean they are hesitant to engage with aged care, institutions or government.

While it is envisaged that care finders will mainly work directly with the person who needs to access services, they may also (where appropriate and with the person's consent) work with the person's carer(s), family and/or representative(s) (providing they also need intensive support to interact with My Aged Care, access aged care services and/or access other relevant supports in the community) to help the person to access the services they need.

Care finders (or, where relevant, the care finder organisation's intake point) will be responsible for determining whether a person is within the care finder target population (further information about intake approaches is at *sections 9.2* and *9.3* of this guidance). 'Eligibility criteria' will not be developed, as a one-size-fits-all approach does not allow for the flexibility and discretion that may be needed to ensure that care finder support is available for those who need it.

There is likely to be a significant cross-over between people who are within the target population for care finders and the special needs groups under the *Aged Care Act 1997*. However, not everyone from a special needs group will be supported by a care finder and not everyone who is supported by a care finder will be from one of the special needs groups.

Examples of people who would be within the care finder target population

- a person who is uncomfortable engaging with government due to past discrimination and/or trauma (e.g. due to being homeless or identifying as LGBTIQ+, a Forgotten Australian or a care leaver) and whose partner feels the same way about accessing help

- a person who is socially isolated and at significant risk of a fall who is not engaging with aged care because they are in denial about needing assistance and is refusing help from their family to call My Aged Care to find out more about aged care and set up an assessment

- a person who does not speak English and is being cared for by a family member who speaks English but does not feel confident to call My Aged Care to find out more about aged care and set up an assessment

- a person with cognitive impairment and no family or close friends who live nearby to help them through the screening and assessment process

- a person who is homeless or at risk of homelessness and has no family or close friends who live nearby to help them find and choose services

- a person with low literacy who is having trouble understanding the information that providers are sending and has a carer who wants to help them but the person does not give permission for the carer to be their representative due to fear of elder abuse.

Examples of people who would be encouraged to use channels other than care finders

- a person who does not speak English, who has given permission for their adult child to be their representative and their adult child is willing and able to:
  - o   call My Aged Care for the person with an interpreter
  - o   attend the assessment with the person and an interpreter
  - o   talk to providers with an interpreter to set up services

- a person with a hearing impairment who prefers to communicate with someone face-to-face because they find it difficult to hear on the phone and is comfortable with one of the following alternatives:
  - o   for their partner to call My Aged Care to set up an assessment
  - o   to go to a Services Australia service centre to find out more about aged care and set up an assessment
  - o   to take part in a virtual call with assistance from an Auslan interpreter via the contact centre

- a person who is primarily making inquiries about aged care financial information, such as the impact of refundable accommodation deposits, and would be better referred to the My Aged Care face-to-face service or Financial Information Service at Services Australia

- a person who should be referred to OPAN because they require independent advocacy to exercise their right to make a choice in receiving aged care services or resolve problems or complaints with aged care providers in relation to the aged care services they receive, noting the flexibility provided in *section 5.10* of this guidance.

4.2   What should happen if a person wants help from a care finder but is not within the target population?

If a person wants help from a care finder but is not within the target population, they should be referred or, where required and where possible, given a warm handover[1] to the most appropriate support for them. Depending on the person's circumstances and needs, this may include a referral or warm handover to the My Aged Care contact centre or nearest My Aged Care face-to-face service in Services Australia service centres.

A process should be in place to manage enquiries efficiently and provide referrals or warm handovers as appropriate. For example, if a person has a question that can be dealt with in a few minutes, it would not necessarily be efficient or a good consumer experience to refer them on.

If a person is reluctant to be referred or given a warm handover to the My Aged Care contact centre or nearest My Aged Care face-to-face service, the reasons for this should be explored with them by the care finder and (where appropriate and providing the person does not fall within the target population because they are uncomfortable engaging with government due to past discrimination and/or trauma) more information should be provided about the support available for the person through the My Aged Care contact centre or nearest My Aged Care face-to-face service.

4.3   What arrangements should be put in place to monitor whether care finders are focusing on the target population?

PHNs and care finder organisations should put in place arrangements to monitor whether care finders are focusing on the target population. This will not only assist in ensuring that care finder services are being delivered as intended, but will also assist in informing whether additional work needs to be undertaken to embed referral pathways so people are referred to the most appropriate service for their needs.

As outlined in *section 13.2* of this guidance, data collection and reporting requirements will include monthly reporting by care finder organisations via the online reporting portal. Specific data requirements will be set out in a minimum dataset, but will include information relevant to whether care finders are focussing on the target population. For example, this may include information on the:

*   proportion of closed client cases within each of the care finder complexity bands:

    Band 0 = up to 2 hours of support[2]
    Band 1 = 2 to up to 5 hours of support
    Band 2 = 5 to up to 10 hours of support
    Band 3 = 10 to up to 15 hours of support
    Band 4 = 15+ hours of support

*   approximate proportion of clients within the care finder target population (noting that, as outlined in *section 4.2* of this guidance, it may be more efficient to provide a small amount of support to someone who is not within the care finder target population rather than refer them on).

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[1] A warm handover is where the care finder organisation staff member calls another service with the client.
[2] 'Support' includes direct and indirect support provided to the client.

PHNs and care finder organisations should review the information reported in the online reporting portal and take further action where this suggests that there may be an insufficient focus on the target population. For example, depending on the information to be reported via the online portal, this may be indicated where:

- a high proportion of closed client cases are within care finder complexity band 0

- a high proportion of clients are outside the target population.

5 Care finder role and functions

5.1 What is the role of care finders?

Care finders will provide specialist and intensive assistance to help people within the care finder target population to understand and access aged care and connect with other relevant supports in the community.

The functions of care finders are set out below. A summary of the role of the care finder in the client's journey is at **Appendix B** and examples of care finding from the client perspective are at **Appendix C**.

5.2 What are the functions of care finders?

The functions of care finders will include:

- assertive outreach, as described in *section 5.6* of this guidance

- engagement and rapport building with potential clients and local intermediaries

- supporting people to interact with My Aged Care so they can be screened for eligibility for aged care services and referred for assessment

- support to explain and guide people through the assessment process including, where appropriate, attending the assessment

- support to help people to find the aged care supports and services they need and connect with other relevant supports in the community, including supporting people to:

  o understand the different types of aged care supports and services

  o find and make an informed choice about providers/services

  o work through income/means testing, if relevant, and costs (with support from Services Australia as required)

  o complete forms

  o meet with providers to arrange services (such as by calling providers to check availability and attending meetings with providers)

  o understand the agreement that needs to be signed with the provider

  o connect with other relevant supports in the community, noting that, as outlined in *section 5.4* of this guidance, this may occur before they assist a person to access aged care (as well as any other time)

- high level check-in with clients on a periodic basis and follow up support once services have commenced to:
  - o check that the person is still receiving services and providers are managing any changes to their needs
  - o provide support where services have lapsed or needs have changed and providers are not taking appropriate action, such as (depending on the situation and the client's wishes):
    - contacting the provider, with the client's consent, and working with them to put in place new services
    - working with the client to change providers
    - supporting the client to interact with My Aged Care so they can be referred for re-assessment and helping them to move to new services and/or providers (as required).

When exercising their functions, care finders may utilise the following supports (as required):

- the Translating and Interpreting Service (TIS)
- Auslan Connections
- Indigenous Interpreting Services
- the National Relay Service.

5.3   What is meant by 'aged care supports and services'?

Care finders will help people to understand and access aged care supports and services. For the purpose of the care finder program, aged care supports and services are defined as the following supports and services funded by the Australian Government:

- supports and services provided under the Support at Home Program[3]
- residential aged care
- flexible care provided under the:
  - o Transition Care Programme (TCP)
  - o Multi-Purpose Services (MPS) Program
  - o National Aboriginal and Torres Strait Islander Flexible Aged Care (NATSIFAC) Program
- broader supports and services provided under the:
  - o National Aged Care Advocacy Program (NACAP)
  - o Community Visitors Scheme (CVS)
  - o National Dementia Support Program
  - o Dementia Behaviour Management Advisory Service (DBMAS)
  - o Specialist Dementia Care Program.

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[3] Or, until such time as the Support at Home Program commences, supports and services provided under or through the Commonwealth Home Support Programme (CHSP), the Home Care Packages (HCP) Program, the Short-Term Restorative Care Programme (STRC), and residential respite care.

5.4   What is meant by 'help clients to connect with other relevant supports in the community'?

Care finders will help clients to connect with other relevant supports in the community. This function will assist in achieving the intent to improve outcomes for people in the care finder target population, particularly in terms of improved coordination of support when seeking to access aged care.

Care finders should take a multi-dimensional approach when considering a client's needs and other relevant supports in the community that may assist the client to:

- maintain and/or improve their psychological, emotional and physical wellbeing

- break down barriers that may impede their access to aged care.

The types of other relevant supports in the community that a care finder may help a client to connect with will vary depending on the circumstances and preferences of each person and the complexity of their needs. Examples of other relevant supports in the community include:

- health services

- mental health services and supports

- social services and supports

- housing and homelessness services and supports

- drug and alcohol services and supports

- community groups.

Where appropriate, care finders may help a client to connect with other relevant supports in the community before they assist the client to access aged care (as well as at any other time). This recognises that other relevant supports in the community may enable people to improve their wellbeing before they access aged care and/or break down barriers that may impede their access to aged care.

The level and type of assistance that a care finder should provide when helping a client to connect with other relevant supports in the community will vary depending on the complexity of the client's needs. For example:

- some clients may only need a referral or, where required and where possible, warm handover to other relevant supports in the community

- other clients may need more intensive support to connect with other relevant supports in the community, including similar steps to those involved in helping them to access aged care as described in *section 5.2* of this guidance.

As part of their high level check-in and follow up support, care finders should check that the client successfully connected with other relevant supports in the community.

Care finder organisations must not use care finder funding to deliver activities or services that are available to, and suitable for, a client through other government programs. However, care finders may help a client to connect with these activities or services, including where these activities or services are otherwise delivered by their organisation (providing, as described in *section 10.1* of this guidance, this respects and facilitates optimal consumer choice and meets requirements in relation to conflicts of interest).

In addition, as outlined in *section 8.5* of this guidance, care finder organisations must not use funding from more than one government program to provide the *same* support to the *same* client.

5.5 How many hours should care finders spend supporting a person?

All care finder clients will need intensive assistance to understand and access aged care and connect with other relevant supports in the community.

It is expected that a significant proportion of care finder clients will need **15 or more** hours of support from their care finder over a year and some will need considerably more. This includes time associated with:

- assertive outreach, engagement and rapport building with the client
- traveling to, and meeting with, the client
- indirect support (such as background research on potential providers/services and travel time to the client's home or preferred meeting place).

The degree of involvement by the care finder will vary depending on the complexity of the person's needs. For example:

- it may take considerable time to build rapport and trust with some people
- some people may need significant support to connect with the services they need
- some people may need more frequent high level check-in support than others
- the time between re-assessment and navigation to new services or providers will vary.

5.6 What should assertive outreach look like in the context of aged care navigation?

Care finders will undertake assertive outreach to proactively identify and engage with people in the care finder target population. This includes:

- reaching into the local community and actively identifying and engaging with potential clients, including through direct contact and supported contact via intermediaries (such as health professionals, aged care and disability sector professionals and people from within community and voluntary organisations)
- exploring and establishing different ways to effectively engage and build rapport with potential clients, including:
  - o adapting their style of working to suit the individual needs of each person
  - o meeting people in their own environment, such as their home or other environment familiar to them, at a convenient time for them
  - o where needed, connecting with people over a number of occasions to build a relationship prior to providing support to understand and access aged care
- building, maintaining and leveraging networks of intermediaries and otherwise leveraging connections/networks in the local community to support identification of and engagement with potential clients.

5.7 What support should care finders provide while a client is waiting for an assessment or for services to commence?

While a client is waiting for an assessment or for services to commence, care finders should contact the client on a periodic basis to check:

- how they are overall

- that they understand the next steps and where they are in the process

- whether they need support to remain engaged in accessing services

- whether their needs have changed

- whether they have any need for support from the care finder.

The support that a care finder should provide while a client is waiting for an assessment or for services to commence will vary depending on the circumstances and preferences of each person and the complexity of their needs. For example, this may vary based on:

- the time between assessment and service commencement

- the level of support a client needs to remain engaged in accessing services

- how quickly a client's needs are changing.

Where an aged care assessment is not immediately available, the care finder can explore whether urgent aged care services can be set up before an assessment has taken place by contacting My Aged Care with the client.

If aged care services are not available, the care finder should explore other relevant supports in the community. This may include:

- supports funded through state/territory and/or local governments

- supports funded through charitable organisations

- private services, if the client is able to pay for them.

In addition to checking-in with the client, care finders should provide the client with contact details so the client can contact them if they have any questions while they are waiting for an assessment or for services to commence. It may also be useful for the care finder to provide the client with written information outlining the next steps and where they are in the process.

5.8 What is a high level check-in and how often should care finders provide high level check-in support once services have commenced?

A high level check-in is a phone call or visit to the client to ask:

- how they are

- whether their services are in place and still meeting their needs

- whether they have any need for support from the care finder.

A high level check-in should occur within the first two months of service commencement. The frequency of additional high level check-ins should be agreed between the care finder and client and will depend on the individual circumstances of each client. For example:

- some clients may only need one high level check-in each year or may not need on-going check-ins if they have on-going support (e.g. a social worker)

- some clients may need more frequent (such as quarterly) high level check-ins in the first year of service commencement, followed by one high level check-in each year thereafter

- some clients may need frequent high level check-ins every year to ensure they are still receiving services and their needs are being met.

5.9   Do the functions of care finders include care coordination?

Care finders are responsible for providing intensive navigation support and their functions do not include coordination of aged care services. Providers are responsible for the day-to-day management of a client's care needs, including care coordination of services and management of changes to a client's care needs.

5.10   Will care finders provide advocacy?

The primary role of care finders is to support people to understand and access aged care services and connect with other relevant supports in the community. While this may involve discrete elements of individual advocacy, such as support to resolve a problem with a provider that the care finder has helped the client to engage (e.g. if the provider is sending different care workers every time and the client is uncomfortable with this), individual advocacy will not be a primary role of care finders and care finders will not be funded as advocates.

People requiring individual aged care advocacy support and mediation should generally be referred to the Older Persons Advocacy Network (OPAN)[4]. However, to ensure a more seamless and consumer-focused service for clients, care finders may provide clients with advocacy support where the client wants them to and where the care finder has the skills to do so. Where these requirements are not met, or when advanced advocacy skills or intensive advocacy support is required, the client should be referred to OPAN for advocacy support.

It will be important for care finders to maintain strong linkages with OPAN service delivery organisations in their region and establish processes with these organisations to ensure seamless handovers of care finder clients requiring advocacy support via OPAN. This may include:

- referral or, where required and where possible, warm handovers of clients requiring advocacy support to OPAN

- follow up support by the care finder to make sure the person has connected with the advocacy support they need.

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[4] OPAN is a national network comprised of nine state and territory-based service delivery organisations.

5.11 In what type of environments should care finders provide support? Will care finders only provide face-to-face support?

Care finders will provide support at the place of the client's choosing, including the client's home or other environment familiar to them or the care finder's office.

Care finders will predominantly provide face-to-face support. Care finders may sometimes provide support via other channels (such as phone, video call, email or mail):

- if this is the client's preference and the client does not have barriers to using these channels

- to provide flexibility in rural and remote areas

- where face-to-face support is not possible due to COVID-19 restrictions or a natural disaster.

5.12 Will care finders have access to the My Aged Care customer relationship management IT system?

When a care finder establishes an ongoing relationship with a client, they will seek the client's permission to become their 'agent' in the system. The 'agent' relationship enables sector professionals to have visibility of client information in order to help them access the services they need. An 'agent' does not have decision-making power.

From October 2022, 'agents' will be able to do the following:

- register new clients within the My Aged Care service organisation portal

- initiate and create 'agent' relationships with clients within the My Aged Care service organisation portal, then the client can either provide their consent to activate the relationship or the care finder will be able to indicate verbal consent (e.g. in scenarios where the client is unwilling or unable to talk to My Aged Care)

- register a client and initiate an 'agent' relationship via the 'apply for an assessment online' form on the My Aged Care website (as an alternative to using the My Aged Care service organisation portal)

- view and update the client's information from the My Aged Care service organisation portal or by talking to the My Aged Care contact centre

- receive and/or access information about a client's progress in My Aged Care

- facilitate and enact decisions made by the client about their aged care assessment and referrals for services

- be the primary point of contact for the client.

6 Care finder organisation and workforce characteristics

6.1 What type of organisations should deliver care finder services?

Care finder services should be delivered by organisations that have demonstrated local community connections with, and specialist skills and experience in supporting, people within the care finder target population (or a specific sub-group within the care finder target population).

The number and type of organisations delivering care finder services in each region will be determined by the PHN commissioning process and will reflect local needs in relation to care finder support.

It is expected that many care finder organisations will be community-based organisations, but this is not a commissioning requirement for PHNs.

There are potential conflicts of interest where provider organisations help clients to choose providers. However, in some circumstances, it may be appropriate for providers to deliver care finder services (e.g. providers who have specialist skills and experience in understanding the needs of specific sub-groups within the care finder target population or trusted links with these communities).

PHNs will be responsible for putting in place arrangements with care finder organisations in relation to conflicts of interest, which should include a requirement for care finders to respect and facilitate optimal consumer choice (including by providing clients with appropriate alternatives, where available, to any supports and/or services provided by their own organisation). Further information about the requirements that apply and arrangements that should be put in place in relation to conflicts of interest is at *section 10.1* of this guidance.

6.2   What are the characteristics of the care finder workforce?

It is expected that the care finder workforce should have the following characteristics, noting there may be a need for flexibility to build experience and/or skills over time where workforce availability presents challenges:

- relevant qualifications (e.g. social work, human services, aged care, community services or health) and/or relevant experience

- local community connections (or an ability to leverage the care finder organisation's connections) with the care finder target population or a specific sub-group within the care finder target population

- a detailed understanding/ability to rapidly attain a detailed understanding of:
  - o   the range of aged care supports and services and other relevant supports that are available in the local community
  - o   the process to access aged care supports and services, including the steps of this process that are undertaken via My Aged Care
  - o   eligibility requirements for aged care supports and services
  - o   the process to access, and any eligibility requirements for, other relevant supports in the community

- a commitment to delivering a person-centred approach that:
  - o   respects and responds to each person's individual needs, preferences, values and life experiences
  - o   supports each person to lead in decision making
  - o   respects and facilitates optimal consumer choice

- an ability to communicate effectively with a broad range of people, including an ability to:
  - engage in active listening, including building rapport and demonstrating empathy
  - explain information in a clear, concise and accurate manner
  - communicate in a way that is respectful and inclusive
  - build and maintain relationships with local intermediaries
- a commitment to supporting the needs of people with diverse backgrounds and life experiences, with:
  - a commitment to treating people with dignity and respect and in a way that values their identity, diverse backgrounds and life experiences
  - an understanding of how people's diverse backgrounds and life experiences may:
    - create barriers to seeking help and/or accessing services
    - affect the support that they may need from a care finder at different stages of their aged care journey
    - affect or influence their needs and preferences in relation to aged care
  - a strong understanding of, and commitment to, cultural safety and trauma-informed care
- strong problem solving skills
- administrative skills, including an ability to use and accurately enter information into systems, databases and/or portals
- a commitment to continuous improvement, including sharing expertise and knowledge.

Care finder organisations may also require care finders to hold:

- a current and appropriate driver's licence
- current and accredited first aid certification.

It is expected that care finders will be remunerated at a level equivalent to the Social, Community, Home Care and Disability Services (SCHADS) Industry Award 2010, Social and Community Services Employee Level 5 or Level 6.

7 Care finder service delivery principles

7.1 What are the principles for care finder service delivery?

Care finder service delivery should be guided by the following principles:

Person-centred approach

- care finders:
  - place clients at the centre of care finder service delivery
  - respect and respond to the unique needs, preferences, values and life experiences of each client
  - recognise the client is the expert in their own life
  - support clients to lead in decision making

Dignity and respect

- care finders treat clients with dignity and respect and in a way that values their identity, diverse backgrounds and life experiences

Choice and self-determination

- care finders respect and facilitate optimal consumer choice and client control in decision making

Quality

- care finders provide clients with accurate, relevant, timely and independent information

Equitable access

- care finder support is accessible to all people within the care finder target population

Partnerships

- care finders:
    - o actively build and maintain local community connections with:
        - the care finder target population
        - organisations delivering aged care supports and services and other relevant supports
    - o recognise and (where appropriate and with the client's consent) work in partnership with the client's carer(s), family and/or representative(s)
    - o actively build and maintain relationships with local intermediaries

Governance

- care finder organisations have strong governance arrangements in place to:
    - o provide strategic guidance and direction
    - o oversee, monitor and be accountable for performance
    - o manage and protect client privacy
    - o monitor and manage risk
    - o encourage continuous improvement

Continuous improvement

- care finder organisations adapt and respond to:
    - o feedback from clients and local intermediaries
    - o key findings from the evaluation of the care finder program
- care finders:
    - o participate in training to build their knowledge and skills in relation to care finder support
    - o share expertise and knowledge of local experiences, lessons learned and innovations to support continuous improvement
    - o participate in, and contribute to, continuous improvement activities led by their PHN.

8 Overarching care finder service considerations

8.1 What arrangements should be put in place in relation to training and capability building?

Care finders will undertake ongoing training and development to build their knowledge and skills in relation to care finder support. This will:

- assist in ensuring that the care finder workforce is appropriately qualified, skilled and trained

- support continuous improvement

- provide national consistency in service delivery.

Care finder organisations should:

- encourage capability building and support care finders to identify and undertake appropriate training

- monitor and manage care finder participation in training.

Training costs (including licences to access the department's learning management system) will need to be covered by program funding provided to care finder organisations.

Mandatory training

All care finders, their managers and triage staff will be required to complete mandatory online induction training regardless of prior training or experience.

The induction training package will be developed by the department[5] (and updated from time-to-time as required) and is expected to cover key foundational information for the care finder role and competencies as follows:

- an overview of the aged care system, including My Aged Care

- the care finder program, including care finder functions and client populations

- referral pathways, complementary supports and other supports (such as the TIS)

- assertive outreach

- use of the My Aged Care website, agent portal and client portal to support clients

- confidentiality, privacy and information security in relation to the My Aged Care system

- use of the online reporting portal.

In addition to the mandatory online induction training, all client-facing staff in care finder organisations will be required to have completed training in cultural safety and trauma-informed care.

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[5] Except training on use of the online reporting portal, which will be developed by the program evaluator.

Supplementary training

Supplementary training should also be undertaken to complement existing care finder training and experience, but will not be mandatory.

The department will identify supplementary training topics to guide care finders on the key capabilities and knowledge base relevant to the care finder role.

While the source of any supplementary training is at the discretion of the care finder organisation and/or PHN, recommended supplementary topics will be available online through the department's learning management system.

8.2 What requirements apply in relation to workplace health and safety?

Care finder organisations (including care finder organisation personnel[6]) must meet the requirements set out in the Standard Funding Agreement Terms and Conditions in relation to workplace health and safety.

A particular consideration in the care finder context is where personnel provide support from, or travel to, a client's home or other environment familiar to them. Care finder organisations may wish to develop a home visiting policy to provide guidance in relation to relevant workplace health and safety considerations.

8.3 Will care finders need to be vaccinated against COVID-19? What other considerations should care finder organisations take into account in relation to COVID-19?

Care finder organisations must comply with public health orders or directions in their state/territory, including any public health orders or directions in relation to COVID-19 vaccination of workers.

Where COVID-19 vaccination is not mandatory under a public health order or direction in their state/territory, care finder organisation staff are encouraged (unless they have a proven contraindication) to have an up-to-date COVID-19 vaccination status prior to engaging with clients face-to-face.

Care finder organisations should also comply with broader advice issued by their state/territory government in relation to COVID-19.

8.4 What arrangements should be put in place in relation to service continuity and transition-out of services?

PHNs and care finder organisations should identify and develop strategies to respond to risks relating to service continuity for clients, including service continuity during a transition-out period.

In the event of an incident, such as a natural disaster, care finder services should continue to be available for clients where safe and possible.

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[6] A definition of 'care finder organisation personnel' is provided at *section 10.1* of this guidance.

Services will need to be transitioned-out if an organisation is no longer commissioned as a care finder organisation (e.g. if their agreement has concluded and is not renewed or is terminated). If services are being transitioned-out, arrangements should be put in place to:

- ensure service continuity for clients during the transition-out period
- facilitate seamless client handovers to appropriate alternative care finder organisations, with client consent and in consultation with clients
- otherwise facilitate an effective and client-centred transition-out.

PHNs should work with care finder organisations in their region to develop a service continuity plan that:

- sets out the systems, policies and processes in place to identify, manage and respond to risks relating to service continuity
- specifically identifies the arrangements that will be put in place to address service continuity in the event of:
  - o serious incidents (e.g. significant failure of, or inability to access, ICT systems)
  - o natural disasters (e.g. flood or fire)
  - o other emergency events (e.g. pandemics)
- includes a transition-out plan to address the arrangements that will be put in place if an organisation is no longer commissioned as a care finder organisation, including:
  - o the process and timeframe for transitioning clients to appropriate alternative care finder organisations
  - o a communication strategy, including key messages for communicating with clients
  - o any other arrangements that will be put in place to facilitate an effective and client-centred transition-out.

8.5 Can care finder organisations use funding from more than one program to support the same client?

Some care finder organisations may receive funding under other government programs. For example, a care finder organisation may also be funded:

- under the NACAP to provide individual advocacy support via OPAN
- as an aged care service provider
- under state/territory government programs to deliver other support services.

Care finder organisations are able to use funding from more than one program to support the same client. For example, an organisation may first support a client in their capacity as a care finder organisation (to support the client to access aged care) and then in their capacity as an organisation that provides individual advocacy support (if the client needs advocacy support to resolve a complaint with an aged care service provider). However:

- they must not use funding from more than one program to provide the *same* support to the *same* client
- use of funding must be consistent with the purpose for which the funding was allocated to the organisation

- any conflicts of interest must be handled in accordance with the requirements that apply and arrangements that should be put in place in relation to conflicts of interest outlined at *section 10.1* of this guidance.

Where care finder organisations have used funding from more than one program to support the same client, they should maintain a record of this and document how funding was used to provide different supports to the client.

9 Referral pathways and connections between programs

9.1 How will people access care finders? Will they need a referral?

People will not need a professional referral to access care finder services.

Taking into account the care finder target population, it is expected that the majority of people will access care finders:

- via an intermediary (such as health professionals, aged care and disability sector professionals and people from within community and voluntary organisations)
- following assertive outreach and engagement and rapport building undertaken by care finders.

Some people (or their support person/representative) may directly approach a care finder organisation and others may be referred by staff in the aged care system (such as aged care assessors and the My Aged Care contact centre).

9.2 How should referrals be handled so people are connected with the most appropriate care finder in their area?

In some cases, the referrer will know which care finder or care finder organisation to refer to because they will have met through assertive outreach activities. In other cases, referrers may be aware that the care finder program exists but not know the care finder organisations available in their area.

Each PHN will be responsible for determining how to best coordinate referrals to care finders in their region so that people are connected with the most appropriate care finder in their area. This will provide flexibility for each PHN to determine an approach based on local circumstances.

Where PHNs establish a referral coordination point, either at the state/territory level or within a region, this should consider the person's needs and inform the referrer of/provide a warm handover to the most appropriate care finder organisation in their region. For example, where possible, if a person:

- is at risk of homelessness, they would be connected with a care finder who specialises in supporting people who are homeless/at risk of homelessness
- is from a CALD background, they would be connected with a care finder who speaks their language (if one is available) or is from a similar cultural background
- is a care leaver, they would be connected with a care finder who has particularly good connections with care leaver organisations or who is from a care leaver organisation

- has a range of vulnerabilities/diverse needs, the coordination point would seek to establish which care finder the person would most likely be comfortable with in their area based on their specific needs and requirements.

In addition to any referral coordination points established by PHNs:

- each care finder organisation should establish and maintain an intake point

- PHNs will need to develop and maintain a contact list of the care finder organisations in their region, including information on any referral coordination points, to inform a national directory to be included on the My Aged Care website.

If care finders identify potential clients via assertive outreach, they may (depending on the person's needs and wishes and the care finder services available in their local area):

- help the person if they are well placed to do so (e.g. a care finder from a homelessness focused care finder organisation has identified a potential client who is homeless and has already established rapport with the person) or are the best placed care finder to help the person in the local area

- where appropriate and relevant, refer the person to another care finder in their organisation who is better placed to help (e.g. a care finder from a CALD focused care finder organisation has identified a potential client from a CALD background and the organisation has another care finder who speaks the person's language)

- contact the referral coordination point, if one exists in their region or state/territory, if they think there may potentially be another care finder organisation that is better placed to help the person (e.g. a person is homeless and from a CALD background and has been identified by a care finder from a homelessness focused care finder organisation but there may be a CALD focused care finder organisation that is better placed to help the person if they have a care finder that speaks their language)

- refer the person to a more appropriate care finder organisation that they know of in their area.

9.3   How should care finders handle requests to support people who are not within the care finder target population?

If a care finder receives a request to support a person who is not within the care finder target population, they should:

- contact the referrer and explore the reasons why they referred the person to a care finder

- where the referrer's response confirms that the person is not within the care finder target population:
  - o   explain the care finder target population to the referrer
  - o   suggest (depending on the person's needs and circumstances) that the referrer connects the person with the My Aged Care contact centre, their nearest My Aged Care face-to-face service or other relevant support (e.g. the Carer Gateway contact centre or nearest National Disability Insurance Scheme office).

Where the request is being made directly by the person (or their support person/representative), the person should be referred or, where required and where possible, given a warm handover to the most appropriate support for them. Further information about referrals and warm handovers is provided in *section 4.2* of this guidance.

9.4 How can PHNs and care finder organisations assist in embedding referral pathways so people are referred to the most appropriate service for their needs?

Referral resources are being developed to help the sector to refer people to the most appropriate service for their needs and promote the development of a cohesive system of tailored supports.

PHNs and care finder organisations will assist in embedding referral pathways and this will contribute to broader actions that PHNs and care finder organisations will undertake to assist in integrating the care finder network into the local aged care system.

PHNs can assist in embedding referral pathways through:

- local partnerships and relationships with referrers and intermediaries
- raising awareness of care finder services, including the specific focus of the care finder target population and care finder services available in their region
- identifying care finder services available in their region in relevant *HealthPathways*
- providing a forum, through community of practice meetings, for care finder organisations to share local experiences and lessons learned in relation to referral pathways.

Care finder organisations can assist in embedding referral pathways through:

- relationships with local intermediaries
- raising awareness of the care finder service that they provide
- where they are receiving requests to support people who are not within the care finder target population, explaining the care finder target population to referrers and redirecting them to appropriate supports
- sharing local experiences and lessons learned in relation to referral pathways at community of practice meetings coordinated by their PHN.

9.5 How will care finders complement other aged care supports?

Existing aged care supports do not provide the same support as care finders, as they are either more general in their target population or different in terms of service scope. For example:

Other supplementary intensive navigation support

Trusted Indigenous Facilitators will be available nationally from mid-2022 and will offer a similar service to care finders. They will be located in Aboriginal Community Controlled Health Services, Indigenous aged care providers or community hubs and will support any Aboriginal and/or Torres Strait Islander person who needs their help.

Older Aboriginal and/or Torres Strait Islander people who are within the care finder target population will be able to choose whether to receive support from a care finder or Trusted Indigenous Facilitator, if both are available.

Complementary specialist support

Some existing programs currently provide navigation support as part of their offer, but this is not their main focus and may be services that care finders would access with or on behalf of clients (if relevant). For example:

• The National Dementia Helpline provides a range of support (including counselling, guidance on dementia supports and information) to people with dementia.

• OPAN (under the NACAP) supports people who are receiving or seeking to receive aged care services to resolve disputes or complaints when the older person's rights are not understood or being respected (including elder abuse information and education) or to be informed of and exercise their rights in accessing and receiving aged care services. They also undertake community capacity building to support people to self-advocate and understand home care service costs.

10 Conflicts of interest

10.1 What requirements apply and what arrangements should be put in place in relation to conflicts of interest?

The Standard Funding Agreement Terms and Conditions sets out the requirements that apply in relation to conflicts of interest[7]. A particular consideration in the care finder context is that conflicts of interest (actual, potential or perceived) do not influence, impact or restrict optimal consumer choice (including consumer choice of their service provider).

Care finder organisations should declare any conflicts of interest as part of the PHN commissioning process and prior to entering into an agreement with a PHN. For the avoidance of doubt, a conflict of interest includes any situation where the care finder organisation is a service provider.

In terms of conflicts of interest and consumer choice, PHNs should ensure that their agreements with care finder organisations include the following:

• a conflict includes any conflict of interest, any risk of a conflict of interest and any apparent conflict of interest arising through the care finder organisation (or care finder organisation personnel[8]) engaging in any activity or obtaining any interest that is likely to conflict with or restrict the care finder organisation in delivering care finder services fairly and independently

• the care finder organisation must warrant that, to the best of its knowledge after making diligent inquiry, no conflict, except as disclosed in writing to the PHN, exists or is likely to arise in relation to its delivery of care finder services

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[7] Supporting guidance is provided in the *PHN Conflicts and Related Party Policy* available at https://www.health.gov.au/resources/publications/primary-health-network-phn-conflicts-and-related-party-policy.

[8] Care finder organisation personnel includes each subcontractor; any sub-subcontractor; any officer, employee, partner, volunteer or agent of the care finder organisation, a subcontractor or a sub-subcontractor; and if the care finder organisation is an individual that individual.

- if a conflict arises, or appears likely to arise, the care finder organisation must agree to:

  o notify the PHN immediately in writing of the conflict making a full disclosure of all relevant information relating to the conflict and setting out the steps the care finder organisation proposes to take to resolve or otherwise deal with the conflict

  o take such steps as have been proposed by the care finder organisation, or at the discretion of the PHN or Department of Health, take such steps as the PHN or Department of Health may reasonably require to resolve or otherwise deal with the conflict

- the PHN must retain a right to terminate its agreement with the care finder organisation if the care finder organisation fails to notify the PHN of a conflict or is unable or unwilling to resolve or deal with a conflict as required

- the care finder organisation must agree that it will:

  o ensure that a situation does not arise which may result in a conflict

  o use its best endeavours (including making all appropriate enquiries) to ensure that its personnel does not engage in any activity or obtain any interest that is likely to conflict with or restrict the care finder organisation in delivering care finder services fairly and independently

- the care finder organisation must warrant that, in delivering care finder services, it will respect and facilitate optimal choice for clients (including by providing clients with appropriate alternatives, where available, to any supports and/or services provided by their own organisation) and that no corporate or other relationship between the care finder organisation and another organisation will influence, impact or restrict this choice due to an actual, potential or perceived conflict of interest.

For the avoidance of doubt, care finder organisations (including their personnel) must not receive any financial benefit (sometimes referred to as a 'finder's fee') as a result of referring a care finder client to a service and/or service provider.

Where care finder organisations have referred care finder clients to their own organisation, they will need to report the following via the online reporting portal on a monthly basis:

- the number of occasions where care finder clients were referred to their own organisation during the reporting period

- a statement to confirm the following for the reporting period:

  o optimal choice for care finder clients was respected and facilitated (including by providing clients with appropriate alternatives, where available, to supports and/or services provided by their own organisation)

  o conflict of interest requirements were met.

11   Complaints

Complaints will be handled in accordance with the *PHN Program Complaints Policy*[9].

It is expected that care finder organisations have a procedure in place for handling complaints relating to care finder service delivery in the first instance.

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[9] Available at https://www.health.gov.au/resources/publications/primary-health-network-phn-program-complaints-policy

12 PHN commissioning of care finders

12.1 What is expected of PHNs?

PHNs will establish and maintain a network of care finders to provide specialist and intensive assistance to help people within the care finder target population to understand and access aged care and connect with other relevant supports in the community. PHNs will:

- commission care finder services based on local needs in relation to care finder support

- support a transition of the ACH program (with the exception of hoarding and squalor services) to the care finder program

- develop, implement and maintain processes to meet data collection and reporting requirements

- support the integration of the care finder network into the local aged care system

- support continuous improvement of the care finder program

- identify and address opportunities to enhance integration between the health, aged care and other systems at the local level.

Further detail is set out below.

Commission care finder services based on local needs in relation to care finder support

PHNs will:

- undertake additional activities, to supplement their existing needs assessments, prior to the initial commissioning of care finder organisations to identify local needs in relation to care finder support

- develop a plan, to be reflected in their activity work plans, for commissioning care finder services based on local needs in relation to care finder support

- commission care finder services that:

  o provide specialist and intensive assistance to help people within the care finder target population to understand and access aged care and connect with other relevant supports in the community

  o specifically target senior Australians who have one or more reasons for requiring intensive support to interact with My Aged Care (either through the website, contact centre or face-to-face in Services Australia service centres), access aged care services and/or access other relevant supports in the community

  o deliver the functions set out in *section 5.2* of this guidance

  o respond to local needs in relation to care finder support

  o are delivered by an appropriately qualified, skilled and trained workforce

  o commence service delivery from January 2023, noting the flexibility provided in *section 12.3* of this guidance

- monitor and manage the performance of care finder organisations, including by reviewing data reported by care finder organisations in the online reporting portal.

Support a transition of the ACH program (with the exception of hoarding and squalor services) to the care finder program

PHNs will support a transition of the ACH program (with the exception of hoarding and squalor services) to the care finder program, by:

- offering existing ACH providers a contract as care finders from 2022-23 to 2024-25

- quarantining an amount of funding, to be determined by the department taking into account existing funding received by ACH providers, to be used to contract ACH providers as care finders from 2022-23 to 2024-25.

The ACH program will not be a sub-program under the care finder program. Once contracted by PHNs, ACH providers will operate as care finders and will need to meet the requirements of the care finder program. Further information about the arrangements for transitioning the ACH program to the care finder program is at *section 12.5* of this guidance.

Develop, implement and maintain processes to meet data collection and reporting requirements

PHNs and care finder organisations will develop, implement and maintain processes to meet data collection and reporting requirements. This includes:

- establishing and maintaining enabling IT infrastructure, systems and databases

- developing, implementing and maintaining appropriate processes to assist in ensuring the accuracy, completeness and timeliness of data and reports such as:

  o standard operating procedures

  o processes to address any issues identified by the department and/or program evaluator in relation to the accuracy, completeness and timeliness of data and/or reports

  o staff training and support in relation to data collection and/or use of enabling IT systems and databases

- establishing and maintaining processes to monitor and manage data integrity.

As part of broader reporting requirements, PHNs and care finder organisations will engage with, and contribute to, the evaluation of the care finder program. This includes:

- activities to support the accuracy, completeness and timeliness of data and reports

- participating in interviews with the program evaluator

- assisting to identify local intermediaries and other referrers who may participate in interviews with the program evaluator.

Support the integration of the care finder network into the local aged care system

PHNs will undertake activities to support the integration of the care finder network into the local aged care system. This includes:

- developing and delivering appropriate activities to promote and raise awareness of care finder services with potential referrers, intermediaries and the target population

- establishing and maintaining partnerships and relationships to support effective implementation and management of care finder services

- assisting in developing and embedding referral pathways so people are referred to the most appropriate service for their needs (further information on how PHNs can assist in embedding referral pathways is at *section 9.4* of this guidance).

Care finder organisations will also undertake activities to support the integration of the care finder network into the local aged care system. This includes:

- developing and delivering appropriate activities to promote and raise awareness of care finder services with potential referrers, intermediaries and the target population

- establishing and maintaining relationships with local intermediaries

- assisting in developing and embedding referral pathways so people are referred to the most appropriate service for their needs (further information on how care finder organisations can assist in embedding referral pathways is at *section 9.4* of this guidance).

Support continuous improvement of the care finder program

PHNs will support continuous improvement of the care finder program. This includes:

- establishing, coordinating and maintaining community of practices to share local experiences, lessons learned, innovations and key evaluation findings across care finder organisations

- collaborating and sharing experiences, lessons learned and innovations across PHNs

- undertaking activities to assist in addressing key findings from the evaluation of the care finder program, including:
  o adapting and responding to key evaluation findings
  o sharing key evaluation findings with care finder organisations
  o encouraging and promoting opportunities for care finder organisations to adapt and respond to key evaluation findings.

Care finder organisations will also support continuous improvement of the care finder program. This includes:

- adapting and responding to:
  o feedback from clients and local intermediaries
  o key findings from the evaluation of the care finder program

- care finders:
  o participating in training to build their knowledge and skills in relation to care finder support
  o participating in, and contributing to, community of practice meetings and other continuous improvement activities led by their PHN.

Identify and address opportunities to enhance integration between the health, aged care and other systems at the local level

PHNs will identify and address opportunities to enhance integration between the health, aged care and other systems at the local level within the context of the care finder program. This includes:

- identifiying opportunities in their region to enhance integration between the health, aged care and other systems as part of their needs assessment activities

- developing a plan, to be reflected in their activity work plans, to address identified opportunities in their region to enhance integration between the health, aged care and other systems.

12.2   Additional guidance on what is in-scope and out-of-scope

In addition to matters addressed elsewhere in this guidance, further guidance on in and out-of-scope activities is outlined below.

In-scope activities and expenditure

For care finder organisations, the following are deemed to be **in scope**:

- care finder recruitment, on-boarding and training

- care finder staff wages/salaries, including on-costs

- assertive outreach in a group environment

- helping clients who are homeless or at risk of homelessness to connect with appropriate and sustainable housing (including by assisting them to locate, apply for and relocate to housing in an area suitable to their needs)

- domestic travel and motor vehicle lease associated with:

    o   assertive outreach and providing support at the place of the client's choosing

    o   establishing and maintaining relationships with local intermediaries

- catering and venue hire associated with assertive outreach

- IT infrastructure to support data collection and reporting, including upgrades and maintenance

- communication costs associated with care finder service delivery.

Out-of-scope activities and expenditure

The following are deemed to be **out-of-scope**:

- provision of support to people who are not within the care finder target population, noting the flexibility provided in *section 4.2* of this guidance

- delivery of aged care supports and services, as described in *section 5.3* of this guidance and which include hoarding and squalor services, to a client

- evaluation of care finder program activities, given an independent evaluator will manage a national and ongoing evaluation of the care finder program.

12.3   What flexibilities do PHNs have?

Flexibilities in relation to commissioning

Noting the requirement to offer existing ACH providers a contract as care finders from 2022-23 to 2024-25 and other matters addressed in this guidance, PHNs have flexibility to determine how care finder services across their region will be commissioned to best address local needs in relation to care finder support. This includes flexibility in determining:

- the number and type of care finder organisations in their region, including where care finder organisations are engaged through subcontracting arrangements

- whether care finder organisations in their region will focus on specific care finder target population sub-groups

- the workforce that will deliver commissioned services, taking into account considerations such as any specific care finder target population sub-groups being focused on and existing workforce supply/capability in their region.

While PHNs will commission care finder services within their region, they are encouraged to collaborate across regions, where appropriate, to achieve better outcomes for their respective communities. Particular considerations may be where:

- care finder target population sub-groups span multiple PHN regions

- care finder organisations operate across multiple PHN regions.

Flexibility in relation to service commencement

Care finder service delivery (i.e. delivery of services to clients) will commence **from** 1 January 2023.

Existing ACH providers who are contracted as care finders should commence care finder service delivery **on** 1 January 2023.

For remaining care finder organisations, a ramp-up period will be provided from 1 January 2023 to allow for service establishment (e.g. additional care finder recruitment and training that may need to be undertaken, establishment of data collection and reporting systems, and initial activities to promote and raise awareness of services). The ramp-up period for service establishment should conclude no later than 31 April 2023, when service delivery is expected to be available to clients.

Additional flexibility, beyond 31 April 2023, may be provided on a case-by-case basis. For example, additional flexibility may be provided in regions where workforce availability has presented significant challenges to service establishment.

12.4 What additional activities should be undertaken by PHNs, to supplement existing needs assessments, to inform implementation?

Prior to the initial commissioning of care finder services in their region, PHNs will undertake additional activities, to supplement their existing needs assessments, to identify local needs in relation to care finder support. These additional activities will provide the evidence base for each PHN's initial commissioning approach to care finders and will therefore determine the services that PHNs will commission alongside the existing ACH providers who will be offered a contract as care finders.

The additional activities that PHNs are expected to undertake to supplement their existing needs assessments should align with those undertaken as part of the needs assessment process more broadly and include:

- analysing the needs of their region in relation to care finder support

- analysing the distribution of potential care finder organisations and potential care finder workforce in their region

- analysing and identifying opportunities to enhance integration between the health, aged care and other systems in their region

- undertaking stakeholder and community consultation in their region

- determining the priorities to be addressed in their region in relation to care finder support and how they will meet the needs of all diverse groups that will form part of the care finder target population (noting some clients from diverse backgrounds will be less likely to engage with a care finder who does not come from a trusted organisation or similar background to them).

PHNs will submit a once-off report on the outcomes of the additional activities undertaken to supplement their existing needs assessments. Following this, PHNs will report on the outcomes of needs assessment activities relevant to the care finder program as part of their annual updated needs assessments.

12.5 What are the arrangements for the transition of the Assistance with Care and Housing Program to care finders?

As outlined in *section 12.1* of this guidance, PHNs will support a transition of the ACH program (with the exception of hoarding and squalor services) to the care finder program by:

- offering existing ACH providers a contract as care finders from 2022-23 to 2024-25

- quarantining an amount of funding, to be determined by the department taking into account existing funding received by ACH providers, to be used to contract ACH providers as care finders from 2022-23 to 2024-25.

The ACH program will not be a sub-program under the care finder program. Once contracted by PHNs, ACH providers will operate as care finders and will need to meet the requirements of the care finder program. Transition arrangements should ensure service continuity for existing ACH clients.

Arrangements in relation to functions and focus

As part of their functions, care finders may provide specialist and intensive assistance to help people who are homeless or at risk of homelessness to connect with appropriate and sustainable housing and other supports in the community targeted at avoiding homelessness or reducing the impact of homelessness. As outlined in *section 5.4* of this guidance, where appropriate, care finders may help a person to connect with other relevant supports in the community before they assist the person to access aged care. For people who are homeless or at risk of homelessness, this is particularly important in breaking down barriers that may impede their access to aged care.

When transitioning to the care finder program, ACH providers can continue to provide a specialist focus on clients who are homeless or at risk of homelessness. Alternatively, they may consider broadening their focus within existing funding to also include other/all care finder target population sub-groups. If an ACH provider is proposing to broaden their focus within existing funding, they should consult with their PHN to discuss local needs identified by the PHN in relation to care finder support.

If an ACH provider would like to broaden their focus outside of existing funding or wishes to otherwise express interest in receiving additional funding as a care finder organisation, they will need to be considered as part of the broader PHN commissioning process for care finder services in their region.

Arrangements following the initial commissioning period

On conclusion of the initial period from 2022-23 to 2024-25, PHNs will no longer be required to offer existing ACH providers a contract as care finders and have full flexibility to determine how care finder services across their region will be commissioned to best address local needs in relation to care finder support.

13 Program evaluation and reporting

13.1 What is the purpose of the care finder program evaluation?

An independent evaluator (Australian Healthcare Associates) will manage a national and ongoing evaluation of the care finder program. The evaluation will assess implementation, appropriateness and effectiveness. Findings will support continuous improvement.

13.2 What data collection and reporting requirements will PHNs and care finder organisations need to meet?

Data collection and reporting requirements will largely be determined by the information needed to monitor the progress of program activities and otherwise support the evaluation of the care finder program. Requirements will be set out in the PHN funding agreement and a minimum dataset, but will broadly include information on:

- number, type and geographic spread of care finder organisations
- number of care finder clients
- care finder services delivered
- care finder client outcomes
- training completed by care finders
- activities to assist in integrating the care finder network into the local aged care system
- activities to support continuous improvement of the care finder program
- activities to enhance integration between the health, aged care and other systems to address local level issues.

Ongoing reporting will include 12 monthly reporting by PHNs and monthly reporting by care finder organisations via the online reporting portal.

Care finder organisations will report aggregated data in the online reporting portal. To support this, care finder organisations will need to ensure that their IT infrastructure collects the raw data that is needed to inform reporting against the minimum dataset.

14 Useful resources

COTA Australia will be developing resources to support implementation of the care finder program, by sharing knowledge and lessons learned from the aged care system navigator trials. These resources will be circulated to PHNs, once available.

Appendix A: Access and navigation supports for senior Australians from January 2023

My Aged Care is the **consumer-facing entry point** to access aged care services, consisting of three channels. It is underpinned by the Aged Care Gateway ICT system, which includes a central client record and user portals.

Senior Australians and their support networks

My Aged Care

Consumer choice of channel

- Telephony — Contact Centre
- Face to Face — Services Australia Service Centres
- Digital — Website / GP e-Referrals

Consistent user outcome → Assessment

Australian Government funded navigation support helps people understand the process and use My Aged Care

Supplementary intensive navigation services:
- **Care finders**
- **Trusted Indigenous Facilitators**

Complementary specialist support:
- **Older Persons Advocacy Network (OPAN)**
- **National Dementia Helpline**
- **Carer Gateway**

Australian Government subsidised aged care at home and in residential aged care

Connections to other services to keep people safe and well:
- health
- housing support
- transport
- other government support
- community and social groups

Support type	My Aged Care			Supplementary support		Complementary support		
	Contact Centre (telephony)	**Aged Care Specialist Officer (face-to-face)**	**Digital channels**	**Care finders**	**Trusted Indigenous Facilitators**	**OPAN advocates**	**National Dementia Helpline**	**Carer Gateway**
Target audience	People who are comfortable/able to talk on the phone and need My Aged Care services	People who would prefer to talk face to face and/or want in depth financial information	People who have internet access and are comfortable/prefer to use online tools at a time to suite them	Senior Australians who need intensive support to access My Aged Care and services who would otherwise fall through the cracks	Aboriginal and/or Torres Strait Islander people who need intensive support to access services (who would like a Trusted Indigenous Facilitator)	People who need individual advocacy support in relation to aged care services they are receiving or arranging	People with dementia and their families	Carers of people who need aged care and other services
Role and functions	• Information about types of care available • Registering for services • Applying for an assessment and information about eligibility • Finding service providers and understanding costs • How to manage services • Follow up support for small proportion of clients (case co-ordination team)	• Same as Contact Centre • Identifying how a client's financial situation impacts the cost of aged care services • Connecting people to local community and external services where appropriate	• Self-service access to information and tools • My Aged Care website includes: eligibility checker; apply for an assessment online; find a provider; fee estimator and non-compliance checker • Client portal enables: viewing/ updating client information; and viewing assessment, wait time and services	• Assertive outreach and rapport building • Support through registration, screening and assessment and means testing • Support post assessment to access aged care and connect with relevant supports in the community • Follow up support if needs change or services have lapsed	• Support to understand the process to access services, what support is available, costs and their rights • Assisting clients in assessment, choosing a provider and when in care • Assist clients with other types of help	Individual advocacy providing: • Support to talk to aged care providers to resolve a problem or make a complaint • Information on general aged care navigation as needed	Linking to dementia specific supports e.g. counselling post diagnosis	Linking to carer-specific supports e.g. carer support groups

Proportion of clients supported through access channels and navigation from January 2023

Care finders will intensively support a small proportion of clients (approx. up to 38,000) who would otherwise fall through the cracks

Trusted Indigenous Facilitators will support approx. 60,000 Aboriginal and/or Torres Strait Islander people and their families

15 **case coordination staff** in the My Aged Care contact centre help resolve a point-in-time issue for approx. 4,000 clients a year

80 **Aged Care Specialist Officers in Services Australia** will support those who prefer to interact with My Aged Care face-to-face

The **My Aged Care contact centre** receives over 1.5m calls a year

The **My Aged Care website** has more than 4.2m visits a year

Intensive navigation

Access support

General access

Complexity of support needs and proportion of clients

Appendix B: The care finder's role in the client journey

Assertive outreach, engagement and rapport building	Support through registration, screening and assessment	Support post assessment to access aged care and connect with relevant supports	High level check-in to see if services are still in place and meeting client's needs	Follow up support if needs change or services have lapsed
• Make **connections with local intermediaries e.g.** in health/community sectors • **Make contact** with potential clients directly and via intermediaries • **Build rapport** with clients • Organise **interpreter/Auslan support** if needed • **Encourage** clients to consider accessing support if they are resistant • With client consent, **add information to** care finder organisation's **secure IT system** • Provide clients who are not in the care finder target population with **relevant contacts for other supports**	• **Continue to develop rapport** and reassure client about next steps • **Explain types of support** and services available (in any relevant sector) and processes to access services • With client consent **create My Aged Care client record** (if they don't have one) nominate self as their 'agent' • With consent, **help clients contact My Aged Care** or use the website to **apply for an assessment** online or call other services/fill in forms • Work with client to **arrange an assessment and attend** if the client wishes	• Support client **to follow up on referrals** made by the assessor **or find appropriate providers** e.g. on the My Aged Care website and help client review quality and costs information • Help **complete income/means testing forms** and calls to Services Australia • Set up appointments/**meet with providers**/visit aged care facilities with the client and **help them compare costs and quality** • **Call other support services** with client e.g. housing services • **Ensure they have understood** any agreements they need to sign	• **Call or visit** the client after the services are in place (regularity will be based on circumstances) • **Talk through any concerns** or issues client has experienced with services to prevent escalation to the point of client unnecessarily refusing services or being unable to receive them • **Proactively identify other services** that may support the client to maintain health and independence • Note: aged care providers are responsible for meeting client's changing needs. Care finders' role is to confirm this is happening **not duplicating provider roles**	• Help the client **take steps to resolve issues** e.g. call the provider (with the support of an advocate if required and if client consents and is comfortable or can refer to an advocate) • Work with the client to **arrange re-assessment** (if not identified by provider) or **set up new services** • Work with clients to **change services with existing provider(s)** if needed • **Support clients to find alternative provider**(s) if they are not happy with their services

Appendix C: Care finding from the client perspective

Care finding from the client perspective – focus on aged care services

Mary is 82. Her husband died 5 years ago and her 3 children have all moved away. She has deteriorating hearing and has been diagnosed as being in the early stages of dementia by her GP. Her GP has said she can get help through My Aged Care but Mary thinks this means she'll have to go into a home so has not called. She speaks to her children regularly but is not willing to admit she is having trouble keeping the house clean and has not told them about her diagnosis. She is less connected with her community than she used to be and is no longer confident to drive. She does not know how to use a computer or have access to the internet.

Assertive outreach, engagement and rapport building

- When Mary next visits her GP, the **GP asks if she'd like to be contacted** by someone called Louise from [named organisation] who could help her get some support to stay at home for as long as possible. Mary says OK.
- **Louise calls Mary and introduces herself** as the person the GP said would call and arranges a time to visit to talk about how she could help.
- Louise **visits Mary and they have a chat** over a cuppa. Louise tells Mary about herself and what she would like some help with.

Support through registration, screening and assessment

- Mary says she could do with some help to keep the house clean and tidy and Louise says **she might be able to get some help with cleaning.** She asks if Mary would like to see what she is eligible for. Mary agrees.
- They **complete the apply for an assessment online form together** on Louise's ipad and Mary is happy to **nominate Louise as her 'agent'.**
- **Louise asks Mary if she would like her to be there at her assessment** and Mary is keen to have her there. She is assessed as eligible for transport and social support

Support post assessment to access aged care and connect with relevant supports

- **Mary completes the means test form with support from Louise** at her home and they call Services Australia together to work out answers to some questions.
- They **look for local providers together on the My Aged Care website** and make appointments for them to visit. **Louise helps Mary choose providers and understand the agreements she needs to sign.**
- They also **call the National Dementia Helpline together** and learn about a local support group for people living with dementia.

High level check-in to see if services are still in place and meeting client's needs

- After a month **Louise calls Mary to see how things are going.**
- Mary says the transport to the social group is working well but **doesn't like that she gets different care workers** each visit and they don't come at the time they say they will. Last week she cancelled the service.
- Louise arranges a time to visit Mary and they talk about Mary's concerns. Mary says she is having trouble with keeping the house clean and tidy. Louise **suggests they could talk to the provider** about the issues and Mary agrees.

Follow up support if needs change or services have lapsed

- They call the provider but they can't resolve the issue.
- Louise **asks Mary if she'd like to be put in touch with an advocate** to help but Mary doesn't want to talk to anyone else.
- Louise **suggests Mary could change to a different provider** and Mary agrees.
- They **call one of the other providers in the area** who promises to send only 2 different care workers and to be on time. They set up the service together.
- Louise **checks in again a few weeks later** and all is going well. She checks in around every 3 months after that.

Care finding from the client perspective – focus on other relevant supports in the community

John is 66. He has experienced mental health issues all his life, has not been able to work for many years and has lived with his sister most of his adult life. His sister is in her seventies and has recently moved into residential aged care and given up her rented flat. He doesn't have any financial support from the Government as he is afraid of them knowing his business but his sister can no longer support him. He has moved in with an old friend as a short-term solution but she doesn't have much space.

Assertive outreach, engagement and rapport building	Support to access aged care connect with relevant supports	Support through registration, screening, assessment and setting up aged care services	High level check-in to see if services are still in place and meeting client's needs	Follow up support if needs change or services have lapsed
• John's friend calls the local council and explains John's circumstances, without giving his name, and asks about how he can get more permanent housing. She is **given the number of a local care finder** organisation. • She calls and describes the situation. A care finder called **Pete calls her back and offers to talk to John**, if he agrees. • John agrees to talk on the phone and is reassured that Pete says **he doesn't need to give any personal information** if he's not comfortable. • After many conversations, including at his friend's place, **John says what he wants most is help to visit his sister at her care home regularly**	• Pete says John can get transport through My Aged Care but, while they're arranging that, **a volunteer from his organisation can drive** him there. • John is really happy about this and soon after agrees **to reconnect with his GP** for a medication review. A few weeks after seeking support from his GP, John is feeling well and is **interested in accepting more help.** • Pete **helps him apply for financial support** through Services Australia and **social housing**. This takes some time as **John remains fearful** of providing information. • Eventually John moves into a **social housing property.**	• Pete suggests John might benefit from some further support, such as **help with cleaning and a social group.** • **John is wary** of people coming into his space but acknowledges he would like the help and to have more company. • They **apply for an assessment on the My Aged Care website** together and Pete promises he will be there when the assessor comes. Pete **ensures the assessor is aware of John's fears** before the meeting. • After the assessment Pete helps John **contact local providers** and over a few months gets the services organised.	• After a couple more months Pete calls John to see how he is going. • John is still living in the apartment but is **no longer getting cleaning or going to the social group.** • Pete **offers to come round to talk about it.** When he gets there John says the cleaner stopped coming and he doesn't know why. • Pete **calls the provider** and is told the apartment is too cluttered and dirty for the cleaner. • John says he only went to the support group a couple of times because he **had nothing in common** with the other people.	• With John's consent **Pete arranges a deep clean of the apartment** through a hoarding and squalor specialist provider and they then **work with John on strategies** to avoid getting into the same situation. • Pete also **talks to the cleaning provider about coming more frequently** and helping John to decide what to throw away at each visit. • Pete **explores other options for community support** and puts John in touch with a local **Men's shed.** John thinks this will be a better fit for him. • Pete **stays in regular touch** with John and helps adjust his support as needed.