Charles Darwin University

Evaluation of the EnCOMPASS: Muticultural Aged Care Connector Program Final Report

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CHARLES DARWIN UNIVERSITY AUSTRALIA

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Executive summary

This evaluation project was conducted by Charles Darwin University on behalf of the Federation of Ethnic Communities' Councils of Australia (FECCA) and the Commonwealth Department of Health and Aged Care. The project aimed to evaluate the EnCOMPASS: Multicultural Aged Care Connector (EnCOMPASS Connector) program – a partnership between FECCA and 23 local community organisations to provide navigational support to older people of Culturally and Linguistically Diverse (CALD) backgrounds and their communities to access the aged care system (My Aged Care) and other supports through a dedicated network of support navigators called Connectors. My Aged Care is the Commonwealth Government's organisational structure and set of systems and processes that screen and assess older persons' eligibility for support services provided by the Australian aged care system and then facilitate access to these services.

Connectors were employed by 23 organisations across 29 sites in all states and territories. The evaluation aims to evaluate both the EnCOMPASS program itself and to inform the Care Finder program, a new aged care navigation program implemented by Primary Health Networks (PHNs) and with a broader remit than older persons from CALD backgrounds. The evaluation may also inform other FECCA programs and other care navigation programs in general.

The evaluation used realist methodology, aiming to explain how, why and for whom the EnCOMPASS Connector program worked, and did not work. Hypothesised program theories were developed with key informants from the program, and these were tested in interviews and with reports written and data collected by sites delivering the program. Quantitative data provided by sites included client (older person/carer) demographics, occasions of service provided to clients, and community awareness and development activity in relation to the program. The sites also provided time and costs data in relation to Connectors' time spent on different program activities. Analysis of all data sources against the hypothesised program theories informed refinement of the program theories, resulting in 18 refined theories that provide plausible explanations for the program's success and limitations.

The evaluation project also included an assessment of the program's value for investment using a rubric developed for the project. The Value for Investment rubric allowed for transparent decisions on the program's performance in relation to equity, effectiveness and efficiency.

Key findings

Client profile

There were 6,505 clients (including older persons and carers)[1] registered with the EnCOMPASS Connector program between January and December 2022. Of those, 1,304 (1,038 older persons and 266 carers) gave permission for their information to be shared with the evaluation team.

Of the 1,038 older persons, almost all were aged 65 years and above, and there were 1.75 times as many females as males. Around 38% of older persons were of Asian ethnicity and 27% of European ethnicity. Over half (55%) spoke an Asian language.[2] Around 35% had a refugee background. Of those whose year of arrival was recorded, 60% had been in Australia for 20 years or more, while around 28%

[1] Advised by FECCA, 29 March 2023.

[2] Ethnicity and language classifications are based on ABS level 1 ethnic and language groups. These groupings put Middle Eastern languages in the Southwest & Central Asian language category, but people of Middle Eastern ethnicity are included in the North African & Middle Eastern ethnic group. This is the main reason why the proportion of clients that speak an Asian language is substantially higher than the proportion of clients of Asian ethnicity.

had been in Australia for less than 10 years. Around 70% of older persons had challenges with English and required a bilingual Connector, other worker, or interpreter in at least some settings.

Around 96% of older persons had at least one known health issue and around 73% had two or more health issues. Two-thirds of older persons had at least one known impairment. Almost all were eligible for Medicare – of those with eligibility recorded, around 98% were eligible. Almost two-thirds of older persons had a support person available who could assist them. Self-referral was the largest single source of referrals, accounting for 28% of older persons, with carers accounting for a further 17%.

There were 266 carers registered with sites. Around two-thirds of carers were aged under 65 years. Over two-thirds (68%) were female and 40% were from a refugee background. Around 62% of carers required a bilingual Connector or other worker, or interpreter, and almost half spoke an Asian language.

Outcomes for clients

A 'complexity index' was calculated for use in some analyses. Among older persons where overall complexity could be assessed, 52% were rated as medium complexity (with three or four health issues, impairments, or other issues that may have increased their support needs), 39% high complexity (five or more issues), and only 9% low complexity (fewer than three issues).

Older persons with higher complexity were more likely to be referred to My Aged Care and for their case to remain open at the end of 2022, while those with lower complexity were more likely to be referred to another service and for their case to be closed.

The support of clients was found to operate through four incremental phases. These were the Connector's engagement of the client, working with different levels of client readiness, making the My Aged Care connection work, and getting the most out of aged care services. Each of these phases is represented by two refined program theories explaining different patterns of outcomes for clients.

Connector's engagement of the client

- *Bicultural engagement creates high rapport*

Connectors who were from the same community and spoke the same language as their clients (had inherent cultural knowledge) or those who were able to access relevant cultural knowledge and language support from colleagues within their employing organisation were most successful in engaging clients. When combined with a proactive and responsive approach, and persistence in engaging clients, the Connectors were able to show respect for culture, develop interpersonal warmth, and communicate clearly with the client. In response, the client felt respected and understood, and the outcome was high rapport with, and trust of, the Connector.

- *Engagement via interpreter creates low rapport*

Engagement of the client was less effective when the client did not speak English and the Connector did not speak the client's language or understand their culture (and there was not a bicultural colleague available). Use of professional language interpreters (in-person or via telephone) did not establish the same level of rapport and trust with older persons and/or their carers. When working with an interpreter, there was a lack of emphasis on the relationship or interpersonal warmth and, in response, the client felt less personal connection. This instrumental interaction resulted in a superficial or weak engagement of the client.

Working with different levels of client readiness for aged care services

- *Cultural rapport is critical when need is high but readiness low*

When a client did not feel ready to engage with the aged care system but was likely to be eligible (had the need), high rapport with the Connector enabled the Connector to influence the client's readiness. Low readiness could be due to any of a range of factors such as:

- misunderstandings about aged care (thinking aged care was only residential care);
- a reluctance to accept help from people they did not know and trust;
- grieving the loss of independence;
- stigma about particular illnesses or conditions;
- views about having outside help, including that adult children should provide care;
- an older person and carer having different views, wants and needs;
- worry about the costs of support;
- concerns related to disclosing income and assets to the government; or
- hearing about others' negative experiences with aged care services.

In such cases, and when rapport had been established between the older person and/or carer and Connector, the Connector provided personalised care and attention, including gentle and respectful challenging of cultural beliefs and perceptions and providing information, stories of others' positive experiences and encouragement so that the client better understood and accepted their need for support and registered with My Aged Care. If, however, there was low rapport and the client felt misunderstood or that services could not provide what they needed, the Connector was unable to influence this and the client declined offers of support and disengaged.

- *Rapport is not critical when readiness is already high*

Conversely, when a client's readiness was already high and the Connector was able to provide comprehensible information in the client's language, the client was able to act on the new knowledge – either by registering themselves with My Aged Care or accepting support from the Connector to do the same. Strong rapport was not essential to this process.

Making the My Aged Care connection work

- *High rapport is critical for high complexity*

In situations of social or medical complexity, rapport between the client and Connector, and the Connector's persistence and commitment, were important for successfully connecting with My Aged Care. These enabled timely and personalised support, information exchange, and advocacy by the Connector across multiple episodes and over time.

Sometimes connecting a client to My Aged Care required the Connector to assist them with administrative processes with other government departments and systems. Connectors assisted older persons / carers with interpreting letters, completing forms or attending appointments at Centrelink. This also helped rapport and reduced complexity.

A Connector's persistence and commitment were important for checking progress, troubleshooting, jumping through bureaucratic hoops in English,[3] and ensuring the process was still moving. In response, the client felt assured knowing that the Connector was across everything, felt buffered from harsh, unclear and inflexible interactions with My Aged Care, knew what was coming next, and was encouraged to see the My Aged Care registration and assessment processes through. Connectors also helped clients honestly articulate their needs so that the assessment outcome would be a true reflection of need.

- *Low need, low complexity but preparing for the future*

When an older person had low English proficiency and low (current) need for aged care services but an interest in registering with My Aged Care in preparation for the future, Connectors provided language and communication support for My Aged Care registration. This support helped older persons feel

[3] No Connectors or clients referred to translated written materials provided by My Aged Care. For findings related to the use of language interpreter services see section 3.3.1.2.

informed and secure, and prepared for the future. Clients also knew that they could re-contact the Connector any time their needs changed.

Getting the most out of aged care services

- *Hanging in there with the client*

For clients with immediate need for support, the wait for an assessment and subsequent service delivery was frustrating due to low certainty and low accountability. Clients were left waiting for unknown periods of time, and the Connector had no or limited authority to directly check with My Aged Care on the process or to expedite it. For this reason, Connectors typically 'held onto' clients and stayed in touch until assessment was completed and services were in place. Connectors found if they did not do this the process was likely to break down.

- *Where Connector capacity ends, the aged care system often fails older persons and carers*

It was commonly found that where a Connector's influence ended, clients were failed by the system. For many older persons / carers, services were not available (they did not exist or could not meet the local demand), there were surprising and impractical limitations to the services (for example, cleaning services that required older persons to move their furniture before the cleaning), services were unreliable (frequently changing booking times) or inconsistent (with high staff turnover so that the clients needed to meet and brief a new person every visit), or the co-payments for services were more costly than anticipated. Some clients found the unreliability and inconsistency so disruptive and distressing or the cost so prohibitive that they cancelled the service they were eligible for and went without it. When appropriate services were not forthcoming, clients generally understood that the problem was not due to the Connector – that the Connector had tried their best in constrained circumstances. However, for some clients, this was not enough. Even when the Connector was kind and tried their best, if the process did not result in the receipt of needed services the client saw little point in the Connector's work.

Program implementation

Three key elements of program implementation were identified. These were: Connector capacity building; flexible, co-designed delivery; and stakeholders with reach to older persons from culturally and linguistically diverse communities. Each of these is explained by refined program theories.

Connector capacity building

- *Capacity development through training*

Training provided to Connectors afforded them opportunities to gain knowledge required for the role. It also provided consolidation and reflection time and an opportunity to share with others, which increased common understanding of how best to support clients in a culturally responsive, safe and respectful manner. Connectors with formal training and past experience in the field benefited least from the training. Connectors who started later in the program were able to watch recordings of past trainings and speak with program administrators, but also felt pressured to get up to speed with their skills and knowledge.

It was common for Connectors to view their training on 'Understanding Australia's aged care system' as inadequate, saying it needed to be more practical and provide more transparency in relation to working with My Aged Care, the client screening process, assessment, and details about the aged care service system including the fee structure.

- *Learning on the job*

Due to the low transparency of My Aged Care processes and many Connectors not having past experience working in the aged care system, much learning was through trial and error, and learning from experienced staff within their employing organisations (see pages 56–57 for details).

- *Community of Practice*

The Community of Practice (CoP) established by FECCA provided opportunities for peer learning, collective problem solving, and collegial support and validation of shared challenges. The CoP meetings also generated increased awareness and ideas for good practice. Hearing from others, collegiality and validation of concerns and frustrations made the Connectors feel connected with others. They also felt validated that the role could be challenging and were provided assurance that they should not take the challenges personally or as a reflection that they were not good at their role. This gave Connectors motivation to persevere with difficult situations.

Flexible, co-designed delivery

- *Flexible KPIs and enough time*

As the Connector program was new and did not have any profile within the community, the KPIs recognised that time and resources were required for community development and they were flexible enough to enable Connectors to focus on what was most needed for their community. Some of the employing organisations and Connectors understood why the KPIs were not as directive as other programs and they embraced working flexibly. They also had the time and resources required for both community engagement events and client case work. This provided a supportive environment for Connectors to work autonomously, balancing client and community work as they saw fit. However, where employing organisations imposed additional KPIs, or Connectors were part time or had too many target communities to support, Connectors were unable to balance both aspects of the role.

- *Co-design of culturally appropriate approaches*

When Connectors or their employing organisations had existing positive relationships with target communities and the Connectors had the time and resources to develop marketing and engagement approaches with them, they were able to design nuanced marketing and engagement approaches. However, engagement preferences and techniques were ever-evolving and Connectors continued to learn and develop their understanding of community preferences, recognising that all communities would require multiple strategies.

Stakeholders with reach to older persons from CALD communities

- *Expertise and networks of employing organisations*

Many of the employing organisations had experience supporting older persons and a good reputation with and connection to local CALD groups and clients. Where a Connector had time and capacity to support their organisation's existing clients, the Connector built relationships and trust with other staff in the organisation through reciprocal working relationships. This gave the other staff increased awareness of the EnCOMPASS Connector program and an understanding of how it could benefit their existing clients and networks. With such trust and awareness, staff in the employing organisations referred existing clients and networks to the Connector. Leveraging the connections of the organisation and existing staff was most useful where the Connectors did not have their own existing relationships with target communities prior to commencing the role.

Within some organisations, the referrals also went in the opposite direction, with the Connector referring clients into the organisation's other services (such as social support services). This was especially valuable when clients were not yet eligible for aged care services or were waiting for their assessment or receipt of services.

- *Linking with other CALD organisations*

Multiple factors were necessary for Connectors to be able to work with other CALD organisations. The Connector's employing organisation needed a good reputation and existing relationships with CALD organisations, the Connector needed specialist knowledge of the aged care system and dedicated time to engage CALD communities, and the Connector needed to be experienced by clients as being culturally

responsive and safe. In these circumstances, Connectors were able to best promote the program and provide value to these other organisations.

Provision of community education and awareness sessions was a significant component of linking with other CALD organisations and groups. A total of 369 community outreach sessions were reported by participating sites as being led or attended between January and November 2022. On average, a site received around one inward referral per week in weeks where no outreach sessions were held compared to 3.6 referrals in the seven days following a 'townhall' session and 2.9 referrals in the seven days following other types of sessions. However, the pattern varied significantly across sites and the overall impact of community outreach activities on inward client referrals was unclear.

- *Health professionals 'buy in' and refer in*

For some older people, general practitioners (GPs) and other health professionals were trusted sources of information from whom Connectors could seek referrals. When Connectors were employed by well-known organisations, were highly trained, competent, and proactively promoted the program to health professionals they were able to build relationships and promote the program to them. The health professionals saw the value of referring their clients.

However, accessing GPs can be difficult. Analysis of client referral sources found that only 2.6% of clients were referred to the program from GPs or other health professionals, although it is unknown whether and how many self-referred older persons or carers were first told about the EnCOMPASS Connector program by health professionals.

- *Community leaders engaged and endorsing program*

The importance of community leaders was evident across the program. However, the way the Connectors identified and defined community leaders varied, from those in formal positions such as faith leaders to informal community leaders. Community and faith leaders (referred to as 'Touchpoints' within the program) were often a trusted, credible source of information for CALD community members. When Connectors or their employing organisations had existing (or built new) relationships with community leaders, and the leaders saw aged care as a community priority, the leaders engaged with the program by attending community events and meetings about the program. This enabled them to see the Connector in action and determine their level of credibility. If the Connectors were deemed credible and trustworthy, and the program relevant, the leaders endorsed the program, granted access to their community, and referred older persons and carers to the program.

Community leaders were often in demand, very busy, and in volunteer roles, which made it difficult to engage them. However, Connectors believed it essential to put in concerted time and effort to build relationships with community leaders, and that rushing this would not allow the building of trust.

- *Clients become program champions*

Word-of-mouth between older persons and carers was found to be a powerful promotion mechanism. When a client had a positive experience with a Connector and knew other people who may benefit from the Connector's support, they championed the program. Other older persons and carers valued the recommendation from known and trusted peers. However, word-of-mouth was also a powerful deterrent or barrier when negative experiences were shared.

Time and tasks of Connectors and other staff

The time and task snapshots showed that client support made up just over a third (36%) of the overall workload of Connectors, followed by community education and outreach (25%). When client support was analysed separately, time spent on direct client contact was less than half of a Connector's client support workload, and more than half their workload was spent on indirect work associated with supporting clients.

For community level work, 28% was provision of community education and outreach, with the remainder spent on behind-the-scenes preparation and travel. In some cases, this preparation also involved community engagement in the form of co-design and collaboration with older persons.

The time and task snapshots also revealed the contribution of other workers within employing agencies to the program. Time for other staff members (that is, aside from Connectors) was recorded for 31% of tasks recorded by all sites during the two snapshot weeks combined. It was more common for other staff members to be involved in community outreach and network meetings tasks than with client support or other tasks.

Across all sites combined and both snapshots, around 45% of the recorded non-Connector time was for tasks relating to community education and development, and 25% was for client support tasks. While it was relatively common for non-Connectors to be involved in network meetings and professional development, the total amount of non-Connector time recorded for such tasks was relatively small, most likely reflecting that not all sites did such activities during the snapshot weeks.

Value for investment

The grant to FECCA for the EnCOMPASS Connector program overall was $9.74 million (exclusive of GST). Value was created for several stakeholder groups in different ways, including:

- for older people, linkages to My Aged Care and other services, resulting in increased ability to remain at home, reduced stress and improved quality of life;
- for carers, reduced pressure to meet all of the older person's needs;
- for older people and carers, information and referral services resulting in improved understanding of current and future options;
- for Touchpoints and CALD organisations, increased understanding of the Australian aged care system and greater capacity to support older people and their families;
- for CALD communities, tailored information resources in their own languages;
- for providers of navigator programs, increased understanding of the requirements for effective programs in CALD communities;
- for providers and funders of navigator programs, more accurate estimates of the time required to undertake particular aspects of the navigation role, and development of a rubric to support evaluation;
- for EnCOMPASS Connectors, a period of paid employment and experience and skills to apply for future related employment; and
- for the Commonwealth Government, improved access for a vulnerable community to an important area of service provision (that is, meeting its obligations and promises).

Analysis in relation to formal theory

The EnCOMPASS Connector program was designed to help older persons and their carers to access aged care support services. Analysis of the evaluation findings against the *Conceptual framework of access to health care* (Levesque et al., 2013) has assisted understanding of the EnCOMPASS Connector program's strengths and limitations.

The framework conceptualises health service access as a dynamic interplay between demand-side (client) and supply-side (health system) factors. Health service demand comes from an individual's capacity to demand care, including their 'ability to perceive', 'ability to seek', 'ability to reach', 'ability to pay', and 'ability to engage'. Corresponding dimensions on the supply (health service) side are the 'approachability', 'acceptability', 'availability and accommodation', 'affordability', and 'appropriateness' of services.

The EnCOMPASS Connector program was found to be effective in increasing the ability of older persons and carers to perceive, seek, reach, and engage with My Aged Care and aged care support services. It did not affect their capacity to pay for services.

Some clients and carers were assisted to connect with My Aged Care and received services that were approachable, acceptable, available, affordable and appropriate *enough* to warrant keeping them. In some cases, Connectors were able to influence the provision of services by recommending services known to be of better quality, or by negotiating with service providers about client needs. However, in most cases, the Connector had no influence over services. Some clients made it clear that they had traded off the pros and cons of the services, and decided that they were not (due to low acceptability or affordability, for example) worth the effort and expense of keeping them.

Most significantly, the program was not able to influence the multiple barriers experienced within My Aged Care itself, some of which are identified in this report and its recommendations.

Recommendations

The following recommendations are addressed to different actors within aged care navigation and support and the broader system they connect to, to ensure a comprehensive approach.

Recommendations for program implementers

Ensure comprehensive training opportunities for aged care navigators

Program implementers should continue to ensure training opportunities are provided. Areas suggested by participants in the evaluation included cultural safety, co-design, women's health, intersectionality, dementia awareness and person-centred approaches. Further training opportunities may be required in report writing, designing and delivering community events and community engagement, and working with clients whose expectations are hard to meet. More comprehensive and practical training on My Aged Care should also be provided to support navigators to understand the My Aged Care assessment processes more thoroughly, to ensure they have the insight and confidence to support and guide their clients through the registration and assessment processes.

Provide peer-learning and engagement opportunities for navigators

Program implementers should ensure regular, structured Community of Practice peer-learning opportunities to support navigators to build peer networks and learn from each other's experiences. Meeting days and times should be varied to enable accessibility for part-time workers and those outside dominant time zones. Providing ample advance notice (e.g., four weeks' advance notice) for meetings is also essential to ensure navigators can prioritise them and schedule community events and client meetings around them. Meetings should focus on shared/common issues that can be workshopped as a group, and meetings should be long enough to allow enough time for all participants to contribute.

Provide flexible KPIs to support a place-based approach

Program implementers should continue to commission programs with flexible KPIs to ensure that navigators can work in a flexible and responsive manner based on the needs of their local communities. Funders should also work closely with employing/host organisations to ensure they understand why flexible KPIs are in place and the importance of not adding internal KPIs which may detract from navigators' ability to build the necessary trust within their communities.

Commission organisations that are known and trusted by CALD communities

Program implementers should seek to commission organisations who are trusted and respected by local CALD communities. These organisations should have existing networks into CALD communities.

Whilst not optimal, where the organisation does not have existing connections with local CALD communities it is imperative to provide them with the time and resources needed to build such networks.

Retain existing EnCOMPASS Connector staff and transition them to Care Finder roles

The program implementers should investigate the possibility of retaining staff when programs transition. In the case of the EnCOMPASS Connector program, this would ensure the relationships built to date are not lost and that the Care Finder or other program staff would have existing relationships with CALD communities.

Evaluate at the whole of program level

Monitoring and evaluation processes and indicators should be developed at the whole of program level to enable consistency and aggregation of findings across the program. Contribution of data to monitoring and evaluation processes should be a requirement for all employing organisations.

Recommendations for employing organisations

Understand the need for culturally safe practice, respect the flexible KPIs and support Connectors to work in a flexible manner

Employing organisations should understand and support culturally safe practice and recognise the need for time to be spent building trust within the local CALD communities. Employing organisations should understand and support the use of flexible KPIs to support trust building within local CALD communities.

The employing organisation should work intensively with navigators in the early stages of the program to build their comfort around working without directive KPIs and provide guidance and support that reiterates the need to be flexible and adaptable to local needs.

The organisation should also develop ways of assessing navigator performance that do not depend on KPIs (such as the number of clients seen) as this may detract from the flexibility to perform the role in the manner most suitable for the local communities.

Recruit the right navigators and support them to develop skills and connections

Employing organisations should look to recruit and retain staff who have existing CALD networks within their local community, and where possible are from the same culture and speak the same language as the main local CALD communities. They should also look to employ staff who have experience in aged care and/or working with CALD communities. Additionally, employing organisations should have the workforce capacity to provide internal mentoring and support to navigators from people who are highly experienced in the field and/or who work in similar roles. Lastly, employing organisations should support navigators to engage with their local CALD networks by providing warm introductions and endorsement.

Remunerate community leaders

Employing organisations should allocate funding to ensure community leaders are appropriately remunerated for their time and expertise.

Recommendations for navigators

Prioritise and enhance stakeholder networks

Navigators should prioritise the building of networks with stakeholders who will support them to connect with CALD communities. Navigators should make a concerted effort to work with CALD service providers to build trust that the navigator's host organisation will not take clients from them and that clients can be safely referred.

Prioritise and enhance program promotion

Navigators should promote the program amongst CALD communities, continually looking for opportunities to enhance the frequency and reach of promotion. Navigators should also use national networks (such as PHNs) to promote the program to GPs and other health professionals who are networked nationally.

Navigators should prioritise promotion of the program to groups who had lower engagement with the EnCOMPASS Connector program, such as newly arrived communities.

Recommendations for My Aged Care[4]

Increased integration with My Aged Care

My Aged Care should investigate ways of integrating Care Finder with My Aged Care, to provide navigators with increased recognition and authority within My Aged Care, including access to the My Aged Care portal to allow tracking of referrals.

Improve the My Aged Care phone system

My Aged Care should improve the functioning of their phone system to reduce the number of dropped calls and have processes in place where if a call is dropped the My Aged Care worker calls the client back immediately so they do not have to re-start their screening process with a new staff member. My Aged Care should also change how their phone number is listed on caller-ID so it is not displayed as a private number. This would allow CALD clients to save the number in their phone so they can recognise the caller and not avoid answering the calls for fear they are scam calls. My Aged Care should also employ a process whereby they send a text message (in the client's preferred language) to older persons / carers, providing advanced notice for phone calls and letters.

Improve the transparency of My Aged Care assessment questions and process

My Aged Care should provide greater transparency around assessment questions, processes and criteria. Information should be available to navigators and clients about the assessment process, including a list of assessment questions to help older people to prepare for their assessment.

Improve the cultural safety and responsiveness of My Aged Care and its staff

My Aged Care should immediately review and improve the cultural appropriateness of the service as a whole. All staff should be provided with cultural competency and safety training as well as training in appropriate interpreter use.

All communications (including phone calls and letters) with CALD older persons should be in the older person's recorded first language. Client files should be reviewed in advance of calls and where a client's preferred language is not English, the My Aged Care staff should engage an interpreter to ensure their first interaction with the older person/carer is in their preferred language. Letters from My Aged Care should be sent to clients in their preferred language, not in English.

My Aged Care should prioritise the employment of staff from CALD backgrounds, and increase the diversity of languages spoken by My Aged Care staff.

Recommendations for the aged care service system

Increased capacity, availability and transparency of aged care service provision

The aged care service system should investigate and plan for increasing the number and spread of Home Care Package providers and community health service providers, to increase older people's access to services and reduce wait times. Supply and availability are important elements of accessibility, which is an aspect of service quality. Service providers should be required to increase transparency regarding costs of services and co-pay requirements.

[4] Department of Health and Aged Care reviewers suggested that many of the recommendations in this section had been addressed with the introduction of IT for My Aged Care and the Learning Management System. However, these recommendations arose from the findings of the current evaluation and have been retained to be faithful to those findings.

Increased capacity and availability of culturally diverse aged care service providers

The system should support the establishment of more CALD service providers and increased diversity of languages spoken by staff working in aged care services to enhance accessibility.

1 Introduction

In February 2021, the Commonwealth Department of Health and Aged Care engaged the Federation of Ethnic Communities' Councils of Australia (FECCA) to implement the EnCOMPASS Connector program, a dedicated network of support navigators, called Connectors, to assist older persons from culturally and linguistically diverse (CALD) backgrounds and/or their carers to connect with My Aged Care. My Aged Care is the Commonwealth Government's organisational structure and set of systems and processes that screen and assess older persons' eligibility, and then facilitate access to support services provided by the Australian aged care system.

FECCA sub-contracted 23 organisations across 29 sites in all States and Territories to employ EnCOMPASS Connectors (navigators) and deliver the program in locations with high CALD populations. The following list shows contracted organisations:

Australian Capital Territory

Multicultural Communities Council of Illawarra

New South Wales

Southwest Sydney

Western Sydney Migrant Resource Centre

Cass Care

Multicultural Care

Western Sydney

Cass Care

Multicultural Disability Advocacy Association

Islamic Women's Association of Australia

Southeast Sydney

Ethnic Community Services Cooperative

Advance Diversity Services

North Sydney

Australian Nursing Home Foundation

Illawarra

Multicultural Communities Council of Illawarra

Inner West

Co.As.It. Italian Association of Assistance

Victoria

Southern Metro

Southern Migrant and Refugee Centre

Loddon-Mallee

Sunraysia Mallee Ethnic Communities Council

South Australia

Metro North

Australian Refugee Association

Metro East

Multicultural Communities Council of SA

Metro West

Multicultural Communities Council of SA (previously with Uniting SA)

Riverland/Mallee

Multicultural Communities Council of SA (previously with Uniting SA)

Tasmania

Northern/Northwestern

Migrant Resource Centre Tasmania

Southern

Migrant Resource Centre Tasmania

Western Australia

Metro

Multicultural Services Centre of Western Australia (MSCWA) (previously Metropolitan Migrant Resource Centre)

Chung Wah Association

Umbrella Community Care

Southwest

Multicultural Communities' Council of WA

Northern Territory

Darwin

Multicultural Council of Northern Territory

Queensland

Metro North/ Metro South/West Moreton

World Wellness Group

Inala Community House

South Coast/Logan River

Islamic Women's Association of Australia

The program includes support to individuals (CALD older persons and their carers seeking to access the aged care system), development of resource materials in different languages, and increasing CALD

community awareness of the aged care system and how to support people to access required services. The latter is undertaken through network building with 'community influencers' and 'Touchpoints' (such as faith or other formal or informal community leaders) to develop their capabilities as part of an 'ecosystem of care' in CALD communities.

The EnCOMPASS Connector program commenced in July 2021, with all sites contracted by August 2021 and operational by October/November 2021. The program ceased in June 2023 after the commencement of a new aged care navigator program called Care Finder, in January 2023. Care Finder is implemented by Primary Health Networks (PHNs) and has a broader remit than older persons from CALD backgrounds. The transition of EnCOMPASS Connector program activity and transfer of knowledge between EnCOMPASS and PHNs occurred between January and June 2023.

CDU was contracted to evaluate the EnCOMPASS Connector program to inform Care Finder, other future FECCA programs, and other care navigation programs.

1.1 Evaluation questions

The overarching evaluation question was:

For whom, in what contexts, in what respects and to what extent has the EnCOMPASS Connector program worked (and not worked), how and why, at what cost, and creating what value?

Individual sub-questions included:

1. What outcomes have been achieved, to what extent, for whom (including the most vulnerable) and in what contexts? (Positive & negative, intended & unintended.)
2. What mechanisms have caused what outcomes, in what contexts? What contexts prevent intended mechanisms from operating?
3. How well has the EnCOMPASS Connector program been implemented? What variations in implementation have affected outcomes, in what ways? What elements/aspects of implementation are necessary to generate intended outcomes, and why?
4. What value has been created, for whom, in what contexts, at what cost? What factors affect the costs of achieving outcomes for different groups or in different contexts?
5. What lessons and implications can be drawn from the program for scaling of effective navigator programs for CALD older persons and their carers?

1.2 This report

This report presents the methods and findings of the evaluation of the EnCOMPASS Connector program. The results contain responses to the evaluation questions along with a set of program theories that detail the situations where the program works effectively, less effectively, or not at all for older persons and/or their carers supported by EnCOMPASS Connectors. The report synthesises the findings using a formal theory, the *Conceptual framework of access to health care* (Levesque et al., 2013), and assesses the program's value for investment. It also presents suggestions for the Care Finder and other navigator programs designed for people from diverse cultural and linguistic backgrounds, and/or for older people. Many of its findings and recommendations are also likely to be relevant for navigator programs for other vulnerable or at-risk groups.

2 Methodology and methods

2.1 Realist evaluation methodology

This study used realist evaluation methodology, which aims to identify how, when, and for whom a program works – and does not. Realist evaluation recognises that programs do not directly cause change but rather provide resources and opportunities to which "actors" respond in different ways based on their reasoning, which is shaped by context (social, material, cultural, economic and individual). These interactions between resources and reasoning are known as program mechanisms (Pawson & Tilley, 1997).

The realist evaluation cycle of inquiry starts with the development of hypothesised program theories structured as Context-Mechanism-Outcome (CMO) configurations, followed by the collection of data to test the theories. The theories are tested and refined, resulting in plausible explanations for how, when, and for whom the program works (and does not work) (Pawson & Tilley, 1997).

2.2 Theory development

Sixteen hypothesised program theories were developed from workshops with key informants for the program, in September and October 2021. Hypothesised theories 1 to 7 were in relation to older persons supported in the program, theories 8 and 9 were about carers, 10 to 12 were about cultural networks/organisations with reach to older persons from CALD communities, 13 and 14 were about Touchpoints (defined in this project as individual community leaders with reach and influence in CALD communities), and 15 and 16 were focused on Connectors. The hypotheses are available as Appendix 1.

2.3 Data collection

Qualitative and quantitative data were collected to test the hypothesised program theories.

2.3.1 Interviews with clients

Realist interviews were conducted with current and past clients of the program, both older persons and carers. The clients were recruited via Connectors working in the program. Connectors were asked by the evaluators to invite clients who:

- had a positive outcome and a smooth experience in working with a Connector;
- had achieved a good outcome in the end but for whom there were difficulties along the way; or
- had not achieved a desired outcome or had stopped engaging with the Connector after one or two appointments.

The Connectors spoke with relevant clients about the interviews, and asked those interested in participating for permission to pass on their contact details to the evaluators. A consent form was completed by the Connector and client, including the client's name, address, phone number, preferred language for interview and whether they required an interpreter. Completed consent forms were sent by the Connectors to the evaluators. The evaluators contacted the clients by telephone (with a telephone interpreter from the national Telephone Interpreter Service (TIS) if required) about the interviews. Written participant information and consent forms were provided in the client's preferred language (professional translations were obtained by FECCA) and emailed to prospective participants with email access. For those without email, the participant information was provided verbally over the phone (in English and, if using an interpreter, interpreted for the client). Prospective participants provided consent via emailed consent forms or verbally at the commencement of interviews (in accordance with their preference and literacy levels).

The interviews were conducted in person in clients' homes or in public/community locations, or by telephone, in accordance with participant preference. Interpreters were used when required, in person when available or by telephone. Interviews were audio recorded with consent and professionally transcribed. Clients who participated in interviews were each provided with a $50 retail gift card for Coles or Woolworths.

The interview schedule comprised an introduction and 14 theory-specific questions (structured around contexts, mechanisms, outcomes, and interactions between them). The client interview schedule is available as Appendix 2.

2.3.2 Focus groups / interviews with Connectors

All Connectors who were currently working in the program were invited via email (list provided by FECCA) and Microsoft Teams group messaging (access provided by FECCA) to participate in online focus groups. Participant information and consent forms were provided electronically via a Qualtrix (survey software) link. Prospective participants consented online and selected one of several available focus group timeslots. They were sent a zoom link for their focus group. Connectors who indicated that they were not available during the pre-allocated times were interviewed separately. The Connector focus group schedule is available as Appendix 3. The Connector focus groups / interviews were professionally transcribed for analysis.

2.3.3 Focus groups / interviews with Managers

As for Connectors, Managers of the EnCOMPASS Connector program were invited via email (contact list provided by FECCA) to participate in online focus groups. Participant information and consent forms were provided electronically via a Qualtrix link. Managers who were interested in participating consented online and selected a timeslot, and were sent a Zoom link for a focus group. Managers who indicated they were not available during the pre-allocated times were interviewed separately. The Manager focus group schedule is available as Appendix 4. The Manager focus groups / interviews were professionally transcribed for analysis.

2.3.4 Focus groups / interviews with Touchpoints

Touchpoints were recruited for focus groups via Connectors and Managers. A flyer inviting Touchpoints was provided by the evaluators and circulated among community networks by Connectors and Managers. The flyer detailed the purpose, when and how the focus groups would be conducted; that interpreters could be used; and that Touchpoints who worked as volunteers would be reimbursed for their time and contribution with a $50 Coles/Woolworths voucher. Participant information and consent forms were provided electronically via a Qualtrix link. Touchpoints interested in participating consented online and selected a pre-allocated timeslot or indicated that they would prefer another time. Alternative times for separate one-on-one interviews were arranged between the evaluators and Touchpoints, and a Zoom link was provided via email. The Touchpoint focus group / interview schedule is available as Appendix 5. The Touchpoint focus groups / interviews were professionally transcribed for analysis.

2.3.5 All interview and focus group participants

Sixty-seven focus groups and interviews were conducted with EnCOMPASS Connectors, Managers, Touchpoints, clients and carers between March 2022 and January 2023. The numbers of focus groups and interviews and their participants are presented below.

Table 1. Interviews and focus groups conducted and participant numbers, by type of participant

	Total number of focus groups / interviews	Number of participants
Clients (older persons or carers)	36	46
Touchpoints	4	5
Connectors	19	34
Managers	8	14
Total	67	99

Most client interviews were conducted face-to-face in their homes. One was conducted at the Charles Darwin University campus and one other was conducted at a restaurant. Three that were initially scheduled in person needed to be changed to telephone interviews when flooding prevented travel to participants' local communities. Approximately half of the client participants required language interpreters. In-person interpreters were booked when available; telephone interpreters were booked when in-person interpreters were not available locally. All focus groups / interviews with Connectors, Managers and Touchpoints were conducted online using Zoom.

2.3.6 Qualitative data from site reports

Site reports submitted monthly and quarterly to FECCA were provided to the evaluation team. Monthly reports included progress on key program issues and corrective actions, and community activities and events. Quarterly reports also provided information on key issues and corrective actions, and community events and activities, with more detail on the aims and types of activities, target groups, and types of engagement. Quarterly reports also provided information about program impacts and how these were achieved as well as client case studies.

2.3.7 Community of Practice recordings

Quarterly online Community of Practice meetings led by FECCA staff and attended by Connectors were recorded. Recordings were provided to the evaluation team and transcripts were produced with otter.ai software.

2.3.8 Quantitative client, carer, occasions of support and group sessions data

Connectors collected and submitted quantitative data each month on an Excel spreadsheet provided by the evaluators. Instructions for this data collection were provided on the cover page of the Excel spreadsheet and support was provided by the evaluators in Connectors' Community of Practice sessions and to individual Connectors on an as-needed basis by email or phone.

The data included information from clients who had provided permission for Connectors to share their de-identified information with the evaluators. Demographic data from older persons included their resident state/territory, age, gender, country of birth, year of arrival in Australia, ethnicity, whether they required a bilingual worker or interpreter, primary language, whether they were from a refugee background, Medicare eligibility, and referral source. Other personal and health information collected was whether they had a support person in their life and the number of health issues and types of impairment they were living with.

Carer data included their state/territory, age, gender, whether they required a bilingual worker or interpreter, primary language, and whether they were from a refugee background.

Details of all occasions of individual support and group/community activities provided by Connectors were also collected.

2.3.8.1 Quantitative data sample

EnCOMPASS Connector program sites provided de-identified records of 1,038 older persons and 266 carers (1,304 clients in total)[5] registered with the program in 2022.

2.3.9 Time and task data

Two time and task snapshots were conducted to better understand the resources required and costs of particular program functions. All Connectors were provided with an Excel template and asked to record all tasks and time spent on each task for a one-week period, twice in the year. Program Managers were provided with a second spreadsheet and asked to provide information about staffing costs. The time and task data collection tool and staff costs tool are available as appendices 6 and 7.

Two detailed snapshots of how Connectors and other staff members used their time were provided for one week in May/June 2022 and another week in October/November that year. For snapshot one, 23 of 29 sites provided data for various seven-day periods between 16 May and 12 June 2022. A total of 726 tasks were recorded. Client ID numbers were provided for 173 individual clients associated with 301 task records (41%). For snapshot two, 22 sites provided data for various seven-day periods between 24 October and 13 November 2022. A total of 765 tasks were recorded. Client ID numbers were provided for 211 individual clients associated with 404 task records (53%).

Staffing cost data was provided by 25 of the 29 sites. Sites were asked to provide information about full-time equivalent (FTE) employee numbers for positions associated with the EnCOMPASS Connector program and corresponding staffing costs over a 12-month period.

2.3.10 Quantitative data from site reports

Quantitative data reported by sites in monthly and quarterly reports to FECCA included number of clients supported, number of self-referred clients, contacts with carers, and number and type of community activities.

2.4 Theory testing and refinement

Theory testing and refinement involved concurrent analysis of qualitative and quantitative data.

2.4.1 Qualitative data analysis

All interview, focus group and CoP transcripts as well as site reports to FECCA were uploaded to and coded in MAXQDA software. The data were coded against the 16 hypothesised program theories. Each piece of evidence was coded to an existing hypothesis – either supporting or refuting it – or led to the creation of new codes and then new CMO configurations.

2.4.2 Quantitative data analysis

The data provided by sites was combined, standardised and cleaned to create a single dataset with consistent recording of client characteristics, activities and other information across sites (to the extent possible).

[5] While the CDU evaluation team only had access to data from clients who gave permission for its use, FECCA has advised that the EnCOMPASS program registered 6,505 clients (both older persons and carers) in 2022. The evaluation sample therefore was around one-fifth of all clients. The representativeness of this sample is not able to be calculated because FECCA did not collect demographic data for clients.

Where appropriate, client characteristics were aligned with standard classifications such as the Australian Standard Classification of Cultural and Ethnic Groups,[6] and the Australian Standard Classification of Languages.[7] Other classifications such as for client referral sources and types of community outreach activities were created based on the natural groupings arising from the data. Some additional characteristics were also calculated from the data provided, such as whether the client's case was open or closed at the end of 2022 and the duration and number of support sessions provided to each client.

Analysis was designed to describe the data and to answer specific questions about patterns and relationships in the data to support various aspects of the evaluation. For descriptive analysis, proportions of sub-groups of characteristics of clients and activities were calculated and graphed. As no data was available for clients who did not give permission for their data to be shared, the extent to which the data on clients is representative of the full population of clients is unknown. For this reason, client proportions have not been weighted and should be interpreted as proportions of clients who gave permission for their information to be shared.

Analysis to support evaluative questions was undertaken by defining appropriate sub-groups of clients and/or activities and performing comparisons of summary statistics such as proportions and means across these sub-groups. This was done using standard statistical tests assuming that the dataset available for analysis was a representative sample of the full set of potential clients and activities. The main statistical methods used were Chi-squared tests and confidence intervals for proportions, *t*-tests for means, and logistic regressions for binary outcomes. Given the relatively small sample sizes in some cases, a 10% statistical significance threshold was used in reporting, and comparisons for sub-groups with fewer than 10 clients or activities were suppressed.[8]

2.4.2.1 Client complexity index

Based on some client characteristics, a 'complexity score' was defined for clients that was intended to reflect how much support they were likely to require. Table 2 shows how a client's complexity score was calculated based on their characteristics.[9] Potential scores ranged from zero to seven.

Table 2. Calculation of client complexity scores

Characteristic	Score
Support person available	Yes = 0 / No = 1
Interpreter required	No = 0 / Yes = 1
Refugee background	No = 0 / Yes = 1

[6] https://www.abs.gov.au/statistics/classifications/australian-standard-classification-cultural-and-ethnic-groups-ascceg/latest-release

[7] https://www.abs.gov.au/statistics/classifications/australian-standard-classification-languages-ascl/latest-release

[8] In addition, 'bootstrapped' *t*-tests were used instead of standard *t*-tests where appropriate. Bootstrapped tests involve re-sampling from the actual data when calculating *p*-values rather than making specific distributional assumptions. Such tests are generally more reliable when sample sizes are small.

[9] Homelessness was also identified by FECCA as a significant driver of client complexity, but this was not recorded in the data available for analysis.

Characteristic	Score
Health issues	None = 0 / 2–3 issues = 2 / 4 or more issues = 3
Impairments	None = 0 / 1 or more = 1
Complexity categories	
Low complexity	Total score of 0, 1 or 2
Medium complexity	Total score of 3 or 4
High complexity	Total score of 5 or more

All characteristics necessary to calculate a client's complexity score were recorded for 673 clients (65%) of the 1,038 clients with some demographic data provided.

2.4.3 Synthesis methods

The evaluation team iteratively synthesised the results in regular meetings (KO and LM), two internal sense-making workshops (KO, LM and GW) and one final sense-making workshop (KO, LM, GW and AS and FECCA representatives). Synthesis also included an assessment of value for investment using a rubric developed for this project, and analysis in relation to formal theory on health care access.

2.4.3.1 Value for Investment rubric

This economic component of the evaluation combined analysis of value for investment (VFI) supplemented by a costs analysis. The approach included the development of a VFI rubric, based on program theory, and against which the program and its components were assessed.

The rubric described:

a) expected outcomes of the program;

b) essential criteria for the program (e.g., equity); and

c) selected aspects of implementation of the program.

Each of these were listed as 'elements' or subsidiary elements. The rubric then described the standards that would be observed or required at different levels (e.g., unsatisfactory, satisfactory, good, excellent) for each element. Monitoring data, outcomes data, some costs data and qualitative information all informed assessment against the standards. The rubric also took account of variations in context and population group which might affect achievement of the standards.

Elements of the rubric were developed in online workshops involving staff from FECCA, representatives from some EnCOMPASS Connector program sites, and CDU evaluators. Dr Julian King, who developed the VFI approach and who is a CDU adjunct researcher, facilitated the workshops and advised on construction of the rubric. The final draft of the rubric was developed by CDU staff.

The rubric was a key tool in the evaluation of the EnCOMPASS Connector program, enabling transparent decisions about whether the program was providing good value for the financial investment. The advantages of this approach were that it:

- enabled consideration of all key outcomes, including those that could not sensibly be valued in monetary terms;
- did not require a comparison program;

- enabled differential judgements about particular aspects of the program as well as a judgement about the outcomes and efficiency of the program as a whole; and
- made the basis for judgements transparent.

To enable future use of the rubric in other programs, the rubric tool (Section 3.5) includes some standards for which data were not available in this evaluation, but which were considered important for future data collection in aged care navigation programs.

2.4.3.2 Use of formal theory

Levesque et al.'s *Conceptual framework of access to health care* (2013) was applied to the evaluation results to assist synthesis and situate the results within a broader a conceptual framework.

3 Results

The results are presented in four sections (see Table 3). These are 'client characteristics', 'client outcomes' (answering evaluation questions 1 and 2), 'program implementation' (answering evaluation question 3) and 'Value for Investment' (answering evaluation question 4). Client outcomes and program implementation are explained by refined program theories.

Table 3. Structure of Results section

Results section	Evaluation question/s	Program theories
Client characteristics	N/A	N/A
Client outcomes	1 and 2	Refined program theories 1 to 8
Program implementation	3	Refined program theories 9 to 18
Value for Investment	4	N/A

3.1 Client characteristics

Client characteristics are based on descriptive analyses of quantitative data collected by sites. These and all other analyses of the quantitative data are also presented as Appendix 8.

3.1.1 Older persons

Characteristics of the 1,038 older persons registered with sites up to December 2022 and who have given permission for their information to be shared with the evaluation team are summarised in

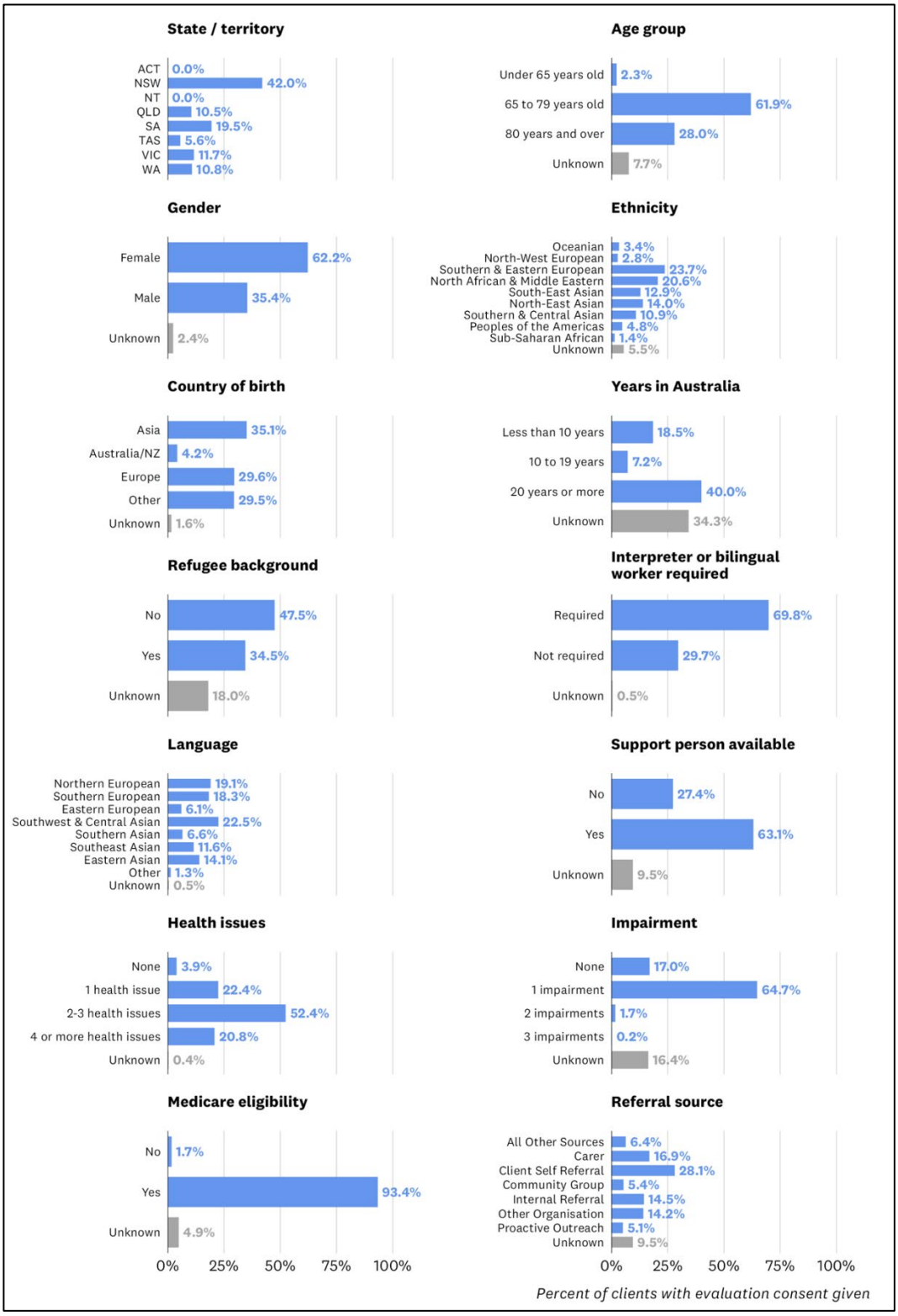
Figure 1 and as follows:[10]

- Almost all older persons in the program were aged 65 and older. Among those whose age was recorded, around two-thirds were aged between 65 and 79, and one-third were aged 80+.
- There were 1.75 times as many female older persons as male older persons.
- Around 38% of older persons were of Asian ethnicity and 27% were European. Around 55% of older persons spoke an Asian language.[11]
- The number of years in Australia was not recorded for around 34% of clients whose data was shared. Of those whose year of arrival was recorded, 60% had been in Australia for 20 years or more, while around 28% had been in Australia for less than 10 years.
- Around 70% of older persons had challenges with English and required a bilingual Connector or other worker, or interpreter in at least some settings. Around 55% spoke an Asian language and 38% were of Asian ethnicity.
- Around 35% of older persons were recorded as having a refugee background.
- Around 96% of older persons had at least one known health issue and around 73% had two or more health issues.
- Around two-thirds of older persons had at least one known impairment. Due to the way that this data was collected, older persons with multiple impairments may have been recorded as having one impairment, thus the number of older persons with more than one impairment was probably understated. In addition, impairment status was not recorded for around 16% of older persons.
- Around 70% of older persons required an interpreter in some settings at least.
- Almost all older persons were eligible for Medicare – of those with eligibility recorded, around 98% were eligible.
- Almost two-thirds of older persons had a support person available who could assist them.
- Self-referral was the largest single source of referrals, accounting for 28% of older persons, with carers accounting for a further 17%.

[10] While the CDU evaluation team only had access to data from clients who gave permission for its use, FECCA has advised that the EnCOMPASS program registered 6,505 clients (both older persons and carers) in 2022. The evaluation sample (1,304 older persons and carers) therefore was around one-fifth of all clients. The representativeness of this sample is not able to be calculated because FECCA did not collect demographic data for clients.

[11] The ethnicity and language classifications shown in Figure 1 are based on ABS level 1 ethnic and language groups. These groupings put Middle Eastern languages in the Southwest & Central Asian language category, but people of Middle Eastern ethnicity are included in the North African & Middle Eastern ethnic group. This is the main reason why the proportion of clients that speak an Asian language is substantially higher than the proportion of clients of Asian ethnicity.

Figure 1. *Demographics of older persons who gave permission for their information to be shared with the evaluation team*

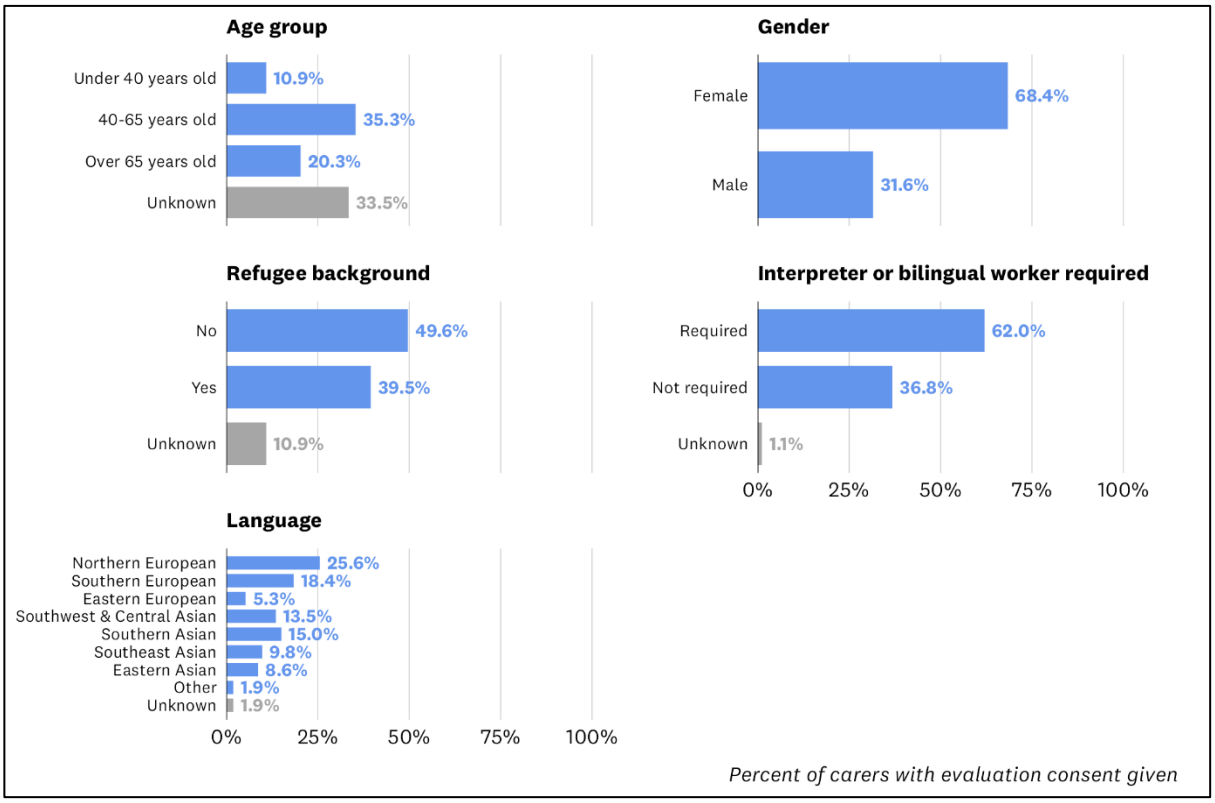


3.1.2 Characteristics of carers

Figure 2 summarises demographics of 266 carers registered with sites up to December 2022 and who gave permission for their information to be shared with the evaluation team. Less information was collected about carers than older persons.

- Carers tended to be younger than the older persons they were caring for. Of carers where age was recorded, around two-thirds were under 65 years old.
- The proportions of carers who were female and carers from a refugee background were similar to the proportions of older persons who were female and older persons from a refugee background, at around 68% and 40% respectively.
- Around 62% of carers are recorded as requiring an interpreter or bilingual worker, and around 47% were recorded as speaking an Asian language.

Figure 2. Demographics of carers who gave permission for their information to be shared with the evaluation team



3.2 Community education and awareness-raising outreach activity

This section provides an overview of the community education and awareness-raising outreach activities conducted by the Connectors. Community outreach activities were undertaken by the Connectors to increase the CALD communities' awareness of the aged care system and how to support people to access required services. The Connectors employed a range of strategies to increase the aged care awareness and knowledge of CALD organisations (not employing the Connectors), Touchpoints (such as community leaders and faith leaders) and health professionals. This helped to develop their capabilities in aged care navigation and service knowledge to enhance the capacity of the community to provide an 'ecosystem of care' in CALD communities.

Raising community awareness is an inherent part of all many of the program theories discussed in section 3.4, which covers the flexible, co-designed delivery of the project and engaging with stakeholders who have reach to older persons from CALD communities. The following section presents the results of the quantitative data analysis, detailing the number and reach of community group sessions.

3.2.1 Education outreach activities

Community education and awareness-raising outreach activities were delivered in a variety of ways. Delivery methods were based on insights from co-design sessions, where people from the local communities discussed the best way to reach out to the community, based on their preferences and the environment in which they would best engage with aged care information and education. Outreach methods included 'town-hall' community briefings/events; meetings with CALD community groups, church groups or seniors' groups; and meetings with CALD organisations and health professionals. Connectors also attended community meetings or events that were pre-existing or had been organised by other groups or organisations such as seniors expositions and community seniors events. Broader community outreach was also conducted through information mediums that catered to specific languages such as local radio, newsletters and flyers, and newspaper and magazine articles.

3.2.2 Education outreach findings

A total of 369 community outreach sessions were reported as being led or attended by participating sites between January and November 2022. Throughout the year, there were community outreach sessions in most months in most states. Across the sites there is considerable variation in the total number and types of group sessions reported, ranging from 1 to 76 sessions.

There does not appear to be a clear relationship between community outreach sessions and inward referrals to sites (based on data only from clients who gave permission for their information to be shared). There are some instances where a site received a relatively large number of inward referrals soon after a community outreach session, but there are also many other instances where this did not occur. On average, a site received around one inward referral per week in weeks where no outreach sessions were held, compared to 3.6 referrals in the seven days following a 'town-hall' session and 2.9 referrals in the seven days following other types of sessions. However, the pattern of outreach sessions and inward referrals is very variable across sites and across time so it is difficult to be sure of the extent to which referrals were caused by community outreach sessions.

Community outreach activities can be time and resource intensive. Connectors spent around 32% of their available time on community outreach tasks, i.e., community education and other community development. Within this time, providing education accounted for 28% of Connector time, while planning, organising, and developing materials accounted for 64% of time, and travel accounted for 9% of the time spent on community outreach activities. Many community outreach activities were also supported by non-Connectors, who were more likely to be involved with community outreach tasks than with client support. On average, 45% of total non-Connector time across sites was for community outreach tasks, versus 25% for client support.

More detailed analysis of the data and illustrative insights into how these activities raised awareness and for whom, along with the resulting outcomes, are presented in section 3.4.

3.3 Client outcomes

This section provides the results of evaluation questions 1 and 2.

1. What outcomes have been achieved, to what extent, for whom (including the most vulnerable) and in what contexts? (Positive & negative, intended & unintended.)
2. What mechanisms have caused what outcomes, in what contexts? What contexts prevent intended mechanisms from operating?

The support of clients was found to operate through four incremental phases. These were:

- the Connector's engagement of the older person and/or their carer/s;
- working with different levels of client readiness for aged care services;

- making the My Aged Care connection work; and
- getting the most out of aged care services.

Each of these phases is addressed by two refined program theories. Table 4 shows the structure of this section and the names of the program theories. Following the table, each phase is detailed with explanations of what outcomes were achieved, for whom, in what circumstances, and why, with supporting evidence and refined CMO configuration/s.

Table 4. Evaluation questions and structure of this client outcomes section

Evaluation questions	Results on client outcomes	Name of refined program theory
1. What outcomes have been achieved, to what extent, for whom (including the most vulnerable) and in what contexts? (Positive & negative, intended & unintended.) 2. What mechanisms have caused what outcomes, in what contexts? What contexts prevent intended mechanisms from operating?	3.3.1 Connector's engagement of the client	1. Bicultural engagement creates high rapport 2. Engagement via interpreter creates low rapport
	3.3.2 Working with different levels of client readiness	3. Cultural rapport is not critical when readiness is high 4. Cultural rapport is critical when readiness is low (but need is high)
	3.3.3 Making the My Aged Care connection work	5. Rapport is critical when there is high complexity 6. Low need, low complexity but preparing for the future
	3.3.4 Getting the most out of aged care services	7. Hanging in there with the client 8. Where Connector capacity ends the aged care system fails older persons and carers

3.3.1 The Connector's engagement of the older person and/or carer

3.3.1.1 Program theory 1: Bicultural engagement creates high rapport

Connectors who were from the same community and spoke the same language as their clients (had inherent cultural knowledge) or those who were able to access relevant cultural knowledge and language support from colleagues within their employing organisation were most successful in engaging clients. When combined with a proactive and responsive approach, and persistence in engaging clients, and the client was competent to understand what was going on and could express concerns, needs and wishes, bicultural Connectors (or those working with bicultural colleagues), were able to show respect for culture, express warmth, and communicate clearly with the client. In response, the client felt respected and understood, and the outcome was high rapport with, and trust of, the Connector.

> *It is the familiarity of cultures, similar cultures. So, there is the start of trust building straight away. It's much easier to build trust with somebody you think is coming from a culture that understands your own. … And If she [the Connector] doesn't speak the language then we get somebody else who works with her to speak the language. (Manager).*

> *I tell you; they don't trust the people who does not speak his language. (Touchpoint).*

> *I think the face-to-face interaction definitely made a difference, because over the phone I had spoken to her about – I think three or four times on the phone before I was able to confirm an appointment, just because she didn't recognise me; she didn't know me. But once she saw my face – and we come from similar cultures, which made it a little bit easier. … One thing that definitely helped is referring to them by titles they prefer. Like in [language removed to de-identify participant] you can call an older client [name removed] and then [name removed], and then also in [language removed] … which I think she quite liked. And then there was also different greetings in different cultures, different things that you can do. There's like a bow and things like that which I think made her feel a bit more comfortable and respected as well … I think if there had been a person who only spoke English, someone who came from a non-Asian background who came to visit her, it might have been a little bit less trusting. (Connector).*

In some cases, when neither the Connector nor other staff within the organisation had the relevant cultural expertise, the Connector worked with known community volunteers/Touchpoints to assist client engagement.

> *I was a volunteer in their hub for senior people and I helped them translate the conversation as well as the contact with My Aged Care, because members of the project team cannot speak [language removed to de-identify participant], so I help them with the [language removed] potential clients. (Touchpoint).*

Being proactive and responsive as well as persistent was important at the engagement stage.

> *The Connector gave me [the number for a] husband and wife and said, "Can you help me to call them?" I call. I call many times. No answer. So, I come back to the person that [initially] gave the [Connector the] number. I say, "I cannot call him, so is anything wrong with the number?" And she say, "No, it's not the problem with the number. It's the problem that he only receives the call when he knows who's calling. He doesn't receive the call from stranger, because not only the scam call, but he's kind of the very careful person. … You have to leave a message and say who you are and when are you going to call him." It's a long way to contact [people]. (Touchpoint).*

Table 5. Program theory 1: Bicultural engagement creates high rapport

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
Connector is a member of the same (target) community and speaks the same language as the client (has inherent cultural knowledge) OR Connector can access relevant cultural knowledge and language support from colleagues (staff or volunteers) in their host organisation	Bicultural Connector or community worker – making contact, listening and sharing information in client's own language	Respect, warmth and clear communication about the Connector's role	Client feels respected and understood by the Connector and understands the Connector's role	High rapport – the client trusts the Connector and buys into the program
Connector is both proactive and responsive as well as persistent in engaging older persons and/or carers				
Client is competent to understand what's going on and can express concerns, needs and wishes				

3.3.1.2 Program theory 2: Engagement via interpreter creates low rapport

Engagement of the client was less effective when the older person did not speak English and the Connector did not speak the client's language or understand their culture (and there was not a bicultural colleague available). Use of professional language interpreters (in-person or via telephone) did not establish the same level of rapport and trust with older persons and/or their carers as bicultural Connectors who spoke the client's language. When working with an interpreter, there was a lack of emphasis on the relationship or interpersonal warmth and, in response, the client felt a less personal connection. This instrumental interaction resulted in a superficial or weak engagement of the client.

> *We find that the interpreters aren't quite – I think the relationships, because they're not face to face, a lot of them are over the phone, you get different interpreters, it's a different kind of relationship to a bicultural worker … that trust element, that rapport. (Manager).*

> *We tried getting an interpreter; it didn't really work … it crashed and burned, and it does sometimes, which is fine with us, we're all good with that. Then we had to rearrange, to make sure our bicultural support worker was there. … The bicultural worker was there to support them. It was hard – there were hearing issues … there were language issues, there was oh-my-god-I'm-exhausted-now issue, I've-forgotten-what-I'm-saying issues. … It was obviously really, really productive having the [language removed to de-identify participant] speaking bicultural worker there, because they*

managed to support, make sure she was on track, make sure we got what we needed to get, explained the answers, support them through it. (Manager).

If I have to call an interpreter in, it's kind of like a bit hard, like the client – like they understand me and I understand them, but it's always – I mean it's not really smooth. … It's just that we get the work done but it's still kind of hard. Yeah. Yeah, so language is the most important thing. (Connector).

We are open to having clients from other ethnicities. And so, what we do is we also have multicultural peer support workers, so bilingual workers, and we can engage with them throughout the period that we engage with the client. So, it's really helpful because even if we can use interpreters, like that's just over the phone, or they could get a different interpreter each time in person, but at least having the same worker who can work with the client and ourselves, it builds the trust and rapport more and we're able to help them more. (Connector).

Table 6. Program theory 2: Engagement via interpreter creates low rapport

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
Connector is not from the same cultural community and cannot access bicultural/bilingual support from their organisation Connector uses professional interpreter services (in-person or by telephone if in-person not available)	Working with a professional language interpreter	A lack of resources (low emphasis on relationship, interpersonal warmth and rapport)	Client feels an instrumental connection only (less personal, a means to an end)	Low rapport – superficial/weak engagement of the client

Language of older persons and carers engaged in the EnCOMPASS Connector program

Of 1,038 older persons who registered with the program and allowed data to be shared, 70% required a bilingual Connector, other bilingual worker or interpreter. Of the 266 carers registered, around 62% were recorded as requiring a bilingual worker or interpreter. Other clients were able to communicate in English. While many English-speaking clients and carers also valued cultural rapport with a culturally matched Connector, this was not critical for communication and rapport with English speakers.

3.3.2 Working with different levels of client readiness for aged care services

Different levels of client readiness to engage with the aged care system required different approaches by the EnCOMPASS Connector. The Connector needed to meet older persons and/or their carers 'where they were at'. It was found that cultural rapport between a client and the Connector was critical when readiness was low but need was high. However, rapport was less important if client readiness for aged care services was already high.

3.3.2.1 Program theory 3: Cultural rapport is critical when need is high but readiness low

When a client did not feel ready to engage with the aged care system but was likely to be eligible (had the need), high rapport with the Connector enabled the Connector to influence the client's readiness. Low readiness could be due to any of a range of factors such as:

- misunderstandings about aged care (thinking aged care was only residential care);
- a reluctance to accept help from people they did not know and trust;
- grieving the loss of independence;
- stigma about particular illnesses or conditions;
- views about having outside help, including that adult children should provide care;
- an older person and carer having different views, wants and needs;
- worry about the costs of support;
- concerns related to disclosing income and assets to the government; or
- hearing about others' negative experiences with aged care services.

In such cases, and when rapport had been established between the client and Connector, the Connector provided personalised care and attention, including gentle and respectful challenging of cultural beliefs and perceptions, with information, stories of others' positive experiences, and encouragement (e.g., that there is no shame in accepting help, or that aged care can be about maintaining independence and quality of life at home).

> *People have been hearing lots of negative experiences, like ... they heard about [service providers] stealing the jewellery, stealing this, and not working properly, not doing their job. So, all these kind of negative stories they heard from other people who have been using the [aged care] services, kind of discourage them to be part of our program. (Connector).*
>
> *The families are so afraid and ashamed to share that they have somebody in their family that has dementia that they really shut themselves off from the community [rather] than actually getting help through the community. (Manager).*
>
> *It's opposite of our culture to let anybody come and take care of us. We should take care of us together in the family. … But then [the Connector] spoke to us and they [the older people in the community] began to accept that we [adult children] are always busy, work, and have family, so they discover that they are by themselves, a lot [of] the time. … My mum, [she started to see that] when we are here to take care of her, and our own property [and] take care of our [own] family, she start to be sad. She saw we were tired. … So they start to accept that, okay, someone take care of them, cleaning the property, sometimes if they need a ride for somewhere, that's why they try to accept, okay, bring someone to do it. (Client – carer).*
>
> *It was very hard to convince them to get to go to My Aged Care because where they come from … families used to have extended family aunties and uncles and that and their children assist them. … But I started to tell them about their rights here in Australia. I keep telling them … here in Australia, there is no extended family … things [are] different. … It took, it took time for me, to let them accept to have service. (Connector).*
>
> *You know, we are refugee here, so we have Centrelink payments. … Some families … at the beginning, they refuse [help from the Connector]. They said, "Oh no, it will affect our payment from the Centrelink." After [the Connector] said, "No, it won't affect that" they start to accept it, day by day. … She have a good reputation in [our] culture. They*

love her. Yeah, she tell them, if you accept that or not, but I will explain that and you really need it, you need to take it, because here in Australia, our kids always busy, so take it, accept that. (Client – older person).

However, when there was low rapport, the client felt misunderstood or that services could not provide what they needed. The Connector was unable to influence this and the client declined offers of support and disengaged.

I explain everything already, simply about it, and then it just on that day we call My Aged Care together. There was an interpreter involved as well. … [But the client] She's just always repeat the same thing, "I don't want any trouble. I don't want any trouble. Yeah, it's too hard. It's too hard. I don't want to continue. I want to just give up. I don't want to register with My Aged Care anymore. I don't want the services anymore. I just want to give up." So, she stops. (Connector).

In other cases Connectors shared about engaging clients but being unable to build the same level of rapport with, and influence the thinking of, their spouses who were insistent on not engaging with the Connector.

The wife is actually very vulnerable. Her health condition is really bad. She's certainly eligible for I would say even home care package but I don't know why, her husband doesn't want anyone to go into the home to do anything. The husband already said, "If you ever ask anyone to come in I'm going to kick them out. "The lady has been admitted to the hospital a few times already. She had a fall. But she still has to do the housework, can you believe it? … Her husband doesn't believe people. They don't want any stranger coming to the home. That's why he refuse any help and she dare not to apply at all. She's dying for the support, but her husband told her that "I don't want anyone to come into our place, our home, so don't ever try. "(Connector).

Table 7. Program theory 3: Cultural rapport is critical when need is high but readiness low

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
Low readiness Client and Connector have high rapport (outcome of PT 1a)	Responsive and timely information and support about the process of engaging with the aged care system	Client experiences time and personalised attention (across multiple episodes and over time if required) Client experiences respect for cultural beliefs/perceptions. Client's beliefs are respectfully challenged with information, stories and encouragement (e.g.,	Increased awareness of types of aged care services they may be eligible for (Aged care is not only residential care; it is in home support to promote independence, comfort, quality of life) Understanding and acceptance of	Older person and/or their carer agree to registration with My Aged Care

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
		that there is no shame in accepting help)	need and possible supports. If older person and carer were not in agreement, increased understanding of the other's needs	
Low rapport			Client feels misunderstood or that the aged care system cannot provide what they need	Persistent belief that need is low, and/or that outside help would not be appropriate Connector is unable to influence the client's position Declines offer of support to register with My Aged Care, disengages

3.3.2.2 Program theory 4: Rapport is not critical when readiness is already high

Conversely, when a client's readiness was already high, and the Connector was able to provide comprehensible information in the older person / carer's language, the older person / carer was able to act on the new knowledge – either by registering themselves with My Aged Care, or accepting support from the Connector to do the same. Strong rapport was not essential to this process.

> *She heard from a friend and she was looking for the program. Looking for the Connectors…[to] start to research [aged care]…. She rings me up [and] on the [same] day, she just registers straight away. (Connector).*

Table 8. Program theory 4: Rapport is not critical when readiness is already high

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
Client readiness is high	Responsive and timely information and	Readily available and comprehensible information and	Increased awareness of process and	Older person and/or their carer feels more

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
Connector has knowledge of the aged care system and its requirements	support about the process of engaging with the aged care system	support in own language – about the process of engaging with aged care system	confirmation of readiness 'Know-how' to register self or acceptance of offer of support with process	ready – they have a plan for registration with My Aged Care

3.3.3 Making the My Aged Care connection work

3.3.3.1 Program theory 5: High rapport is critical for high complexity

In situations of social or medical complexity, rapport between the client and Connector and the Connector's persistence and commitment were important for successfully connecting with My Aged Care. These enabled timely and personalised support, information, and advocacy by the Connector across multiple episodes and over time.

> *She knew me and knew all my sickness and all the help I need. And she was very clear I needed help, and write it down. [One day] she was here for about hour and a half, or maybe longer, trying to get through the phone. She kept going. They [My Aged Care] said, "Yes … we'll organise an assessment". And for weeks … we didn't hear a thing. So, she [the Connector came again and] start all over again, trying to get through the phone, trying to get through to somebody. (Client – older person).*

Sometimes connecting a client to My Aged Care required the Connector to assist them with administrative processes with other government departments and systems that had similar barriers.

Connectors assisted older persons / carers with interpreting letters, completing forms or attending appointments at Centrelink. This also helped rapport and reduced complexity.

> *I don't know if this is part of my role but she needs someone to advocate for her at Centrelink. … I honestly don't know if that's part of my role or not, but that's something she really also needed help with. She asked me to go with her and [now] there's a bit more trust there than there was initially. (Connector).*

> *Because I understand the language, and she explained for me. You know, she helps – before one of my passports was out of date, I went too many times in the post office to fix it, "Oh, bring this paper, do this, this," and still – I told [Connector] and we went together in the post office, and she explained everything, and then they fixed it up in one weeks' time. I'd been so long, and I'd be there, and I'd tell them and everything and, "Oh, you have to go to this office, oh, you have to ring this number, oh, you do this," you know, too much around. I didn't know what to do, so I ring [Connector] and I asked her, and she helped me, you know. (Client – older person).*

The Connector prepared the client for contact with My Aged Care by being honest about the process being long and frustrating, and provided practical and emotional support for key meetings and phone calls with My Aged Care (such as by preparing and practising with the client what to say).[12]

> *We [the Manager, with the Connector, bicultural worker and client] called My Aged Care, and … it ended up being a three-hour process … we were helping [the client] right through the process. Our bicultural worker was there to support them. … There were hearing issues … there were language issues, there was oh-my-god-I'm-exhausted-now issue[s], I've-forgotten-what-I'm-saying issues. … It was obviously really, really productive having the [language removed to de-identify participant] bicultural worker there, because they managed to support, make sure she was on track, make sure we got what we needed to get, explained the answers, support them through it.*
>
> *Connectors understood the importance of client privacy and clients communicating directly with My Aged Care, but stressed that the operationalisation of such policies required intensive support…*
>
> *It's very tricky with My Aged Care because they only want to hear from the client. … So, it was very much a moral support as well as writing it down in [language removed to de-identify participant] … even spelling the name; the name was the biggest thing. The person over the phone could not understand. There's a certain letter in [language removed] that is pronounced differently. I can't remember what it is. … It's either an L or an E, but the way you say it over the phone, it sounds different to what we recognise it as. … they said, "Spell your name out". And she was spelling it out, but she spelled it out wrongly. No, she didn't spell it out wrongly, she spelled it out correctly, but the lady over the phone at My Aged Care got it down wrongly. … It was so difficult to rectify that issue; it actually took like 20 minutes … to even just get the name down. … And I think this is what a lot of CALD background people face. Not just the spelling, the pronunciation, the sounds of it. So, they're agreeing to things, because it sounds kind of what it should sound like. So, it's like, "Yes, yes". And then it's like, "No, no, don't agree to that. That's not what you want, that's not right, that's not correct". It's so many little, tiny nuances a lot of the time. … It was tedious, but we did get through it, thank goodness. And it was successful, so she got her My Aged Care number. (Manager).*

A Connector's persistence and commitment were important for checking progress, troubleshooting, jumping through bureaucratic hoops in English and ensuring the process was still moving. In response, the client felt assured knowing that the Connector was across everything, felt buffered from harsh, unclear and inflexible interactions with My Aged Care, knew what was coming next, and were encouraged to see the My Aged Care registration and assessment processes through.

> *The thing which is the challenge … was for her to talk to My Aged Care, she needs to get consent from her husband, and her husband is nonverbal. … She's tried once [to register him with My Aged Care] and she gave up [because] My Aged Care is like "no, we need to talk to him" … and then "you need to get him to sign" … and he can't sign because he's paralysed on his hand. [She got him to] scribble [but then] she has to fax it to My Aged Care and she don't know how to fax it. … So, I helped her, I asked My*

[12] No Connectors explicitly mentioned using the My Aged Care apply online function.

Aged Care, "What, it's still the fax! We can't scan or anything?" [But yes] I had to find a place where I can fax that and then I faxed it. (Connector).

They have a lot of patience, that's a key thing. … They explained the whole process in detail before we actually start dialling the number. So, we set up some time, and then went through the whole process. I think I would call it a dry run. … Every step … she would actually listen and then making sure that my mum understands … not rushing. (Client – carer).

Connectors also helped clients honestly articulate their needs so that the assessment outcome would be a true reflection of needs.

Well for instance, in the Chinese community we notice many seniors, when they try to apply for aged care services, they seem to prefer to present as an independent and capable individual, who can usually look after themselves on their own. But they don't really realise that they are actually, when they say that they can look after themselves, they are actually supported by many people surrounding. For instance, there may be someone in the family, the children, who have actually been allocating unnecessary time and effort to support these seniors. And this support can be provided by the Department. … Sometimes they don't really get the satisfactory result from their assessments, so bilingual Connectors will [offer] help, to make them understand that when they apply for services, they do need to present their difficulties, or explain their difficulties without sugar-coating it. (Manager).

Table 9. Program theory 5: High rapport is critical for high complexity

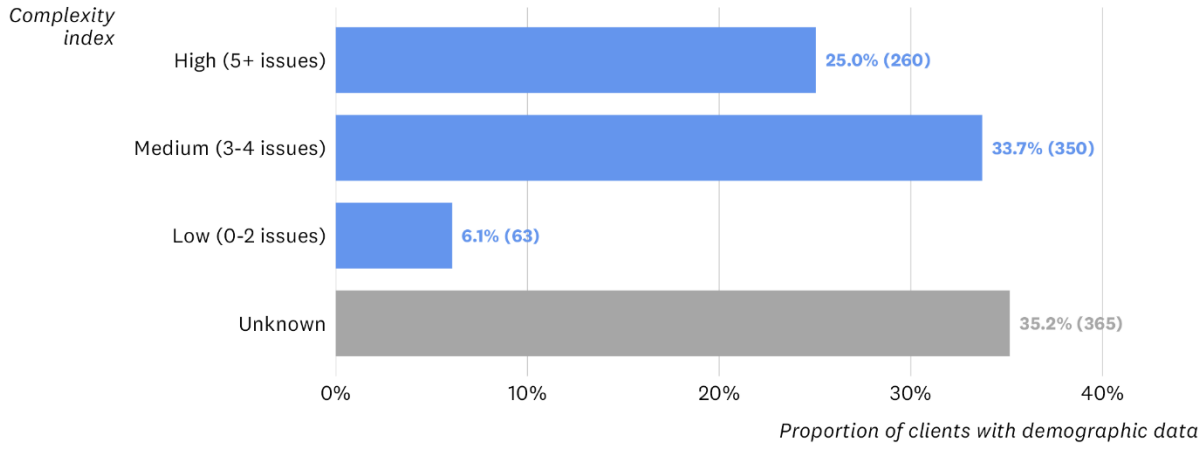
Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
High rapport and some readiness	Personalised, timely and coordinated support, information and advocacy (across multiple episodes and over time)	Honesty and acknowledgement by the Connector that the process can be long and frustrating Opportunity to debrief with the Connector about disappointment and frustration with the process; encouragement to persevere	Assured that someone knows what's going on Buffered from the harsh and unclear system, supported through the messy and frustrating process Knows what's coming next, feels prepared and not as nervous; can prepare answers to anticipated	Client doesn't give up, maintains some hope that they'll be eligible and receive support to live the life they want
Connector is 'can-do'/persistent/committed		Practical and emotional support in key meetings/phone calls between		Client has increased agency and feels confident to speak up (to

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
		client and My Aged Care or Preparation for meetings/calls by pre-briefing and/or dry run/practising what to say	questions, including articulation in English	My Aged Care or assessor)
Crisis or high social/medical complexity		Someone to follow up, check progress, keep the ball rolling, troubleshoot, jump through the bureaucratic hoops in English language		Registration with My Aged Care and assessment occurs

Client complexity

All characteristics necessary to calculate a client's complexity scores (defined above) were recorded for 673 (65%) clients. Of these, 52% were rated as medium complexity (with three or four health issues, impairments, or other issues that may have increased their support needs), 39% high complexity (five or more issues), and only 9% low complexity (fewer than three issues).

Figure 3. Distribution of client complexity scores



Whether or not enough information was provided to enable a client's complexity index to be calculated appears to be related to their level of engagement with the program:

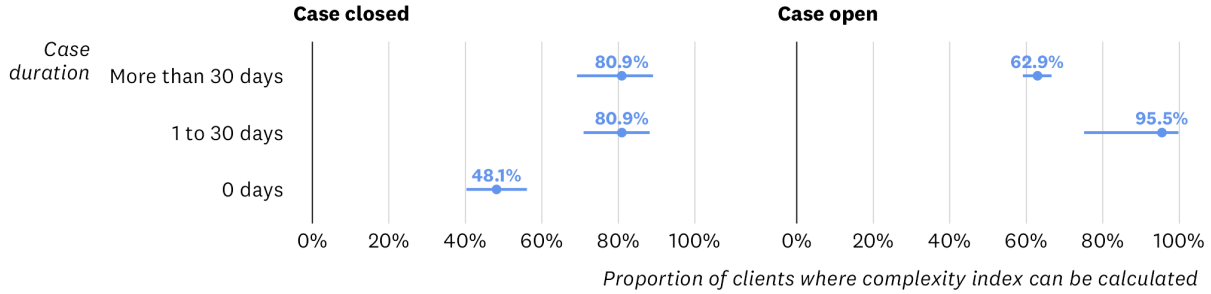
- Among clients with closed cases (i.e., where a case closing date was recorded), the proportion of clients where complexity could be calculated was significantly lower for clients where the case was

opened and closed on the same day, although this may simply reflect less data being collected for these cases (Figure 4, left panel).

- There was no difference in this proportion for clients with case durations from 1 to 30 days compared to those with case durations greater than 30 days (Figure 4 left panel).
- Among clients with open cases (no case closing date recorded), the proportion of clients where a complexity score could be calculated was significantly greater for clients with a case duration of up to 30 days (as of 31 December 2022) compared to clients where the case was open for longer (Figure 4, right panel).

The analysis below of relationships between client outcomes and complexity are therefore reflective of clients who were relatively more engaged with the program.

Figure 4. Relationship between the proportion of clients where a complexity score could be calculated and case duration (with 95% confidence intervals)

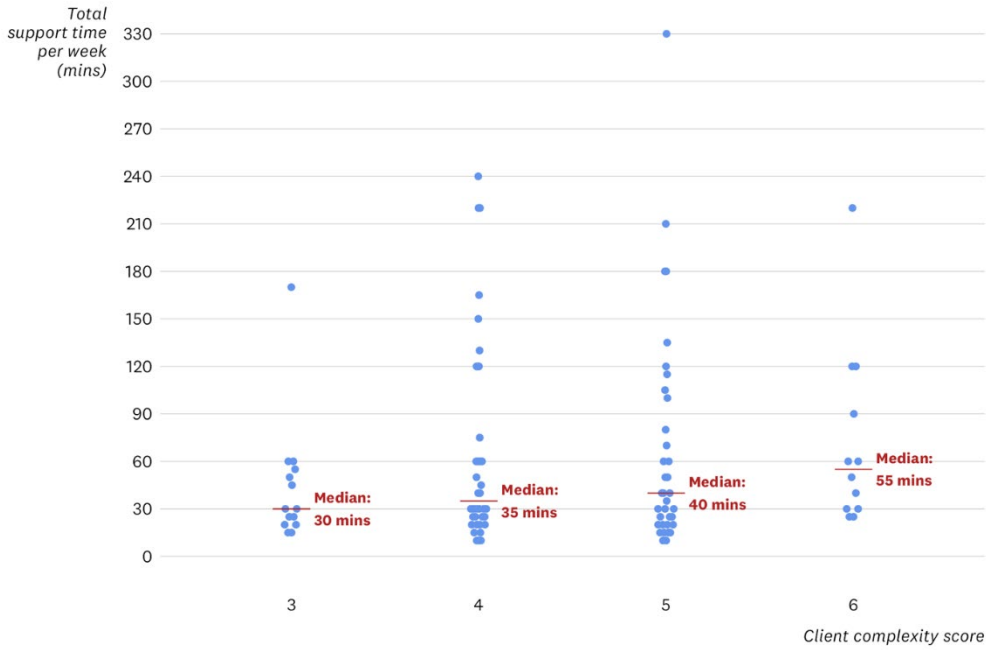


Connector support time provided versus client complexity

Both time and task snapshots combined showed that there was a relationship between client complexity and time spent with clients. While this was not statistically significant,[13] it did show a correlation between increasing complexity and increased time spent supporting clients.

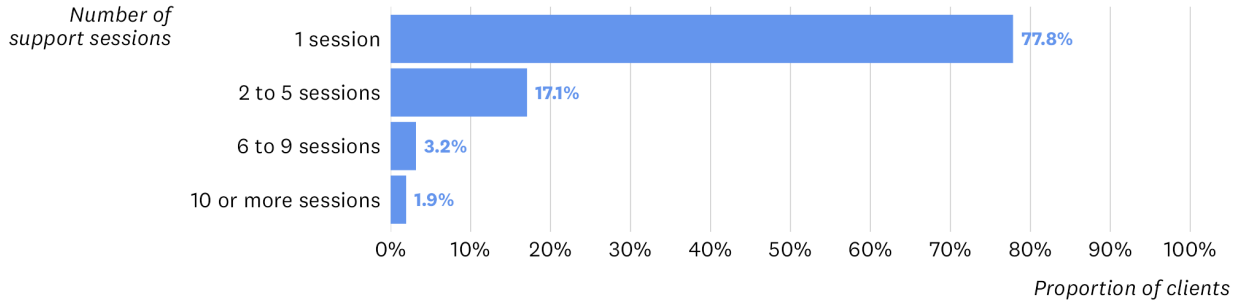
[13] Only 99 clients who consented to having their data used in the evaluation and for whom a complexity index could be calculated were supported during the snapshot periods. This included only 3 clients with complexity scores of 1 or 2, hence these scores are not shown in Figure 5.

Figure 5. Connector time provided to clients during the snapshot weeks, by client complexity index



Occasions of support

Figure 6. Number of support occasions recorded for all clients with cases opened before 1 December 2022



Over three-quarters of clients supported in the program whose case was opened before 1 December 2022 received just one occasion of support by the end of 2022. Some possible explanations for such cases include:

- people wanting information and support in their own language to connect with My Aged Care, but did not have current need for services;
- people not living within the service boundary were connected to another program or EnCOMPASS Connector organisation servicing their residential area;
- people asking for help with accessing particular support services, and when the Connector called My Aged Care they found that the client was already registered and had prior approval for the services, and the client could manage the process independently from there; and
- clients who were first assisted towards the end of the year and required ongoing support beyond the end of December 2022.

Older persons more likely than others to receive only one occasion of support included those who were of Oceanian, North-East Asian, Southern & Central Asian backgrounds, had been in Australia for less than 10 years, had one health issue, and were reached through proactive outreach. Those who were more likely to receive more than one occasion of support were from Southern & Eastern European, South-East

Asian or American backgrounds, had been living in Australia for 20 years or more, had two to three health issues, and were self-referred (Table 10).

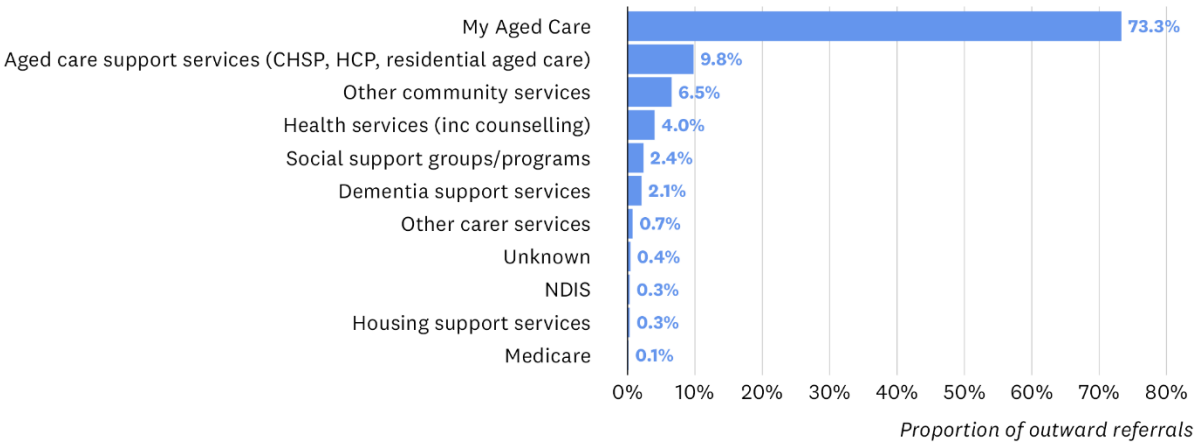
Table 10. Client characteristics and occasions of support

More likely to receive only 1 occasion of support	More likely to receive more than 1 occasion of support
Oceanian, North-East Asian, Southern & Central Asian, born in Australia/NZ	Southern & Eastern European, South-East Asian or American
In Australia less than 10 years	In Australia 20 years or more
One health issue	Two or three health issues
Reached through pro-active outreach	Self-referred
Clients with one or more 'unknown' characteristics	

Referrals to My Aged Care (and other services)

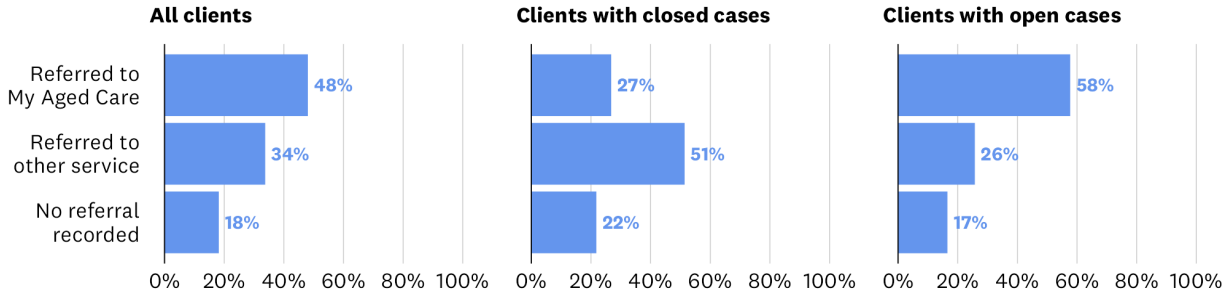
Almost three-quarters of referrals made by Connectors were to My Aged Care. Other outward referrals were made to services including aged care support services outside of the formal aged care system such as programs provided by faith-based organisations or disease-specific charities (10%), other community services (7%), health services including counselling (4%), social support groups and programs (2%), and dementia-specific support services (2%).

Figure 7. Outward client referrals by type of service



Just under half of all clients were referred to My Aged Care by the end of 2022. The following figure (Figure 8) shows that 58% of open cases as at the end of 2022 (active clients) had been referred to My Aged Care. This supports earlier qualitative evidence – that Connectors continue to support older persons / carers after referral. Referral to My Aged Care is just one step in an often long and complicated trajectory.

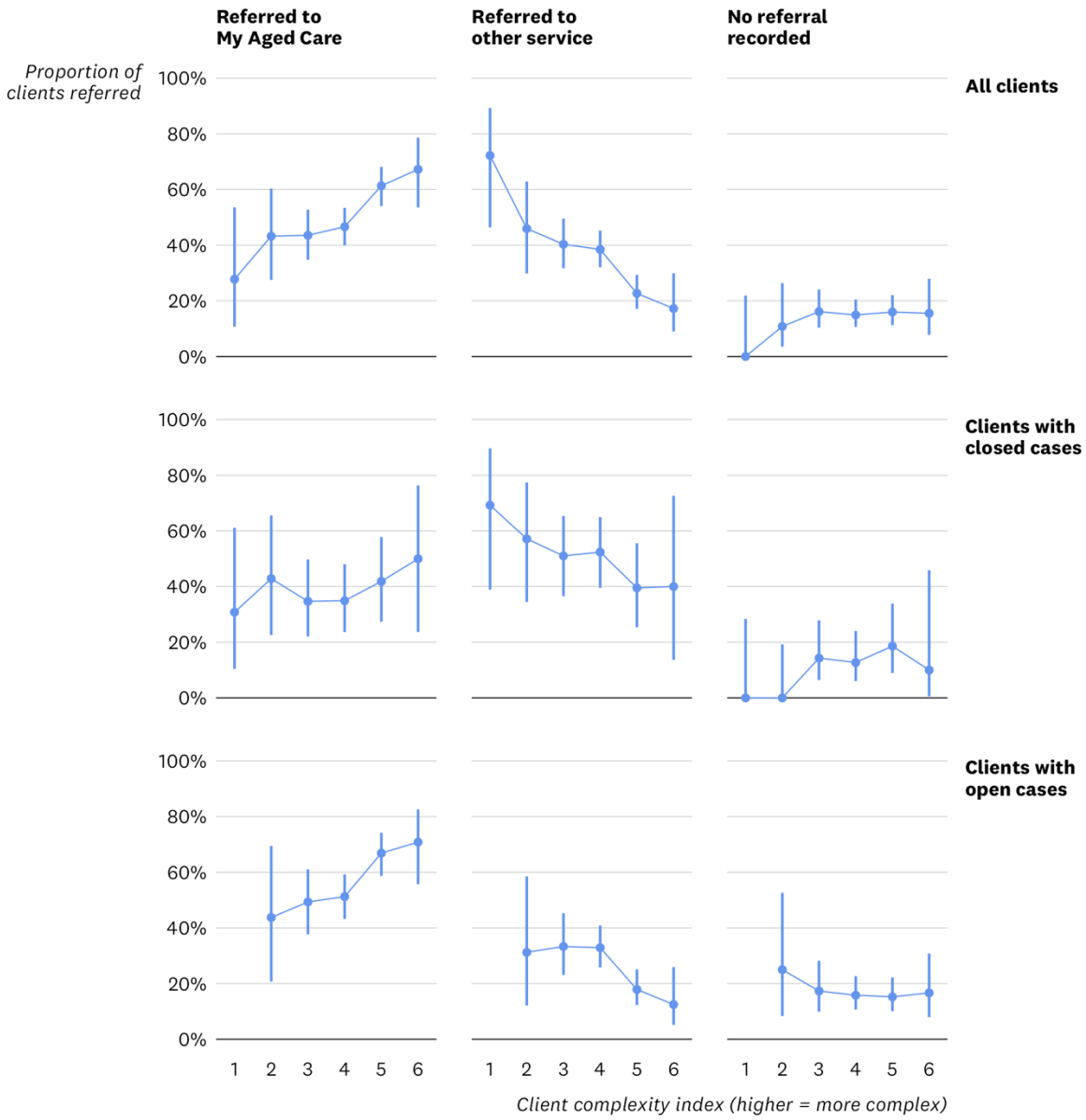
Figure 8. Types of outward referrals recorded for clients by case status



Client complexity also appears to play a role in determining client outcomes. Figure 9 shows how client referral outcomes vary with the client complexity index (described above) and case status (as at the end of 2022). Based on logistic regression analysis, there are statistically significant relationships at the 5% level between complexity and client referral outcomes for:

- referrals to My Aged Care across all clients (increases with complexity);
- referrals to other services across all clients (decreases with complexity);
- referrals to other services for clients with closed cases (decreases with complexity);
- referrals to My Aged Care for clients with open cases (increases with complexity); and
- referrals to other services for clients with open cases (decreases with complexity).

Figure 9. Client referral outcomes by case status and client complexity index with 95% confidence intervals (categories with fewer than 10 clients are suppressed)



Overall, this suggests that there is a relationship between client complexity and the likelihood of being referred to My Aged Care or another service and having an open or closed case by the end of 2022. Clients with higher complexity were more likely to be referred to My Aged Care and for their case to remain open, while clients with lower complexity were more likely to be referred to another service and for their case to be closed.

3.3.3.2 Program theory 6: Low need, low complexity but preparing for the future

When an older person had low English proficiency and low (current) need for aged care services but an interest in registering with My Aged Care in preparation for the future, Connectors provided language and communication support for My Aged Care registration. This support helped older persons feel informed and secure, and prepared for the future.

> *I was ready because I felt Mum needed a bit of extra help and I wasn't always available to help her out, so we definitely did want to try and go down that road, even if it was only a little bit, but just to have our foot in the door. If the worst happen[s], we [are]*

already in the process, and it wouldn't be such a big hurdle to get things going. (Client – carer)

And the things that I told them like, maybe because some of them, they just turned 65. And I keep telling them, it is better to be registered. Because when you need service, not when you when you're sick, and you can't do, or your carer can't assist you, it is better to be in the system before that. And when you need service, you already been registered and have a number (Connector).

I feel very satisfied, very settled, very calm when I am hearing – and I'm just thinking that there's all these … lovely services and to understand about them you feel happy, you feel settled in yourself to know that even if you don't need them now … but in the near future. (Client – older person).

Based on the fact that we are quite well physically, even though we're a bit older, my wife is 70 and I'm 75, we are in still in very good physical health. We are not a priority at the moment even though we have signed up. … That give us some peace of mind because we know that if we need these supports in the future we will be able to action them. (Client – older person).

Clients also knew that they could re-contact the Connector any time their needs changed.

But for the help of my husband … the help down the track, I know they're there. And I will ask for them [the Connector], I will ask for the lady to come to help him have a shower, dress up him or something like that when he's not able to do it. Because now I help and do everything. (Client – carer).

I helped a couple to register with My Aged Care [a few months ago]. And the lady said, "Look, at the moment, we don't need any services." Just four weeks ago or three weeks ago she called me back, and she said, "My husband has been hospitalised for two weeks and we really urgently need the services." (Connector).

Table 11. Program theory 6: Low need, low complexity but preparing for the future

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
Client has low English proficiency Client and/or carer has low need (actual and perceived) but is interested in registering with My Aged Care in preparation for future need	Bilingual support with My Aged Care registration process in own language	Practical support with the process of engaging with My Aged Care	Satisfaction and comfort from being prepared	Older person registers with My Aged Care and understands what to do when need increases

3.3.4 Getting the most out of aged care services

3.3.4.1 Program theory 7: Hanging in there with the client

For clients with immediate need for support, the wait for different parts of the system to activate had been frustrating due to low overall accountability. For example, it was common for My Aged Care registration and screening to be timely, but assessment and then subsequent service delivery to be delayed. Clients and carers had been left waiting for unknown periods of time, and the Connector had had no or limited authority to directly check with My Aged Care on the process or expedite it. For this reason, Connectors typically 'held onto' their clients and stayed in touch until their assessment was completed and services were in place. For example, the Connector would call the client regularly to check on progress, to remind them to anticipate and answer the call from My Aged Care and to let the Connector know when the assessment letter (always written in English, even when the client is known by My Aged Care to not speak or read English) arrived, so the Connector could assist with translation:

> *And we stay with them step by step, until they get a service, which is really, really good. (Connector).*

> *The Connector in my organisation, they help the client to contact and then after about three to six weeks, they contact the client again to check whether the My Aged Care have already contacted. So, they follow up with the case. (Touchpoint).*

Connectors found that if they did not do this, the process was likely to break down. For example, some clients did not receive a letter (for no known reason), so the Connector and client would follow up with My Aged Care by telephone to check the outcome:

> *{But] sometimes they [don't] even … receive the assessment letter from the assessors. So maybe one month later we need to call back My Aged Care to understand what is the assessment result. (Connector).*

The Connector would also help appeal any unsatisfactory assessment outcomes:

> *The assessment person was not great. They didn't assess the person [properly] so they got care package level 2. I had to review challenge. And then we got another assessment done and finally got a level 4 package. (Connector).*

When an older person was assessed as eligible for aged care services and was given a referral code, the Connector assisted them with finding services. Upon receipt of services, some older persons and/or carers felt a heavy weight or burden lift. Some clients reported feeling safer at home and less worried about the future.

> *I'm only in the early stages. I met the gardener here once and the cleaner once, right. But … this is great for me because now I can do my cooking … and I can do the things that I like to do and I will leave the stuff that I can't do, the hanging up clothes … and the mopping … to the professionals. And that just in the last three weeks I feel I'm not as stressed out, I'm not frustrated, it's relieved a lot of the frustration and the anxiety, okay. And I can see that this is going to make my life a lot, lot simpler. (Client – older person).*

> *We just need to keep them safe, so they can stay at home for longer and have some sort of quality. (Manager).*

> *The program helped her to access the services she needed to live independently and safely at home. (Quarterly report).*

So anyway, the clients, when they get the service, you can tell they – when we talk to them, they talk confidently. And they say, "Oh, thank you. This is – we are really satisfied with the service because we got the service. That's what you said and that's exactly what happened." So, we feel good, because they come, take me to doctor's appointment, whatever. I mean, individual support, group support. So they happy. (Connector).

Clients with best outcomes seemed to be those who did not have to wait a long time and could exercise some choice and control (via the Connector) in who provided their services, and those whose needs were so great that they were grateful for any support received.

Finally, then I found the right provider to provide language support and one of the person has similar hobbies in terms of he loves coin collection. They clicked off well, a follow-up call after two months, and she's so happy and relieved. She's like, I've got my life back now. And he's so happy as well, the client is so happy as well. And she can do a lot more things. She's attending social groups now. And more. She's attending gym now. I always think about that client because I saw how hard it was for her. (Connector).

Yeah, they needed a lot. And I remember like when this all got put in place, and the carer had so much more assistance, she actually rang me and her words were, "where have you been [all] my life?" … I definitely knew that was a positive outcome of that one. (Connector).

For many clients, processes of engaging with the aged care system were protracted and complicated but significantly eased by the Connector:

It was a long process and quite overwhelming, but really, the way that the lady handled this helped us. (Client – carer).

When clients became eligible for services, Connectors explored available service providers and presented options to older persons and/or carers. In some cases, when a client had a particular need, the Connector influenced the choice of service provider, ensuring a known and high-quality provider:

[We] understand their situation so try to pick the very gentle support worker, very caring, very gentle one for her. So, she can take care of the wife for two hours and so the husband feel very trustful to that support worker. He can leave home. That is the only support worker he can trust he said. (Touchpoint who also worked as bicultural worker with Connector).

When the Connector first met them, they were reluctant to register with My Aged Care as the system looked too difficult for them and they expected their family could help them. The Connector patiently explained to them with their daughter the registration with My Aged Care as a requirement to access aged care services and how we could assist them and the benefit of receiving aged care services. Eventually they agreed to register. The couple has been mainly staying inside their house during the pandemic, the old woman has been suffering from dementia, therefore the Connector suggested to them to attend a [language removed to de-identify participant] speaking day care program. In the beginning, the couple refused to go. The Connector negotiated with the service provider to let them to a trial. We then received a call from their daughter after the first day, saying that her parents found it very enjoyable. They were telling the stories of their first day to the family and were very thankful for this program. (Connector).

Then, when services were initiated, if they were of lower quality than hoped, the Connector encouraged clients to accept low choice and control, to give the services a go, and to tolerate the services if they provided valuable *enough* support (were better than no support):

> *And we sort of encourage them to say, "Hey, look, give it a go. Why don't you give it a go? You can stop it anytime you don't want it." And often, they have continued in receiving that service. (Manager).*

> *And we also sometimes, just to say, "Well look, just try to see whether you like it or not, and you always can pull out. You don't need to continue." And we actually had a few case that people said, "Okay, I'll try one. I don't really want to commit" and they try once for a day care service, social support service, as soon as they finish on their day they call EnCOMPASS Connector say, "Can you tell them can I go every week?" So, I think that before people actually really try it themselves, sometimes they just don't want to use services. (Manager).*

> *There has been instances where somebody has been provided aged care services but they've not taken them up because they don't trust. … They think, "Oh, we don't know how this is going to work." … But we're saying, "Hey, look, give it a go. Why don't you give it a go? You can stop it anytime you don't want it.' … Because there's aren't enough culturally appropriate service providers here, so we've got to encourage them to take what is there and work with that. So, we've said "Look, it's not going to be too hard. They come in to clean your house. You can tell them this or that, here is the picture you show them if you don't" – and we taught them, "If you use your phone to be able to communicate" – and we know a couple of clients who've actually taken that up and very happy with that. (Connector).*

However, some older persons and/or carers were still waiting (and had been waiting for up to a year) when interviewed for the evaluation. The Connector validated their frustration, but despite this, these clients were 'living in limbo', feeling devalued and despondent. Some disengaged completely from the EnCOMPASS Connector program. It is unclear from the data what made some disengage and others stay connected for longer.

> *One of my client, I have register them with My Aged Care and of course requested for the welcome pack, and she hasn't got any, and she contacted me for the second time and we call together again and request for the second one, and she still hasn't got and she's still waiting for that. When I saw the client I ask her and she said, "Don't worry, they don't like me, they don't want to send me anything." So, she's kind of fed up. She's saying, "That's okay, they don't want to help me." It is really sad, so I told her, "No, we can contact and ask them again" but she said, "Don't worry, I'm not interested anymore." So, it is really sad for our senior people to say that, especially her, she doesn't have anyone, no family members, not much community members, so yes, it was really heartbroken for me. (Connector).*

Table 12. Program theory 7: Hanging in there with the client

<table>
<tr><th rowspan="2">Context</th><th rowspan="2">Intervention</th><th colspan="2">Mechanism</th><th rowspan="2">Outcome</th></tr>
<tr><th>Resources</th><th>Reasoning</th></tr>
<tr><td rowspan="2">Older person is assessed as eligible for services, but services are slow to start, unavailable or poor quality</td><td rowspan="3">Support with seeking, selecting, setting up, changing, and giving feedback to service providers

Expectation management</td><td>Validation and debriefing of disappointment and frustration with service providers; encouragement to wait

Older person / carer can contact and seek support from the Connector any time until services are received and satisfactory</td><td rowspan="2">Older person / carer doesn't give up, maintains some hope that they'll receive support to live the life they want

Tolerance of what's available, acceptance of low choice and control</td><td rowspan="2">Older person / carer receives services that make a valuable (enough) difference</td></tr>
<tr><td>Challenge of high expectations; honesty about what can reasonably be expected/chosen/controlled

Encouragement to persevere or at least try the services out</td></tr>
<tr><td>Unknown context</td><td>Client feels devalued and gives up hope of being supported</td><td>Client disengages</td></tr>
</table>

3.3.4.2 Program theory 8: Where Connector capacity ends, the aged care system fails older persons and carers

It was commonly found that where a Connector's influence ended, clients were failed by the system. For many older persons / carers, services were not available (they did not exist or could not meet the local demand), there were surprising and impractical limitations to the services (for example, cleaning services that required older persons to move their furniture before the cleaning), they were unreliable (frequently changing booking times) or inconsistent (with high staff turnover so that the clients needed to meet and brief a new person every visit), or the co-payments for services were more costly than anticipated:

> *We can't always [get] a culturally appropriate service, unfortunately, because there's aren't enough culturally appropriate service providers here, so we've got to encourage them to take what is there and work with that. (Manager).*

> *Well, yes, having shortages of services. That's been really difficult. That's been really – and that's a wider issue; it's not an EnCOMPASS issue. But it really hasn't – it really causes issues. It causes issues with the clients, with building up all their hopes and then, bang. And then it's like, "We can't really help you". (Manager).*

Some clients had found the unreliability and inconsistency so disruptive and distressing, or the cost so prohibitive that they had cancelled the service they were eligible for and gone without it:

I find them maybe struggling with the money. Because if they every week for the service, when they come, they maybe need to pay $40 to $80 per week. They say, "Oh, I have no money to pay for the gap payment." And they're waiting to apply for home care package, because there is no gap. (Connectors).

A lot of my service users, they didn't use the service either, because they live on Centrelink, they have pensions, which is just meet their daily basic needs. So, they don't want to pay extra, like even $30 for cleaning fortnightly they say. "It's too much for us. We don't have enough savings or enough money to support that part." So, they would just rather, "Oh no, we will think about it later. We don't want that." (Connector).

They reckon that they don't have enough staff. Even the Westhaven people said that they don't have the staff – they have to hire people from agencies. So, I said, "No, I don't want no agencies." (Client – older person).

When appropriate services were not forthcoming, clients generally understood that the problem was not due to the Connector – that the Connector had tried their best in the constraining circumstances:

It's not, it wasn't her fault. She tried so hard. She's got all her papers there, she done it all. (Client – older person)

However, for some clients, this was not enough. Even when the Connector was kind and tried their best, if the process did not result in the receipt of needed services, the client saw little point in the Connector's work. Connectors also often understood this sentiment.

Well, it's been weeks again, and nobody has ring, nobody has come. … So, books and books and books [pointing to several home care program promotional materials] and promises lots there, but not enough help, not enough work happens. … It just hurt me … I know they're [the Connector] trying to help … she is so kind with dignity … but it's just not enough for me. Not enough for me. (Client – older person).

So, I'm going to be honest and tell you the truth, only because I ask around after our experience and see how this service is going with other people in our community, and it seems most of them are happy and fine with it. This is when I questioned myself, is it our sheer luck? Or [the Connector] did not do the job properly? I don't know, and because we don't know, and we don't understand what he needs to do and how he should do things, we don't know these things. But the way we ended up, we do have the question mark, did [the Connector] do what [they were] supposed to do or what is required of him to do, or not? That – we can't answer this question. … It's very hard for me to say, or talk about any other characteristics that [the Connector] should have or [not] have. I don't know. But all what I'm saying this endeavour we went through with [the Connector], it didn't work. But all what I can tell you, we are frustrated, we haven't seen any result. It's been six months and nothing happen. It's really frustrating, I don't know who to blame. The question I want to ask, I still don't know what's going on, I still don't understand how this is going to end, eventuate to. I still have no idea. Where would we go from here, how do we do things? I still don't know. (Client – Carer).

It seems like we are very incompetent, you know what I'm saying? … we are not able to help them. (Connector).

They have been approved something or offered some services but they have not received any services. … I think there's no point for them to be assessed, right, and at the end it's meaningless in a way. (Connector).

So, this is a bit of a frustrating factor, you could call it, for the Connectors in the role. We're out there telling them, "Hey, wonderful services", and you know what? There's no services. (Connector).

Table 13. Program theory 8: Where Connector capacity ends, the aged care system fails older persons and carers

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
Significant delay in assessment outcome	Follow up with client	Regular follow up with older person/carer to check on progress	Client feels disrespected and let down by My Aged Care – exasperated, angry, despondent or resigned Client understands that the Connector has done everything in their power and is grateful	Despite the Connector's best effort, the client's service needs are not met in a timely way
Connector has no authority/leverage in the My Aged Care process My Aged Care staff have no knowledge of the EnCOMPASS Connector program and don't recognise the Connector	Attempt to obtain info from My Aged Care or advocate for client – to no avail.	Lack of resource – Connector is unable to influence My Aged Care		
Client is eligible for services but services are not available	Follow up and advocacy	Lack of resource – Connector is unable to influence services		
Client receives services but considers them unacceptable (e.g., low cultural safety, high staff turnover, does not meet quality expectations)			Client believes that their need for services is not high enough to justify the effort or expense, or to tolerate a poor service	Client does not tolerate and/or cannot pay, so cancels and goes without the services they are eligible for

3.4 Program implementation

This section addresses the third evaluation question:

3. How well has the EnCOMPASS Connector program been implemented? What variations in implementation have affected outcomes, in what ways? What elements/aspects of implementation are necessary to generate intended outcomes, and why?

Three key elements of program implementation were identified. These were Connector capacity building; flexible, co-designed delivery; and stakeholders with reach to older persons from CALD communities. Table 14 outlines the structure of this section – aligning the evaluation question, key elements of program implementation, and respective refined program theories. Each element and program theory is detailed further below with supporting evidence.

Table 14. Evaluation questions and structure of this program implementation section

Evaluation questions	Results of program implementation	Name of refined program theory
3. How well has the EnCOMPASS Connector program been implemented? What variations in implementation have affected outcomes, in what ways? What elements/aspects of implementation are necessary to generate intended outcomes, and why?	3.4.1 Connector capacity building	9. Capacity development through training
		10. Learning on the job
		11. Community of Practice
	3.4.2 Flexible, co-designed delivery	12. Flexible KPIs and enough time
		13. Co-design of culturally appropriate approaches
	3.4.3 Stakeholders with reach to older persons from CALD communities	14. Expertise and networks of employing organisations
		15. Linking with other CALD organisations
		16. Health professionals 'buy in' and refer in
		17. Community leaders engaged and endorsing the program
		18. Clients become program champions

3.4.1 Connector capacity building

Clients, carers, Managers and Touchpoints regularly mentioned Connectors having the necessary knowledge, skills and capacity as a key component, and a key success factor, of the program. The following program theories describe the three main ways Connectors built their capacity for the role, which included formal training organised by FECCA, learning on the job through trial and error and from the experiences of the staff within their employing organisation, and learning through the Community of

Practice (CoP) meetings. Together, these modes of capacity building provided the Connectors with a strong foundation of knowledge, skills and capability to perform their role to a high standard.

3.4.1.1 Program theory 9: Capacity development through training

Where Connectors did not come to the role with prior experience and knowledge of aged care and working with CALD communities, they were able to obtain it through a series of training sessions delivered in a safe learning environment by FECCA:

> *We have been provided a lot of trainings from FECCA. And … the materials … to equip us to conduct that [co-design] workshop … which is very, very useful and helpful to me, because I have no aged care experience before. So yeah, I learned a lot from the trainings provided by FECCA. (Connector).*

> *FECCA did a very good job for training … for my personal learning as well, because I'm totally new in this industry. … I had no knowledge in this industry … trainings, let me know about the theory side, and it just made me grow as well. I'm, I'm very happy to take this role. Because I think I learned a lot. (Connector).*

The training provided opportunities for Connectors to gain a common understanding of client centred principles and methods, and other core competencies needed for the role:

> *All the training I've been attended … this is helpful regarding how to support people, like how to make them feel comfortable … how to respect people … respect the differences and focus on their needs ... how to focus on the person-centred approach. (Connector).*

> *The person-centred approach towards engaging the community … it helped me to change my thinking … if you give them that time, and listen to them, then they would be more transparent and friendly. (Connector).*

Connectors also reported that the training provided consolidation and reflection time and an opportunity to share with others as well as increasing their confidence and knowledge in areas related to their role. This resulted in Connectors being confident to communicate consistent and high quality specialist information about accessing the aged care system to individuals and communities. They also had the strategies and skill sets to provide personalised support, in a culturally responsive, safe and respectful manner:

> *I think for me, it clarified my thinking. … We hope that we present as professional, we hope that we are culturally sensitive, we hope that we are doing the right thing by our clients. So having the training just clarified that and I'm sure it laid down more of a thin foundation for me. (Connector).*

However, the training required a lot of time and some of the training could have been more practical for the Connector role:

> *We were so busy on training … it just very hard to fit in my schedule … put a lot a lot of time. And in terms of the theory … sometimes is just theories that might not very practical for the situation. (Connector).*

Some Connectors had previous experience and expertise in the field and for them the training was less relevant. Previous experience may have been formal qualifications and/or experience in aged care as well as experience working with their local CALD communities:

We also deliberately … chose people with qualifications in this area. So, social work or community services, who understand codes of conduct. … they're highly professional, they're very trustworthy, and respected because they are professionals. … They've been in all the kind of system. Touchpoints as well. (Manager).

I was a support worker person. So, I worked in aged care for 10 years. So basically, most of what they were training, I really had an understanding about it. (Connector).

However, Connectors who started later in the program did not have the same opportunity to participate in the live training program. Instead, the FECCA program administrators provided access to recordings of the previous training materials and highlighted key messages. This provided the new Connectors the opportunity to experience the capacity building training in a self-paced format, increasing the Connectors' knowledge of their role and supporting them to feel more confident to perform their role to a high standard:

For me, I couldn't attend any training because I was the very end of the program. But when I started, they [FECCA] offer to have a separate meeting, along with the community of practise. So, they helped us to understand our role, our responsibility from this program … and how different it is to work with different communities. (Connector).

I started in November, late into the program, but there was a lot training available already, which is uploaded to Microsoft Teams into the training modules for us to access. … For us who have come in a bit later, it's kind of been a little bit up to ourselves, to go into the team's network and kind of train ourselves a little bit. (Connector).

Connectors who started later in the program reported feeling pressured to learn quickly as they had less time to implement the program and get up to speed with their skills and knowledge.

[We were] feeling we have [been] left behind. They already been started. And we have to learn faster than usual because they have time to learn getting everything. … I have processed everything in one month. (Connector).

Whilst the Connectors did receive a number of training sessions, both through FECCA and on-the-job training within their organisations, further training needs were evident for areas in which training had not been provided, such as report writing, community engagement and working with difficult clients:

They're [the Connectors] fantastic out on the field, they're incredible. … But … sometimes when you've got strengths in some, you don't have strengths in others. ... So, clearly reporting writing ... So, I did find that a little bit of a struggle, especially with the quantity of reports as well. (Manager).

[The training] did focus mainly about aged care system stuff, but then … the side of … how to deliver the program … needed more understanding about it. … so they slowly required a lot of marketing. And it's not something I had a skill about previously working in aged care. So how to, how to connect to other community members, and things like that I had difficulty with that. (Connector).

Yeah, and also about other tasks such as how to organise information sessions, how to … look for or … work with stakeholders, like touch points. … how to do casework, how to connect older persons with My Aged Care, how to follow up. I mean like case management. We didn't have training about it. (Connector).

It would be good if we have more training, especially with the difficult clients. … especially with the difficult or fussy client, or some clients have really big expectation and how to deal with them, how to answer their questions. (Connector).

Many of the Connectors interviewed reported that the 'Understanding Australia's aged care system' training they received was inadequate. It did not provide them with the knowledge and skills they needed to be confident in their understanding of different parts of the system, such as assessment, the fee structure for aged care services, and what is available for older people who cannot afford to contribute:

We need the assessors to do some training for us … and we need training about the costs because this is the thing the clients most concerned about. The cost calculation is complicated. We need more training so we can make sure our clients do not pay more than they have to. (Connector).

I was expecting is to have someone actually, from My Aged Care … [to] provide the information on how you register … this is how you do it. … we have a lot of questions, and the person who was providing the training … does not have the answers to any of the questions we have. So, we still on the air. We still trying to find the information. … So that training for me was a fail. … They provided some information, but not to the level that we're working for. (Connector).

For me understanding from the assessor point of view … how they doing the assessment, it [would help] me setting up the client of what to be expected, the questions, so they are familiar. (Connector).

We would need more clear indication of … the step by step how the registration works … what can go wrong and why … so that we could navigate with certainty … better practical instruction of what to do and how. (Connector).

In addition, two Managers noted that formal training alone was not enough to ensure a highly skilled Connector. The Connectors' lived experience, work experience, and community connections also formed part of the Connectors' skillsets. I think a lot of that also has to do with the calibre of workers that we employ. [One Connector] is a [health professional] and actually was born and raised in the [area] so knows that community really, really well. [The other Connector] has a [tertiary qualification in health] and many years' experience of leading teams. … if you have workers that are highly credentialled … and they have the cultural competencies required to do this job … I think those factors combined really contribute to having a successful program. (Manager).

Connectors' capabilities were further supported by the employing organisation's support and networks.

There's no amount of culturally appropriate training, there's no amount of Master degree that's going to give you what [my organisation can] … you need to look at not just the Connector but the organisation that is doing the whole job because it is an ecosystem that it's linked to the communities like a tree. So, within that ecosystem that Connector exists, but they're utilising the existing connections as well as the organisation's name in the community, as well as their own lived experience, as well as whatever they're learning on the go because sometimes we're learning on the go. (Manager).

Table 15. Program theory 9: Capacity development through training

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
FECCA assesses and understands the training needs of the Connector workforce	Training programs are designed and delivered for the Connector program Connectors participate in training about their role and approaches (e.g., client-centred principles and methods) and other core competencies needed for the role	Opportunities to learn – new information, new ideas, 'safe' opportunities to practise	Connectors feel knowledgeable and competent in interactions with older people and carers	Connector communicates consistent and high-quality information to support capacities of individuals and communities to navigate My Aged Care Connector offers personalised support Specialist knowledge of the aged care system and its requirements Connectors have an increased range of strategies Connectors are culturally responsive and safe in their practice
Connectors who start later in the life of the program	FECCA program administrators provide training materials and highlight key messages	Opportunity to 'catch up' on training provided to Connectors earlier in the program	New Connectors feel equipped for their roles	
Connectors with higher levels of prior relevant knowledge or skills	*As above*	Lack of 'advanced' training options	Information as refresher Training as opportunity for reflection	Lesser development of knowledge and skills compared to others

3.4.1.2 Program theory 10: Learning on the job

Due to the low transparency of My Aged Care processes and some Connectors not having experience working in the Australian aged care system, they learned through trial and error and their co-workers' experiences to improve their approach and adapt to the requirements of My Aged Care.

> *So, you try different things, and I'm not saying that they always work immediately, it's a bit of trial and error. (Manager).*

> *During clients' appointments with external service providers or assessors, face-to-face interpreters are not booked, even with prior notifications and written requests on the*

referrals. … When communication attempts with the client are unclear or unsuccessful, a phone interpreter is then used, however this is often inefficient due to audio issues (interpreter struggles to hear the clients and assessor/provider through the phone speaker and multiple people speaking in the room, client struggles to hear the interpreter through the speaker due to hearing issues), multiple disconnection issues, and translation inconsistencies. Connectors have developed a plan to contact assessors and providers before appointments to confirm that an interpreter has been booked. (Monthly report).

Learning through trial and error can be inefficient. However, even when Connectors tried to innovative to reduce inefficiency based on their on-the-job learnings, some My Aged Care system issues were beyond what the Connectors could influence:

Calls with My Aged Care … often dropped normally after 35 minutes while the operator put us 'on hold' and we need to start again. Happened multiple times in the last 2 weeks ago and impacted Care Connector, the client and family members' time to complete the referral process (2 hours for one client). At the beginning of the call, I gave the Care Connector ID & hoping if the phone call dropped, the MAC operator can call us back, so we don't need to start from the beginning again, saving time and less stress for the clients, especially from CALD backgrounds. … Out of 37 calls only 1 MAC operator call the Care Connector back and apologise for the inconvenience and continue the process. (Connector)

Connectors also had access to on-the-job knowledge and training from the experienced staff within their employing organisation. This enabled Connectors to learn from colleagues they respected and recognised as having relevant experience:

I'm sort of like trying to figure out everything by myself and also ask people in my organisation to share their knowledge and experience, because I'm aware that access and support worker, they work in the sector for over 10 years, so they have a lot of experience and knowledge to share with me. So yeah, if I don't have those colleagues, I'm sort of like don't know much. (Connector).

I have a lot of support from my colleagues in my organisation. … Because they have been working in these aged care sector for a long time. … [If] I need to run a, an information session. They will, they will guide me how to do it. … they also guide me [on] how to … assess the information from My Aged Care. … they have been helpful … without them, I don't think I can do my job. (Connector).

This on-the-job learning led to an increase in the Connectors' knowledge of the system and CALD groups in their local areas:

The Connector started this project with little experience of the aged care sector. However, the Connector was quickly equipped with practical training from [the organisation's] Access and Support team and work colleagues, who have a vast knowledge and experience in helping older persons to navigate the aged care system. With the guidance of the project lead, who had well-established networks and significant experience within the sector, the Connector was able to successfully seek out and establish a network with local Touchpoints from the … target communities. (Quarterly report).

Connectors' on-the-job supports also included supervision support from their manager who could provide advice and guidance about the role and how to work with local CALD communities:

I'm … getting a better progress, because now I have a change of a manager. And that person has already worked … worked in the community for long, she's got community network already. … I've already access My Aged Care … [for] two people already. So that that tells me there is improvement in this. (Connector)

I'm quite new in this industry, and not really in touch with aged care. … my manager is very professional, and she had a lot of experience. So, she guided me through all the way. And now I think we work it out quite good as the team. (Connector).

The manager we have, they are very supportive to the program. And we meet actually fortnightly … to see how the project's going and what's the next step … the internal meeting was really meetings were very amazing. (Connector).

However, where the supervisors were inexperienced, they were not able to provide the necessary guidance to the Connector, resulting in the Connector feeling unsupported and unsure about how best to perform their role:

My manager is also new to the program and my connector colleague has been on leave. I feel like I've been very much teaching myself things which has been a bit difficult. (Connector).

My previous manager had also been a new person into the role into the organisation … she wasn't a community development, personal community service person … she gave me a list of people [to email]. … I never get any respond back. (Connector)

Further on-the-job training was also available to some connectors through their organisation. This provided the Connectors the opportunity to continue to build their skill sets beyond that of the FECCA training.

… training outside of the connector program … first aid, [and] other training … (Connector).

The Connectors attended training and local inter-agencies such as; [organisation name] CHSP Forum, the [local] Community of Practice training and workshops. Through these involvements, the Connectors not only improved their knowledge about aged care services but non-aged services such as housing; and built relationships with organisations of these network meetings. (Quarterly report).

Completed [training]: Recognising and Responding to Abuse, Aged Care Quality Standards, Preventing Aggressive Behaviour in the Workplace, Incident and Hazard Reporting. (Monthly report).

Table 16. Program theory 10: Learning on the job

Context	Intervention	Mechanism		Outcome
		Resource	Reasoning	
No practical training in working with My Aged Care	On-the-job learning	Trial and error	Connectors learn through erroneous and inefficient	Connectors adapt to the requirements of

Context	Intervention	Mechanism		Outcome
		Resource	Reasoning	
Low transparency in My Aged Care processes			dealings with My Aged Care	My Aged Care to increase efficiency.
Connectors have access to on-the-job knowledge and training from the experienced staff within their employing organisation		Expertise of co-workers	Respect system, cultural and client expertise of colleagues within employing organisation	Connectors' knowledge of the system and CALD groups is increased

3.4.1.3 Program theory 11: Community of Practice

FECCA established a Community of Practice (CoP). All Connectors were invited to join a peer network which connected quarterly via a Microsoft Teams platform to discuss their experiences implementing the program.

When Connectors valued the CoP meetings they prioritised their attendance at the meetings and participated actively. This exposed them to peer learning, collective problem solving, collegial support and validation of the shared challenges, which made the Connectors feel connected with others. They also felt validated that the role could be challenging, with the meetings providing assurance that they should not take the challenges personally or as a reflection that they were not good at their role. This gave Connectors motivation to persevere with difficult situations.

> *I think many participate in that network meeting. ... It's kind of encouragement and mutual support. (Connector).*

> *And for me I think it is really good to join FECCA discussion because in this case we learn from each other … most of people they are facing the same issues, and we have chance to share how to deal with that, what to do. (Connector).*

> *Like, sometimes when they are these challenges, you start questioning yourself? Oh, my God, am I doing the right thing? Or … do I need to do more or something like that? So, I think when hearing the same experiences from other people, it's really helpful, like normalise things. (Connector).*

The CoP meetings also generated increased awareness and ideas for good practice:

> *Everybody were able to share what they have been doing. … Because we know what everyone has been doing and also that gives us motivations … [it] encourages me. (Connector).*

The CoP meetings also provided an opportunity for the Connectors to collectively inform FECCA about systemic challenges and barriers, which in turn provided FECCA with the opportunity to advocate for change in My Aged Care. This made the Connectors feel heard, which motivated them to persevere with difficult situations as they felt hopeful that they could contribute to broader system change:

> *I think like the same issues, many Connectors are facing, then we raised in the community of practice. Yeah. And then I think FECCA is trying to, you know, liaise with My Aged Care, see whether My Aged Care can grant us a better access, or, you know, easier to talk with them on behalf of our clients. I think this is a good approach, you*

know, deal with a system at a higher level, rather than we every one of them, just, you know, struggling or battle with My Aged Care, individually. (Connector).

FECCA responded to these concerns in relation to their advocacy work:

We're hearing all of you in your feedback to us both in these meetings and in the monthly reports that this is a really chronic issue around My Aged Care. … So, we definitely take that on board and are continuously feeding that through. … As well as to the Department. (FECCA staff member at CoP meeting).

The collegial support and advice extended beyond the CoP meetings, into the shared Microsoft Teams chat:

One of the Connectors was new to this role, and had not had any experience in aged care sector. So, when she expressed her concerns or asked questions on MS team, a lot of people have given the inputs as to how they connect. … So, it helped other Connectors … everyone started putting in their ideas. (Connector).

One Connector who had not attended the CoP meetings, as the meetings were held on their non-working day, commented that they felt isolated and lonely:

I've basically been on my own except for my Manager and then my reading resources I can find. … I know I can definitely reach out and contact someone. But … there's not much interaction with other Connectors or anything like that which can make you feel lonely. … It's a little bit isolating. (Connector).

The Connectors who had missed CoP meetings expressed their interest in attending future meetings and some recommendations to help increase attendance:

[When] those meetings happened was really hard for me to attend those meeting. … So, I hope next time we'll be able to attend. Yeah, it's only the time. (Connector).

I think most of the Connectors actually do work part time. … So, I think if they were more frequent … [or] at different times during the week, that might be helpful. (Connector).

There was not enough time in terms of invite as well, they probably should give us at least three weeks', four weeks' notice. (Connector).

One Connector also suggested some facilitation improvements to enhance the CoP experience:

[The] community of practice meeting was such a good idea … I think it should have been done earlier. … And I think it was too short. So not all Connectors have the opportunity [to share] … if it's individual matters maybe they can raise it later on. But we start with general and then we give opportunities for everyone to talk. … It can be it can be moderated better … there is a lot of common themes in terms of challenges … we could come up with themes, and then maybe FECCA could pick it up [for] the next … practice meeting. (Connector).

Table 17. Program theory 11: Community of practice

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
Connectors actively participate in Community of Practice meetings Connectors value the CoP meetings, prioritising their attendance	Peer learning, collective problem solving, collegial support and validation of the shared challenges Collective advocacy (to FECCA) about systemic challenges and barriers	Hearing from others, collegiality, validation of concerns and frustrations Opportunity to affect system change	Increased awareness and ideas for good practice Connectors feel connected with others and validated that the role can be challenging; the challenges are not personal Connectors feel heard by FECCA and are hopeful of system change	Connectors have an increased understanding and range of strategies for their role Connectors are motivated to persevere with the role

3.4.2 Flexible, co-designed delivery

The following program theories present the value of having flexible key performance indicators (KPIs) and enough time to do the role as well describing how the co-design of culturally appropriate approaches supported the implementation of the program. Flexible KPIs and time allowed Connectors to implement the program suitably for local needs, which in turn meant that implementation differed across the nation. This however should not be seen as a deficit, but rather a strength of the program: it enabled local responsiveness. Co-design of promotional materials supported the development of culturally appropriate messaging to the community and enhanced the reach of the Connectors into the community.

3.4.2.1 Program theory 12: Flexible KPIs and enough time

As the Connector program was new and did not have any profile within the community, the KPIs recognised the time and resources required for community development and were flexible enough to let the Connectors focus on what was most needed for their community. Some of the employing organisations and Connectors embraced working flexibly:

> *I think the strength of the EnCOMPASS program is in the community engagement approach ... organisations can get people or tackle issues in their own way. Always meeting KPIs of course or meeting the deliverables, but pretty much each organisation is free to do so far anyway. (Manager).*

> *FECCA is quite flexible with that [KPIs]. They said, it does depend on what your community wants. (Connector).*

They also had the time and resources required for both community engagement events and client case work. This provided a supportive environment for Connectors to work with autonomy and balance client and community work as they saw fit.

Playing dual roles of community engagement work and individual navigation work can be challenging, particularly if clients have heightened needs during a time when the Connectors have been preparing for an event that requires a lot of planning and preparation. … To address this, we have capped the 'case-load' at 12 clients each as our Connectors are both half-time. We currently have a waiting list. It is evident that the need in the community exceeds our capacity in this project. (Quarterly report).

This supported Connectors to feel confident that they could do what they needed to and that they were able to work with the community 'where they were at':

With the EnCOMPASS small group information session, we were able to build trust and relationships with the elderly people. The information session helped the elders to gain a deeper understanding of aged care services and shortened the time needed for 1:1 support during registration and service requests. (Quarterly report).

I see that the Connectors from my organisation ... they're trying to access the communities on a broader sense ... they arranged meetings with the communities ... it's a good way to connect to the community. ... If the program can support to arrange more and more activity with the community, … it can make more valuable – like they could provide information to more people. (Touchpoint).

A number of Connectors seemed uncomfortable working under such flexible KPIs and commented that they wanted clearer KPIs for one-on-one client support in the program:

Most of our KPIs are focused around [community engagement] … it's like, Oh, should I be trying to find more clients? Or should I just be trying to do more of the information sessions … ? … if it's a community engagement program, then that's good. But if it's really more of a one-on-one program, then just the clarity or the KPIs on that as well. (Connector).

Conversely, where the employing organisations imposed additional KPIs, or Connectors were part time or had too many target communities to support, they did not have the time and resources needed to deliver on both community engagement events and client case work. This reduced autonomy and the ability to balance client and community work, which left Connectors feeling overwhelmed, overworked and that their work was unbalanced. As a result, Connectors were unable to deliver sufficient and effective community engagement events and were not able to establish rapport with the communities:

I am trying to make sure that we reach the community that we need to reach, I know the requirements of the contract … is not set to a number of people monthly. … So, the organisation I'm working for, they are trying to set a goal, … [but] when it comes to the pilot program, especially when you initiating and making awareness to the community, and then you put in on top of that, a set number [of clients] … I'm telling you this because I feel extremely, extremely under pressure … if you pushing this to the community, you pushing the community away. … [I said], No, we're doing this as a pilot program and looking at the requirements of the contract of FECCA, we are providing awareness. That's why there is no a set number of people, by monthly, and there's no KPIs for that. And what's gonna happen is, if you upset one person in the community, everyone is gonna know. (Connector).

I think I will try to balance out the work of the Connector because I feel that for this project, we … do too much outreach activity to promote aged care services and then we don't have much time to do case work, so what is the point of like trying to promote

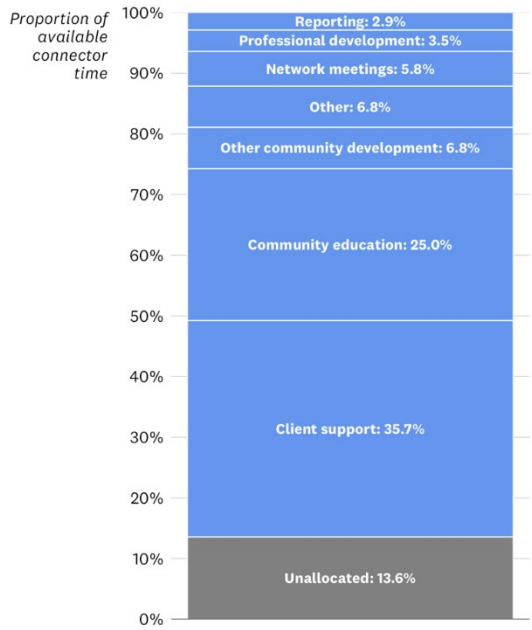
… getting more client coming and then you don't have time to support them? (Connector)

The struggle between community capacity building and casework. … It's about how much manpower we have at the end of the day. Because, as I said, if you have a couple of complicated case, it's really hard … because … community capacity building, you also need a lot of time to build up the trust and the network. So, this is the biggest struggle for me. And if I could change, I don't know, the manpower or structure of manpower. (Connector).

3.4.2.2 Time and task snapshots

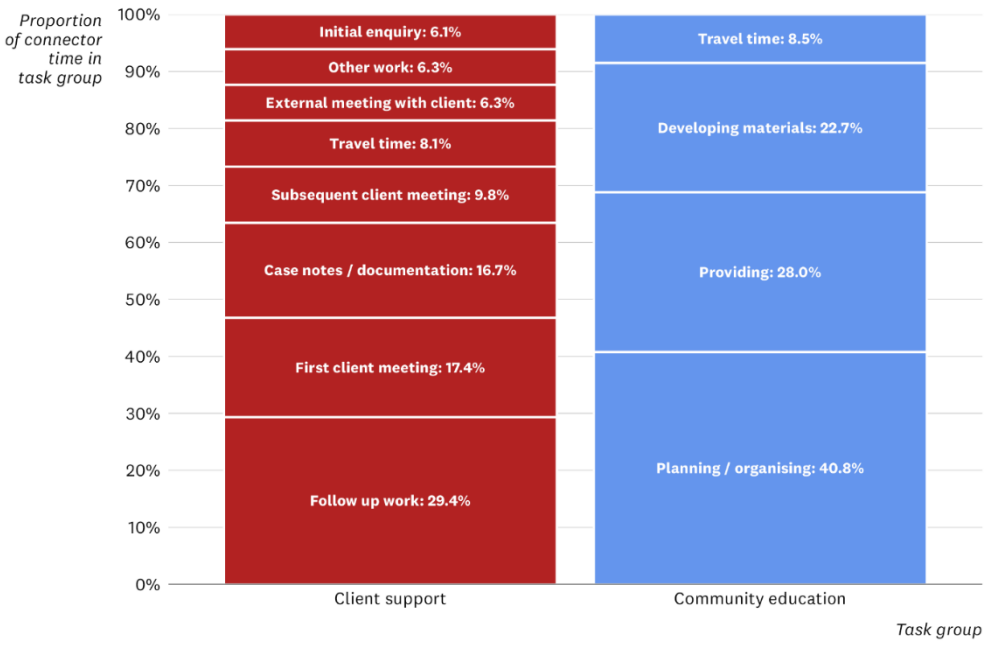
The time and task snapshots showed that client support made up just over a third of the overall workload of Connectors, followed by community education (see Figure 10).

Figure 10. Allocation of available Connector time to tasks (all sites combined)



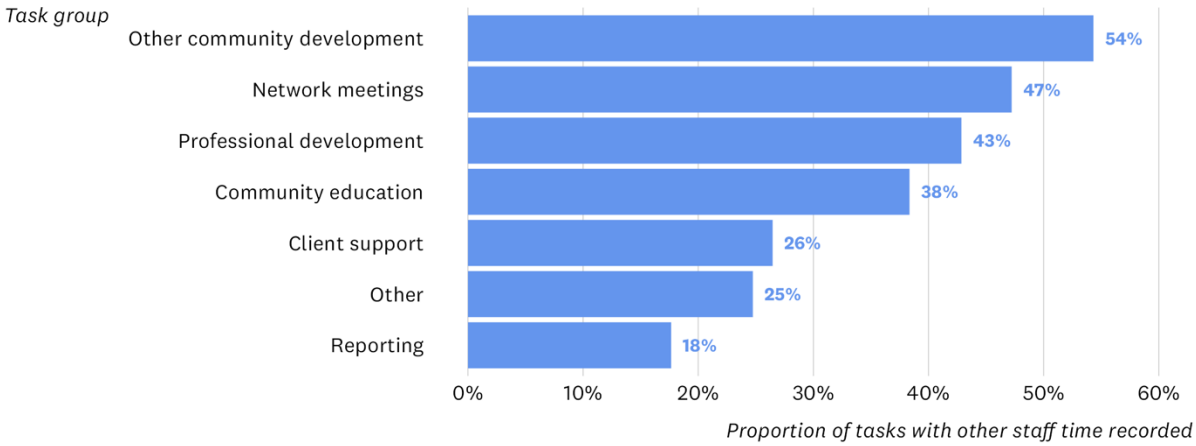
Around 40% of client support time was spent in direct contact with clients (initial enquiries, initial and follow-up meetings with clients, and attending other agency meetings with clients). More than half was spent on indirect work associated with supporting clients (case notes, follow-up work, travel and other client support work). For community-level work, 28% was provision of community education, with the remainder spent on behind the scenes preparation and travel (see Figure 11). In some cases, this preparation also involved community engagement in the form of co-design and collaboration with older people.

Figure 11. Detail of Connector time spent on client support and community education tasks



The time and task snapshots also revealed the contribution of other workers within employing agencies to the program. Time for other staff members (that is, aside from Connectors) was recorded for 31% of tasks recorded by all sites during the two snapshot weeks combined. It was more common for other staff members to be involved in community outreach and network meetings tasks than with client support or other tasks (see Figure 12).

Figure 12. Proportion of tasks with other staff time recorded



While Figure 12 shows the proportion of *tasks* to which other staff contributed, Figure 13 below provides detail about the proportion of *time* that those other tasks required. Across all sites combined and both snapshots, around 45% of the recorded non-Connector time was for tasks relating to community education and development, and 25% was for client support tasks. While it was relatively common for non-Connectors to be involved in network meetings and professional development, the total amount of non-Connector time recorded for such tasks was relatively small. This may reflect that not all sites did such activities during the snapshot week, or that Connectors attended network meetings and training that non-Connectors did not.

Figure 13. Allocation of non-Connector time to tasks (all sites combined)

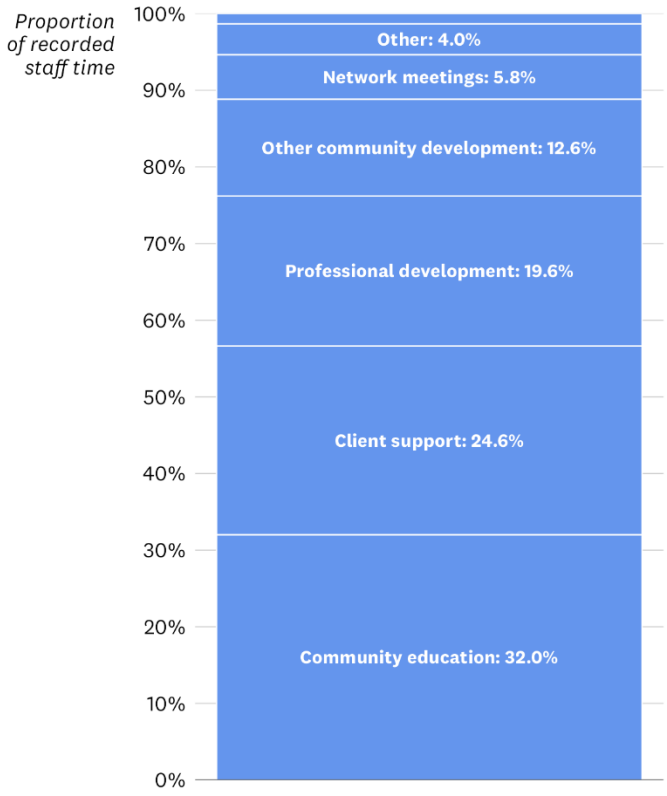


Table 18. Program theory 12: Flexible KPIs and enough time

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
New program with no profile in the community KPIs are flexible enough to let the Connectors focus on what is most needed for their community and recognise the time and resources required for community development. The employing organisation and Connectors understand why this is and embrace it Connectors have enough time and	Both community engagement events and client case work	Autonomy and ability to balance both client and community work as seen fit	Connectors feel confident that they can do what they need to, to 'meet the community where they are at'	Connectors can balance both community engagement events and client case work, based on current community needs and issues

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
resources to do the work required				
The employing organisations impose additional KPIs OR Connectors are part time or have too many target communities to support	Delivering both community engagement events and client case work	Reduced autonomy and ability to balance client and community work	Connectors feel overwhelmed, overworked and that their work is unbalanced	Connectors are unable to deliver sufficient and effective community engagement events as well as client case work and are not able to establish rapport with the communities

3.4.2.3 Program theory 13: Co-design of culturally appropriate approaches

Effective co-design required three contextual factors. Connectors and/or their employing organisations needed existing contacts within the target communities, the Connectors needed the time and resources to develop marketing and engagement approaches with target communities, and Connectors needed an understanding that different groups access information differently. When all three conditions were met, Connectors were able to work with members of each target community to design nuanced marketing and engagement approaches:

> *It is important to approach people in appropriate way like ... So, we have to find different strategies so it is important to be present where they are … So, where the people are we go and you know inform them. (Connector).*

> *We did one [co-deign session] with each community because obviously we expected the information to be different and it was. So, I think that's a really valuable thing to start with, is to talk to people about how they like to receive information and where do they get their information from and if they had to design a campaign for their community how would they do it or what would they have in it. (Connector).*

This gave the Connectors the opportunity to develop an understanding of the specific messages and methods that were most preferred/accessed by communities. This led to marketing and engagement approaches that were appropriate and effective in reaching and maximising the engagement of target communities:

> *The co-design workshop, like is really helpful as well. So those workshop can give more ideas and how to approach to the community members. … depends on the cultural background, as well. So not every theory adapts to older community members. So, in Asian country for seniors, they will more trust to their friends. So, word of mouth is very important role between them. (Connector).*

> *So, the Chinese community and the Filipino community operate very differently. Filipino community are a lot more easier to engage. People love getting together, it's very*

social. In some way, quite a cohesive community. With the Chinese community, it's much harder to build trust. (Manager).

For the Vietnamese community … they get information from SBS, radio, or Viber. … they usually prefer listening to people who they know or trust. Specifically, they share information with each other in social clubs, churches and temples. And they suggest … we shouldn't do newspaper because they don't read newspaper. And it's a good idea to send flyers to their to their house. For the, for the Cambodian community, they told us, they love via Facebook Messenger. … And they usually find information via their community service services organisation. (Connector).

Community engagement preferences and techniques continued to evolve and Connectors continued to develop their understanding of community preferences. Many recognised that all communities will require multiple strategies:

Depends on the context … in terms of reaching out to the clients, we follow different marketing strategies, we're still learning, we're still trying. … We approached the community leaders, we approached other organisations, aged care organisations, we … approached assessment teams, we've gone through the radio, we've approached community radios, we've gone through the print media, this cultural print, we like different language … we have established connections, and we have not struggled for referrals, it's been coming through. (Connector).

COVID restrictions impacted on the delivery of some co-design sessions. One Connector explained how they had to adapt the focus of their co-design workshop to seek assistance from younger carers to get the messages out to the older people during lockdown periods:

So, for these co-design workshops, we run online via zoom, due to the high cases of COVID-19 … the older persons, they're not good with Zoom. … we've been struggling thinking about a solution of how we're going to host the workshop. … we got a very good advice, which is to also target the young generation, because the carers, … they can get the information and then they come back and explain it to their parents or their grandparents. … they're quick to understand, and they can be great help to us to spread the message to the other older persons in the network. (Connector).

Whilst the co-design sessions did provide insights into message promotion, several Touchpoints and carers still commented that they would like to see more promotion and marketing of the program:

Promoting it more … that these things are available. … a lot of these people won't know it because they're probably not on social media, but they do listen to – The older ones listen to the radio, so that's a really important stream for them to be able to get that. (Touchpoint).

Maybe advertise more, … advertise it more so that people can know there is help for them. (Client – carer).

Table 19. Program theory 13: Co-design of culturally appropriate approaches

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
Connectors or their employing organisations have existing contacts within the target communities Connectors have the time and resources to develop marketing and engagement approaches with target communities Connectors understand that different groups access information differently	Connectors work with members of each target community to design nuanced marketing and engagement approaches	Specific information about client and community needs and perspectives and/or feedback about the effectiveness (or otherwise) of specific messaging	Understanding of the specific messages and methods that are most preferred/accessed by communities	Different information sharing preferences are captured and considered in design processes Marketing and engagement approaches are appropriate and effective in reaching and maximising the engagement of target communities

3.4.3 Stakeholders with reach to older people from CALD communities

This final group of program theories presents the value of capitalising on existing networks and connections into CALD communities. The five predominant areas where Connectors leveraged the networks of others were the networks of their employing organisations, other CALD organisations, health professionals, community leaders and past clients. Each of these stakeholder groups provided different access to CALD communities. However, all were grounded in the same principle of trust, specifically, the value that CALD communities place on information and recommendations that come from people whom they trust. These stakeholder groups significantly enhanced the reach of and engagement with the Connector program.

3.4.3.1 Program theory 14: Expertise and networks of employing organisations

Many of the employing organisations had a mandate to support older people and a good reputation with and connection to local CALD groups and clients:

> *Our organisation have a connection – our relationship with the CALD community [as a] provider who's supporting the CALD older persons. … So, our relationship already for [the] last 40 years, it help our EnCOMPASS Connector to build that relationship with those stakeholder much quicker … they have that existing relationship. (Manager).*

[Organisation name] has been working with the community for more than 60 years, which has made it easy for the community to trust the many programs that the organisation offers. (Quarterly report).

[Organisation name] has shown stability, has over 37 years of experience in working with the CALD community. ... We have built trust and good relationships and good linkages over the years with the community. (Quarterly report).

Where the Connector had time and capacity to support the employing organisation's existing clients, the Connector built relationships and trust with the staff through reciprocal working relationships. This gave other staff an increased awareness of the EnCOMPASS Connector program and an understanding of how it could benefit their existing clients. Because the staff trusted the Connector to support their clients and communities, they referred existing clients and networks to the Connector:

The whole team knows and understands what the EnCOMPASS Connector does and will refer on. … So it's very much a team, a network. (Manager).

I think the beauty of having had [the Connector] as part of the community aged care team is the fact that if older persons who were part of entry-level care, if their circumstances changed and they needed to be transitioned to high-level care … the staff … were able to refer their internal clients to [the Connector] who then worked with them, went back to My Aged Care, a review was undertaken and those clients were able to transition to higher-level support. (Manager).

Our culturally diverse staff across the organisation supports EnCOMPASS by referring people they encounter and sharing this program through their network. … To further promote EnCOMPASS, our bilingual workers and staff has been trained and provided information on the program. (Quarterly report).

Leveraging the connections of the organisation and the existing staff was of greatest need where the Connectors did not have connections to the CALD community prior to commencing in the role:

I started speaking to the caseworkers that are at my organisation. And that's how I managed to start, some of them, to meet some of the people, and stuff. And that part worked out well (Connector).

What [Manager] start doing is every person that has event, or they invited to events, she will CC me on it. And she introduced me to those people, …. Because if, if you don't know me … we haven't built trust, I can talk to you about the program and … you won't care whether it's benefit you but if it's coming from someone that you know, it comes as with trustworthy. (Connector).

Within some organisations, the referrals also went in the opposite direction, with the Connector referring their clients into the organisation's other services (such as social support services). Consequently, they had access to needed services while they were going through the My Aged Care registration and approval process:

The benefit is we have support within our agency … we try and provide a holistic support to our clients … we've got older men's group running for social engagement – we've got a women's group running from the other program … and they can be referred on immediately to these groups. And the Connectors being with [the organisation], they have that knowledge, and have the connection with the other staff members. (Manager).

One Connector provided insight into the challenges they experienced when their employing organisation had not yet established a positive reputation within parts of the target community:

> *I know the community, … I can be in contact with them, I can draw them to get in. … I've been working with them in the last 10 years, but they don't know you, your organisation. … there are few people already approached me saying they have issues with the organisation I'm working for. And that means that they don't trust and they don't want to approach anymore. What happens is this community gonna talk to each other and other groups. (Connector).*

Because this was a single comment, a program theory for it has not been included. However, not all Connectors were interviewed, and it is possible that this experience was somewhat more widely spread than it appeared. It may also be an issue for the Care Finder program, which will be a more mainstream service. It is, therefore, something that should be monitored in future programs.

Table 20. Program theory 14: Expertise and networks of employing organisations

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
Connector's employing organisation has mandate to support older people and good reputation and connections to local CALD groups and clients Connector has time and capacity to support the organisation's existing clients living with social complexity, who need support to access My Aged Care	Connector builds relationships with the staff in the employing organisation	Reciprocal working relationships	Staff in the employing organisation have increased awareness of the EnCOMPASS Connector program and understand how it may benefit their existing clients and networks Staff trust the Connector to support their clients and communities	Staff of the employing organisations connect existing clients and networks to the Connector

3.4.3.2 Program theory 15: Linking with other CALD organisations

Multiple factors were necessary for Connectors to be able to link with and work through other CALD organisations. The employing organisation needed a good reputation and existing relationships with CALD organisations, the Connector needed specialist knowledge of the aged care system and dedicated time to engage CALD communities, and the Connector needed to be experienced by clients as being culturally responsive and safe:

> *We've got good relationships with other multicultural providers and mainstream providers as well. So, that has been very helpful for this program to sit where it is sitting within our organisation. (Manager).*

We also attend local aged care interagency, so … we will also raise some issue faced by the EnCOMPASS program at the local interagency as well. (Manager).

In these circumstances, Connectors were able to use their knowledge/skills and networks to build relationships and promote the program. Some also provided tailored capacity building activities for CALD organisations. Staff in the CALD organisations saw the value of the Connector role, trusted the information provided by the Connector and had increased knowledge about aged care options for CALD community members. This supported CALD community organisations to provide accurate and timely information about aged care and the Connector program to their clients, and to refer their clients. It also provided Connectors with increased knowledge of and connection to local CALD groups:

The first thing that we have done when we got the EnCOMPASS we came together with [the other two CALD organisations funded to have Connectors] and we actually hold an event for multicultural service providers and multicultural led or multicultural organisations in general, and leaders in the community, to reassure them how the program works. … So, we very early on very openly discussed of what are our boundaries. … the end result for us is the person is engaged with My Aged Care and … services in a way that it suits them, not [our organisation] or [another organisation] or anybody else. (Manager).

However, when there was not a good relationship between the employing organisation and other CALD organisations, the Connectors were not able to build trust and the other organisations did not refer to the Connector program due to fear that the employing organisation may steal their clients:

It would have been great to build up this network to deal with all the underlying issues that could be going on in the background. … Building up that network makes you stronger as a sector, and it helps you to address some of those issues … then you could have addressed other issues around, "We're not here to steal your clients. In fact, we could channel people to you." (Manager).

Service providers believe the EnCOMPASS program is a competing service provider. Service providers are unwilling to engage with Connectors, or promote the EnCOMPASS program to their community. Connectors invited service providers to information sessions, co-design meetings and support navigator meetings, however they declined the invites. (Monthly report).

In the way the Connector program is currently, we have a few multicultural providers but not all of them. I feel that there is a cohort of people who have missed out on it. Not that we can't take referrals, but then the other multicultural providers don't have the trust. They think we're going to take away their clients, which isn't the case. (Manager).

The above quotes suggest that when the invitation strategy failed, the Connectors did not attempt to re-approach the CALD organisations in other ways. However, this issue was not discussed further during interviewing, meaning it is not known with certainty whether Connectors did attempt alternative strategies.

Table 21. Program theory 15: Linking with other CALD organisations

Context	Intervention	Mechanism		Mechanism
		Resources	Reasoning	
Connector works for an organisation that has a good reputation with other CALD organisations The organisation or Connector has existing relationships with CALD organisations Connector has specialist knowledge of the aged care system and its requirements, suppliers and services Connector has dedicated time to engage CALD communities and is experienced by clients as being culturally responsive and safe	Connectors use their knowledge, skills and networks to build relationships and promote the program Connector provides tailored capacity building activities for CALD organisations	An extra and valuable resource for organisations	Staff from CALD organisations trust information provided by the Connector, see the value of the Connector role, and have increased knowledge about aged care options for CALD community members	Increased capacity of CALD community organisations to provide accurate and timely information about aged care services and the Connector program CALD organisations refer their clients Connector knowledge of and connection to local CALD groups is increased

Context	Intervention	Mechanism		Mechanism
		Resources	Reasoning	
Competitive funding systems	Connectors or employing organisations invite other organisations / service providers to information or education sessions		Other service providers see the employing organisation as a competitor, potentially 'stealing clients'	Other organisations do not engage with the program Referrals not received from other organisations

3.4.3.3 Program theory 16: Health professionals 'buy in' and refer in

For some older people, general practitioners (GPs) and other health professionals were a trusted source of information for CALD older people and were, therefore, stakeholders from whom the Connectors could seek referrals.

> *Because they [GPs] are trustworthy by the elderly. That's the reason why sometimes they will do the referral to My Aged Care on the behalf of the elderly, they get their nurse or administration administrative assistant to do it. (Connector).*
>
> *… GP or doctors at hospital are their trustworthy source of information. (Quarterly report).*

When the Connectors worked for well-known organisations, were highly trained and competent and proactively promoted the program to health professionals, they were able to build relationships with local health professionals and provided information about the Connector program.

> *I think what has really helped the EnCOMPASS being with us is that everybody knows us, our organisation… So, within the health settings … we're already well-known … (Manager).*
>
> *So, I think with our proactive engagement with the hospital, community and primary health care sectors, we now are who they think of when they have either a referral or a discharge to plan for someone from a CALD background who's elderly. (Manager).*
>
> *…we also deliberately … chose people with qualifications in this area. … they're highly professional, they're very trustworthy, and respected because they are professionals… We notice that the first few referrals from the nurse navigators – the nurse navigators didn't trust us yet, and they were hanging onto a few clients, and wanted to do this co-case management type of thing. And then, slowly, slowly, they let the client go when they realised, "Okay, these guys actually do know what they're doing." (Manager).*
>
> *… So not only you're connecting, then you're sending follow-up emails, you're sending out follow-up phone calls, and then you're sending out follow-up information. So, the process is – it's not as simple and it's not as easy. But yes, that's how we've been effective, I suppose, as well. (Manager).*

Active promotion increased health professionals' awareness of the Connector program. Where they trusted that the Connector had the skills to support the client and they saw the value in referring their clients on, they referred clients to the program.

> *So, the [hospital] system because of the sheer volume and the lack of resourcing is under strain just to deal with every day not too complex referrals so as soon as you get one where there could be a language issue, a cultural barrier, maybe a complicated visa situation …– the system is under so much stress for someone to actually unpack that and deal with that. It takes a bit of know how. … prior to EnCOMPASS being there probably a lot of those cases probably slipped away or fell through the cracks or didn't really get managed very well so when our staff presented to [the] nurse navigators … straightaway they got referrals because it's often the nurse navigators who get pulled into discharge planning so you have complex elderly people from a CALD background, things are really unclear, it's not sure what's going to happen so then they bring in the Connector to kind of work out, "okay, what are our options here"… And I think also with the RAS and the ACAT it's the same kind of thing so they have also referred people or wanted to work together. So, I think we're actually giving better capacity to the system*

that's there. …And we're giving cultural capacity to the system which is lacking. And I guess, yeah, if we can somehow preserve that in the future when Care Finder comes in I think that would be really crucial because that, in my opinion, only specialist multicultural services can provide. (Manager).

And the connection with… local GP … that actually help a lot… those who do not necessarily attend any community services… They are the group usually it's hard to reach. So that's why we work with a lot of like GP, bilingual GP, pharmacy, who then may have contact with those older persons. And to build our relationship with those stakeholder who make referral to us or help us to promote the services to the patient. (Manager).

… [we have presented to] RAS assessors, ACAT teams, nurse navigators… PHN, aged care teams and we've had referrals from the system as well. … they [the older people] are highly complex and those service providers are struggling with those clients and then go, "great a multicultural service, we'll just send them there". (Manager).

However, it can be difficult for Connectors to access GPs to promote the program, and some Connectors were not receiving many referrals from GPs.

Connector has had difficulty in accessing general practitioners because they do not hold meetings with members of the community unless they are fee paying patients… I have had no replies from any GPs about my program so this has been a very difficult pathway for the Connector. (Quarterly report).

… how do we get the GP or health or the health workers to promote EnCOMPASS program to the community. What we have, what we're doing now is we try to hand our flyer to some GPs in our in the region that I look after, I also find a difficulty. Because some of them … may not be willing to because … they don't really understand or they don't really know this program. So, if they put something in their clinic, they 'that okay, in a way, it's like, am I endorsing this' You know, so then they may not be willing to do because they may not understand what is EnCOMPASS. (Connector).

And I think also the GP have a time constraint because the number of patients that they have, they can even do a direct referral to their system, but I don't see much of referrals happening from GP... (Connector).

Primary Health Networks may be in a good position to help overcome this issue, for the Care Finder program.

Analysis of client referral sources found that only 2.6% of clients were referred to the program from GPs or other health professionals (Figure 14). It is not known whether, or how many, self-referred older persons or carers were told about the EnCOMPASS Connector program by health professionals.

Figure 14. Client referral sources

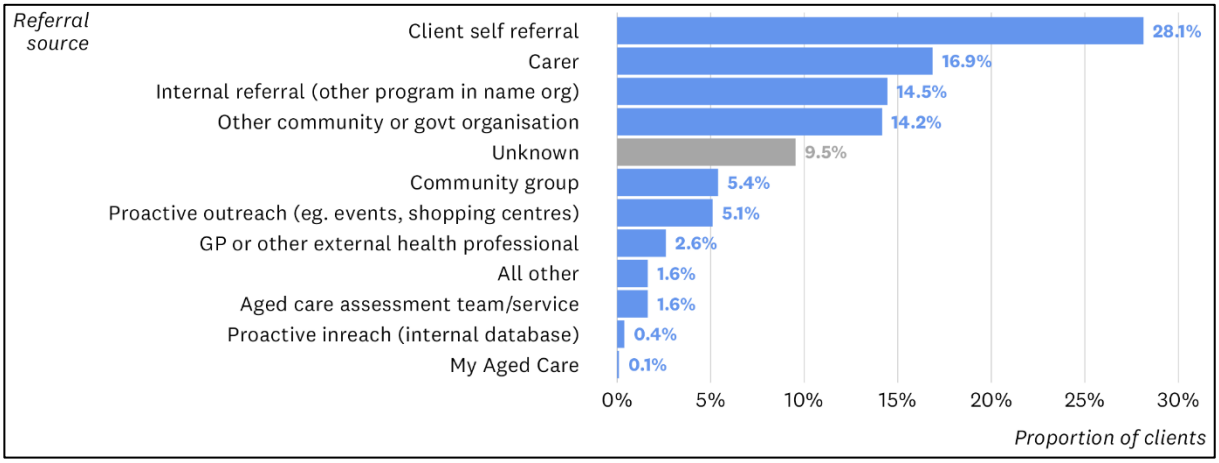


Table 22. Program theory 16: Health professionals 'buy in' and refer in

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
GPs and other health professionals are a trusted source of information for CALD older persons Connectors work for organisations well known by local health services Connectors proactively promote the program to health professionals Connectors are highly trained and competent	Connectors build relationships with local health professionals	Information about and availability of Connector	Increased awareness of the Connector program Health professionals trust that the Connector has the skills to support the client and see value in referring clients on	GPs and other health professionals refer older persons to Connector
GPs are over-committed or restrict voluntary activities	Connectors provide promotional materials	Lack of resource	GPs remain unaware of the program OR are unwilling to endorse a program they do not know well	GPs do not refer clients to the program

3.4.3.4 Program theory 17: Community leaders engaged and endorsing program

The importance of community leaders (referred to as 'Touchpoints' in the program) was evident across all Connector sites. However, the way the Connectors defined community leaders differed across the sites, with some defining leaders as faith leaders or heads of associations and others using the term

more inclusively to include informal community leaders. This report uses the term community leader to cover anyone who had influence within their CALD community, whether that be in a formal or informal capacity.

> *Well, I think community leaders, whether you choose to call them leaders, gatekeepers, whatever, … they're people that have been working in their communities, often in a voluntary capacity, for many, many years. They know the people within their communities, they know what the needs are, so … again it gives us an entrée. And they're trusted people so if they're prepared to vouch for us and promote our program, and tell people that it's really important for them to have a think about connecting with us if they need help, then again it just adds that additional layer of credibility to the work that we're trying to do. And we've actually found the leaders have been wonderful, and they've been very encouraging in getting their members to come along to the community forums, many have attended themselves. (Manager).*

> *Community leaders have not really been very useful in providing us connections. We have written to community leaders to be able to talk about the program to them first. We've not had much success with them. What we found was successful is getting the Touchpoints through the communities and building on those Touchpoints to identify where certain groups meet or where there is a meeting happening so that we can then go through that connection to be able to go and present to that meeting and to be able to then say, "Can we advertise this program through this?" … So, we're getting those sort of links through – more through this – the smaller community context other than the community leaders. (Manager).*

> *I think they [the Connectors] certainly know that I'm an influencer in the community. I'm a reputable person. So, they come to me asking for help, asking if they can join our seminar and to have a spare couple of minutes for them to get started. So, I thought that's a good initiative. At least they're contacting the right person, because I'm a doer. … After that we visited couple of elderlys' house. I realised, "gee, people really need help. Really, seriously." And this program, it is such an amazing program. It is like a diamond in the deep thing, you know? Nobody can see it. … It is a big pity. And I think that's a huge promotion they need to have. … So, when this officer [Connector] contacted me, I quickly tweeted something on my Chat page. Without talking to anyone, people just enrolled, registered straightaway, saying, "yeah, yeah, count me in, count me in. I want to go to the seminar" and "can I take along a friend?" I said, "of course you can." (Touchpoint).*

> *We also kind of went beyond the community leaders. … from the cultural knowledge of the Connectors. … what we've found was, one or two people who happened to work in more senior roles in aged care became almost like the informal go-to people in the community for anything to do with aged care. … So, there are people like that out there who … aren't the official community leaders, but they're … the go-to people in different ethnic communities who, because they've worked in a particular role somewhere or still are, are well-networked and understand the system. … in most ethnic communities, the people who know how to navigate various systems are the go-to people. … So, I think those were the really valuable Touchpoints. (Manager).*

Community and faith leaders were often a trusted, credible source of information for CALD community members:

[Community leaders'] ability to spread the words for us. … If they [the community] hear information from someone they know… they will find it more reliable – more reliable than what they have read on a newspaper or in the news. … Touchpoints, community leaders, they have provided significant help in circulating the news, and directing people to us. (Manager).

The community … trust these community leaders or Touchpoints. (Manager).

When Connectors or their employing organisations had existing (or built new) relationships with community leaders and the leaders saw aged care as a community need, the leaders prioritised engaging with the program:

There wasn't really a big response from the community leaders, so to speak, because I think the leaders are volunteers in the communities, and they don't see ageing because most of them are not in that age group, as well. But we found that because the community leaders that we were communicating with, they were the people who brought people together into groups. … So, building relationships with them, they had more time and they were able to understand the needs of their own people better, because they were meeting their own people on a regular basis as well. (Manager).

I think already the Touchpoint has a built-in relationship with that community or that group. … And also, they also help with … how best we organise a group … how is it that this group received information … And clarifying the language needs … And then also the other thing is that we then now have a connecting point to that community any other time as well. (Manager).

I'm a Connector to the Connectors. That's what I do. … I do a lot of networking even in the health sector, etc. I've been doing what this – EnCOMPASS has been doing, but in an informal way, … I want people to network, to connect, to know what's available, what's not available. So, when I saw this, I thought, "This is brilliant." It's something that we need. (Touchpoint).

The leaders then engaged with the Connectors through town halls, community meetings or one-on-one meetings. Leaders had the opportunity to determine if the Connectors were a credible source of information and support for the community. When they saw them as trustworthy and the program as useful, they saw the value in working with the Connector and granted them access to their community and endorsement. These processes resulted in outcomes at two levels – an increased understanding among community/faith leaders about how they could better support and advocate for older persons and their carers; and increased reach of the program as leaders told older persons and their carers about the program, referred them to the Connector and/or invited the Connector into community meetings:

New communities are asking us for information … inviting us to attend their functions so that we can actually talk about aged care, which is great. (Manager).

There's a thing called trust. Trust is very hard to get. The thing is, to build trust takes time. I'm not saying that they won't trust the person that's in the EnCOMPASS. But coming from me, which they trust me, means that they believe in me to trust the other person. … Especially with the elderly and culturally and linguistic-diverse people, they value trust a lot. So, if they trust you, they will believe in you and whatever you're doing. If I say to them, "Hey. These are the numbers for this guy [the Connector], totally recommended to help you. I can even come if you want," but they won't even need me,

they'll be able – they'll say, "Yeah, he's obviously recommended, it must be okay." (Touchpoint).

II took it [the information about the Connector program] to a meeting and we discussed it. There was a lot of confusion amongst the members [about My Aged Care]. So, I explained it to them and then we – some of them put their hand up and they wanted to meet the EnCOMPASS coordinator here, or Connector. … this Connector was – he was so helpful. He encouraged them to meet him in his office or he would go to their house. And I personally took him to the first client, one of our members, and they were very impressed with him. … Then so the word spread amongst other members and I organised a meeting with the Connector with our members. (Touchpoint).

The participants also reiterated the value of the community leaders, given that the Connector program was a new program which the communities had not heard about before:

I guess you kind of do need them [community leaders]. I feel especially towards the beginning of a program when something is new. People are going "what's this about?" They're not sure. It helps you with trust building. If you can get a couple of key Touchpoints on board. It helps you to open doors. It saves you time in networking because they usually already have extensive networks. They can kind of give you a stamp of approval if they are involved. … It's so much easier for them than for us when we're trying to get stuff off the ground, but I think as we continue to implement, as we continue to engage and stuff, in some way, our reliance on Touchpoints decreases. (Manager).

The Connectors highlighted the need to put in concerted time to build the relationships with the community leaders and specified that faster methods of engagement would not be as successful in building the necessary rapport and trust:

You know, I feel that sometimes that's a little bit overwhelming, reaching everybody … the community groups and the church groups so that they can tell their people. … Because how do you effectively reach them, we've decided that emailing is not the way to go, we need to actually ring and speak to them. And these are all time-consuming things to do … have a cup of tea with them, build connections … you can shoot off 100 emails, and you've ticked all the boxes, but you don't get many replies back, but you actually go and meet 100 people can take two weeks, you know, and build connections. (Connector).

The participants also stated that community leaders were often in demand, very busy and may be in volunteer roles, which made it more difficult to engage with them:

It's very hard to get Touchpoints. Touchpoints can be quite overworked already and kind of everyone is going for them. So, I think it is important to be able to reward them for their time or whatever. (Manager).

We were very committed to getting community leaders and representatives on board. And they were wonderful, again, in assisting us to promote the project. But look, the reality is that these organisations are also pretty stretched themselves, and while they're always happy to spread the word and whatever, we actually found that we had to resource some of that support. … A lot of those Touchpoints – and particularly community Touchpoints, CALD community groups and organisations – they're pretty stretched just trying to do what they need to do for their members. The reality is, there need to be some resources set aside so that when those Touchpoints support us in a

really – in a more concerted way – then we have to be prepared to resource their efforts. (Manager).

The Connectors also discussed the importance of finding the right community leader to promote the program, as not all community leaders would always pass on the information:

So, it work only if you find the right Touchpoint that they also commit to convey the message to the community. You may have some good one but if they don't talk about, it's not of use. (Manager).

Where the community leaders did not see aged care as a community need, the Connectors were not able to engage with them. Evidence of this was seen in new migrant communities and communities where the leaders were younger people:

Community leaders of new migrant communities are often not receptive to requests to deliver aged care information sessions. Their organising committees do not have the seniors on their priority list. This makes it harder to engage with them and build inroads. (Quarterly report).

The other thing is we find the community leaders are probably much younger, and sometimes ageing is something that you understand when you come to that age, I guess. And so they probably don't realise the value of this service and they want, "What can you offer us" straight away. (Manager).

Community leaders don't always respond to emails or calls for connecting to community over events. Some ethnic communities seem not to have an understanding or focus on their elderly. Hence difficult and takes longer to find the community Touchpoints for some communities. (Quarterly report).

Participants also advocated for the need to sustain the connections made by the program, as it transitions to Care Finder:

I think it's really important to keep the people that have been doing it [the Connectors]. ... Because again, these relationships, this trust, these relationships have been going on … they exist; they've been built … And even passing the baton on, happy to pass the baton on, absolutely. It's not that. … don't lose these connections. And these connections are with the core of the communities. These connections are with the old timers, that if they say something, the community listens. It's as simple as that. (Manager).

Table 23. Program theory 17: Community leaders engaged and endorsing program

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
Community/faith leader is a trusted, credible source of information for CALD community members	Connector engages with leaders through town halls, community meetings or	A credible source of information and support for the community	Leaders judge Connector as trustworthy, see value in working with the Connector and grant them	Increased understanding among community/faith leaders about how they can better support and

Context	Intervention	Mechanism		Outcome
		Resources	Reasoning	
Connectors or their employing organisations have existing (or build new) relationships with community leaders Leaders want to help their communities, they see aged care as a community need, and prioritise engaging with the program	one-on-one meetings		access/endorsement (gatekeeping)	advocate for older persons and their carers Leaders tell older persons and their carers about the program, refer them to the Connector and/or invite the Connector into community meetings
Younger age profile in communities Younger leaders in community organisations	Invitations or printed information provided	Low understanding of ageing and the demands it places on older people and carers	Low perceived value of the program or commitment to program	Leaders do not engage with the program or provide referrals to it

3.4.3.5 Program theory 18: Clients become program champions

When a client had a positive experience with a Connector and the client wanted to help other older persons they knew, the client championed the program among people they knew through word-of-mouth recommendations:

> *But honestly, we found that the people that really picked up and encouraged their friends and compatriots to get in touch with us were the older persons themselves who achieved a good outcome from our support. (Manager).*
>
> *I really want to help my friends to get help. Because I can see how much they are struggling. (Client – older person).*
>
> *I think [the Connector] provide me with the things that are helpful to me, and she is a caring person. When she needed some volunteers to work with Vietnamese people, I did. I talked to the other Vietnamese people about this program. … [The Connector] made her presentation on this, My Aged Care service, first on Zoom and then I think this is a good program. That's why I talked to other people in my senior's club about this program. Some of them asked me to include them on the list for the interview. (Client – older person).*
>
> *EnCOMPASS Connector also gets more and more clients from Chinese communities by word of mouth, many Chinese seniors introduce their friends and relatives to join our*

program, which demonstrates we have built trust in the Chinese community. (Quarterly report).

Other older persons saw the value of Connector support and trusted the recommendation because it came from a known person, which led to increased awareness of the Connector program, the Connector being invited to meet with other older persons / carers and people self-referring to the program:

> *We just found that the most important and effective Touchpoints [were] the older persons that we supported themselves, … we would engage with them; they would achieve a positive outcome. And then they would tell their neighbours who also in need of help. … for example, we assisted one lady in [town name] and within six months we were assisting her whole kind of [friendship] group, a group of women who come together for companionship and a cup of coffee and a chat … And then the word spread from there. So, we actually found the most effective way … word of mouth is a really powerful kind of tool with a community. (Manager).*

> *But one of the greatest weapons in our arsenal, I think, is word of mouth. We supported a Greek lady in our designated area … to navigate the system. She, on a weekly basis, meets up with two of her good friends for coffee. She told them about EnCOMPASS, they were also needing support, so before we knew it we were supporting all three of them. … Once the communities trust you, believe that you're doing a good job, they will bring people to you. (Manager).*

> *Yes, I'm over the moon with them [the Connector]. And that's how I got onto the program. And my sister had gone through [the Connector], and she said to me – she had a word to him [the Connector] and then that's where we got the ball rolling. (Client – older person).*

While word-of-mouth was a powerful tool to promote the program, it could also be powerful at creating barriers when people shared their negative experiences:

> *Most of the elderly people receive the information but do not trust that they will receive the support from My Aged Care even they are eligible. This creates a barrier to access the support if an elderly person does need to access the services. … They do not trust the information we deliver to them. We have few elderly people who have been approved for My Aged Care services. But they could not navigate themselves for looking the service provider who provide services they need. They did not get positive outcome when they contact to the service provider. It will create a barrier to promote My Aged Care services to other elderly people as they might listen to the poor experience of the elderly people who got approval from My Aged Care. (Quarterly report).*

Table 24. Program theory 18: Clients become program champions

Context	Intervention	Mechanism		Outcome
		Resource	Reasoning	
Client has had a positive experience with a Connector	Client champions the program among people they know	Word-of-mouth recommendation	Other older persons can see the value of Connector support and trust the recommendation	Increased awareness of the Connector program Invitations to the Connector to meet

Context	Intervention	Mechanism		Outcome
		Resource	Reasoning	
Client wants to help other older persons they know	(word of mouth)		from a known person	with other older persons / carers People self-refer to the program
Client has negative experience with My Aged Care	Client discusses negative experiences amongst people they know	Word of mouth dissuasion	Other older people mistrust My Aged Care	Older people do not self-refer or refer friends to the Connector

3.5 Value for investment

This section addresses the fourth evaluation question:

4. What value has been created, for whom, in what contexts, at what cost? What factors affect the costs of achieving outcomes for different groups or in different contexts?

No separate program theory was developed for this question because the value created for stakeholders flowed from the outcomes of the program, and those outcomes were incorporated in earlier program theories. Instead, a Value for Investment rubric was developed (see Section 2.4.3.1 above for a description of the development process).

The rubric comprises three overarching criteria: equity, effectiveness (focusing on outcomes for different stakeholder groups), and efficiency (focusing on the use of resources to achieve program outcomes). Each of these was described in subsidiary elements.

Table 25. Elements of the Value for Investment rubric

CRITERIA	ELEMENTS
Equity	
Accessibility	Program delivery and accessibility are equitable
Service tailoring	Services and support are tailored to meet the needs of individual clients
Effectiveness	
For older people and carers	Clients receive high quality, personalised, culturally competent support
	Coordinated support is received across multiple episodes and agencies where required
	Clients develop capacity to engage with the aged care system and exercise choice and control where possible

CRITERIA	ELEMENTS
For 'Touchpoints'	Key stakeholders (community/faith leaders, GPs, CALD organisations) increase their capacity to provide accurate and timely information about aged care to CALD communities
For EnCOMPASS Connectors	A variety of supports develop Connector competence and confidence
	The right staff are employed and are able to perform well
Efficiency	
Productivity	Program resources are used to maximise productive delivery and effectiveness
Relational efficiency and capital	Relationships within and outside of the organisation contribute to efficiency and effectiveness
Allocative efficiency	Resources are allocated to enable effective performance across functions

Performance at each of the elements was then described at four levels: Inadequate, Adequate, Good and Excellent. Higher levels of performance build on lower levels: that is, 'Good' performance includes the criteria for 'Adequate' performance but adds additional features and/or achieves the standard for a higher proportion of clients. The program as a whole, and all local programs, should operate at 'Adequate' level for all elements and seek, through continuous quality improvement, to move towards 'Good' in most areas and 'Excellent' in their areas of particular expertise.

In addition to these 'standard' components, this rubric includes a column identifying contextual factors, both internal to the program or the organisations delivering it, and external to the program. These are factors that may affect the standard to which local providers are able to achieve the criterion, and/or which may affect the costs of delivery (for example remoteness, or diversity of the language groups served). If individual organisations were to adopt the rubric for their own use, these contextual factors should be adapted to address local circumstances.

In the pages that follow, details of the standards for each element, and an evaluative judgement for each of them, are presented, with reference to the data based on which the judgement is made.

3.5.1 Equity

Table 26. Value for Investment rubric equity criterion – Element: Accessibility

CRITERION: EQUITY				
Element: Accessibility. Program delivery and accessibility are equitable				
Inadequate	Adequate	Good	Excellent	Contextual factors
Information about services which can provide support (including EnCOMPASS) is: • not available (not provided or provided through a very limited range of strategies) • not accessible (not in simple English OR not in own language OR not clearly interpreted) • not comprehensive enough to identify whether the service is appropriate to needs • not available when needed (timely, in responsive to need) Only better resourced older persons (e.g., those who speak better English, are better educated, or have	Information about services which can provide support is available, accessible, timely and comprehensive Strategies to provide information about support services are tailored to the larger cultural groups in the geographic range of the service The majority (over 50%) of eligible older persons and carers from groups targeted by the local program receive prompt and timely support from the program	Adequate, plus: Strategies to provide information about support services are tailored to sub-groups of older persons and carers who are less likely to access support Warm referrals are provided to other support services where appropriate A significant majority (e.g., around 75%) of older persons and carers from targeted groups receive prompt and timely support from the program within specified timelines Where demand exceeds the capacity of the program to respond, the program develops an equitable process to determine	Good, plus: Strategies to provide information and support understanding of that information are tailored to sub-groups of older persons and carers who are least likely to be able to access support Warm referrals are followed up to assess whether services were appropriate to need The great majority (e.g., around 90%) of older persons and carers from targeted groups receive prompt and timely support from the program Vulnerable clients / complex cases are treated as urgent	Size of cultural groups within the geographic range of the service (larger groups are likely to be easier to access and to tailor resources for) Diversity of cultural groups (great diversity makes providing support across languages and cultures more difficult and more expensive) Size of support program (e.g., EnCOMPASS staffing and access to other staff within auspicing organisations) Availability of other support programs to whom older persons and carers might be referred The proportion of clients with high complexity affects

CRITERION: EQUITY				
Element: Accessibility. Program delivery and accessibility are equitable				
Inadequate	Adequate	Good	Excellent	Contextual factors
private resources) can access support		urgency and responds to urgent cases first Outreach services are provided to clients who may not be otherwise able to access the service, e.g., due to transport or mobility issues		time required to provide services and therefore costs of service provision

3.5.1.1 Assessment against the standards

The EnCOMPASS Connector program performed well (a rating of 'Good') for accessibility. Time was devoted to developing locally, culturally relevant information for CALD communities (see Section 3.4.2.3 of this report). Focus group and interview data demonstrated that warm referrals were provided by at least some Connectors, who attended meetings with their clients to provide additional support if required. (A 'warm' referral refers to the worker making direct contact with other organisations or programs on behalf of the client and/or accompanying the client to the first meeting with those services.) While data was not collected about the proportion of clients seen in their own homes (or another location of their choice), it appeared that outreach was normal for clients who moved beyond an initial telephone call. Data was not collected about timeliness of response; this would require services to keep the date of first contact and the date of first service provision. However, the fact that 75% of cases were opened and closed on the same day suggests a very high level of timely response. Similarly, because data on timeliness was not collected, whether vulnerable clients were prioritised for a timely response could not be assessed.

Evidence was found to suggest that each of the contextual factors identified in the final column did in fact affect service delivery. Where there were multiple CALD communities served by a single Connector, necessary replication of some functions, such as co-design of information materials or conducting community awareness raising, increased workload to such an extent that it was difficult for staff to maintain all their other work roles, with clear implications for equity (see Section 3.4.2.1). Availability of other bicultural workers improved accessibility and effectiveness of the program for some clients (see Section 3.3.1.1), and referrals were made both within employing organisations and to and from other external organisations (see Section 3.4.3). The time and task data demonstrated a clear trend of increased time requirements for the most complex cases (see Section 3.3.3.1). Because staffing is the biggest cost in navigator programs, increased time implies increased costs. These findings suggest that the Care Finder program, and other CALD navigator programs, need to take these factors into consideration in planning and budget allocations.

To improve the rating from 'Good' to 'Excellent', data would be required to assess the timeliness of service provision and the proportion of clients who received prompt and timely support from the program. In addition, analysis would be required of whether all possible strategies to reach those *least* likely to be able to access support had been tried. For example, an earlier evaluation of a CALD navigator program (RREALI, 2021) found that those not closely connected to their communities were less likely to have been reached than those who were well connected. Developing and trialling additional methods is unlikely to have been possible within such a short timeframe and with staff, at least in some locations, already working to capacity. It is clear that the program went to significant lengths to make information about the program available, but there were still calls for additional promotion of the program. This suggests that not all eligible people had been reached, and common sense suggests that those who were not closely connected to their communities and/or with the greatest complexities or vulnerabilities would be more prevalent amongst those not reached.

Table 27. Value for Investment rubric equity criterion – Element: Client-centred services

CRITERION: EQUITY				
Element: Client-centred services. Services and support are tailored to meet the needs of individual clients and their carers				
Inadequate	**Adequate**	**Good**	**Excellent**	**Contextual factors**
Support is poorly tailored or not tailored to individual needs (e.g., provided only over the phone, low cultural fit) No methods are used to assess whether support is adequately tailored to the needs of clients	Consistent methods are used to assess whether support is adequately tailored to the needs of clients At least half of clients report that support is adequately tailored to their needs and circumstances (e.g., vulnerability factors, cultural values and beliefs in relation to care, capacity of individuals to express own needs and choices, program support available in own language)	Around three-quarters of clients report that support was adequately tailored to their needs and circumstances AND At least 25% of clients report that support was well tailored to their needs and circumstances More than half of clients report positive working relationships with their Connector	The great majority (over 90%) report that support was adequately tailored to their needs and circumstances AND At least half of clients report that support was well tailored to their needs More than three-quarters of clients report positive working relationships with their Connector Vulnerable/complex clients are equitably represented amongst those reporting 'Adequate' to 'Good' tailoring and positive working relationships with Connectors	Ability to tailor services to the needs of clients may vary based on: • cultural fit between workers and clients • availability of staff speaking the clients' own language • service budget compared to level of demand in the geographic area served by the service

Specific data was not available to assess some of the standards described above (for example, whether consistent methods were used to assess the adequacy of tailoring of services, or to collect client feedback about tailoring of services). However, the data that is available suggests that the EnCOMPASS Connector program performed well (a rating of 'Good') for tailoring services to individual client needs. This would appear to be the case at least for the 25% of clients who saw the service more than once. Connectors regularly conducted meetings in clients' own homes, thus addressing needs in relation to physical access to the program. Evidence was also available that Connectors used a variety of strategies to assist older people to interact with the aged care system (through registration, screening, assessment and service provision) and that those strategies were tailored to the needs of the client. Many Connectors either spoke the client's language or were accompanied by bicultural workers who did, thus addressing language needs. This enabled the program to develop a clear understanding of the clients'

needs and provide support to address them. It is not as clear that services were well tailored to client needs where services were provided through an interpreter: this affected the quality of client engagement with the program, and consequently may have affected the quality of information about needs that was available to program staff. Where engagement was high, Connectors identified individual barriers for clients accessing My Aged Care and often went out of their way to ensure that those needs were addressed.

Data is not available to assess whether services were tailored for the 75% of clients whose cases were opened and closed in the same day, none of whom were interviewed for the evaluation.

There is clear evidence that the availability of Connectors or bicultural workers who spoke the client's own language affected the quality of engagement (see Section 3.3.1 above) and that some Connectors – in particular, those working across many CALD communities – found it more difficult to keep up with demand. The contextual factors in this section of the rubric are therefore supported.

3.5.2 Effectiveness

3.5.2.1 Older people and carers

Table 28. Value for Investment rubric effectiveness criterion – Element: Outcomes for older people and carers: Older people and carers receive high quality, personalised, culturally competent support

CRITERION: EFFECTIVENESS				
Element: Outcomes for older people and carers: Older people and carers receive high quality, personalised, culturally competent support				
Inadequate	Adequate	Good	Excellent	Contextual factors
Connectors do not provide a culturally competent approach Connectors provide a one-size-fits-all approach Relationships between Connectors and clients are transactional (low trust, low openness)	Connector's approach is underpinned by cultural competence, demonstrates respect Relationships between Connectors and clients are positive, and clients trust Connectors sufficiently to be honest about needs and issues	Satisfactory AND: Connector offers personalised care and support (focusing on what matters to older persons and their families) with dignity and compassion Connectors communicate consistent and high quality information to support capacities of individuals and communities to navigate My Aged Care	Good AND: Connectors consistently provide high quality services and tailored support to the most vulnerable and complex clients	Connector holds specialist knowledge of the aged care system and its requirements Connector or bi-cultural worker speaks the client's own language

There is significant overlap between this criterion and the second 'equity' criterion, 'tailored services'. It was clear that where services were provided through an interpreter (as distinct from a bicultural worker

or bilingual Connector), the quality of client engagement was lower. In some cases, the relationship appeared transactional; less information was provided by clients and it is quite likely that the level of support provided was lower as a result. For some of these clients, the quality of service was likely inadequate to meet their needs.

It is also likely that at least a proportion of the services provided to clients whose cases were opened and closed on the same day were transactional, in part because there was little time for a trusting relationship to develop and in part because the service was likely to be information-based. However, it is not clear that these services should be described as 'Inadequate': it is entirely possible and perhaps even likely that the service provided did meet the needs of at least a proportion of those clients and should at least be described as 'Adequate'. (It is also possible that some clients were dissatisfied with the service on that first day and ended their engagement with the service on that basis.)

However, for clients who engaged with the service on a longer-term basis, 'Good' to 'Excellent' services were provided. Given that this was a smaller proportion of the overall client base, we have rated the overall performance of the program as 'Adequate to Good'.

The contextual factor originally identified for this element was whether or not Connectors held specialist knowledge of the aged care system and its requirements. It is clear that this factor did affect both the quality and the efficiency of the service. Where expertise was not high enough, Connectors sometimes had to learn by trial and error, which slowed the achievement of intended outcomes. Previous experience working in the aged care sector was an asset, and many Connectors clearly developed specialist knowledge over time. This was supported by training and learning on the job. It was hampered by lack of direct access to the My Aged Care system, insufficiently detailed training in relation to My Aged Care, and the point in time at which the individual Connector started working in the program.

Given the importance of speaking the client's own language, this has been added as a second contextual factor affecting the quality of services.

Table 29. Value for Investment rubric effectiveness criterion – Element: Outcomes for older people and carers: Coordinated support is received across multiple episodes and agencies where required

CRITERION: EFFECTIVENESS				
Element: Outcomes for older people and carers: Coordinated support is received across multiple episodes and agencies where required				
Inadequate	**Adequate**	**Good**	**Excellent**	**Contextual factors**
Support is not coordinated – older person or carer needs to repeat story to different workers	A single worker provides continuous service to the client, from entry to exit from the program AND/OR Case records within the agency enable effective transfer to other workers or other programs within the agency,	Adequate AND: Coordinated referral processes to My Aged Care, external agencies or programs ensure 'the first referral is the right referral' 'Warm' referrals support the client in connecting to other services as required, within	Good AND: Referrals to My Aged Care, other programs and agencies are followed up to ensure that intended services and opportunities are being received Where services are not being received, clients' wishes are	Coordination of services may vary according to: • availability and accessibility of culturally and linguistically appropriate programs/services • effective coordination processes within the agency

CRITERION: EFFECTIVENESS				
Element: Outcomes for older people and carers: Coordinated support is received across multiple episodes and agencies where required				
Inadequate	Adequate	Good	Excellent	Contextual factors
	without the client having to repeat their story Client engages with Connector, who supports them to engage with My Aged Care and advocates with other services as required	and external to the organisation	ascertained re: advocacy for services, new referrals or other supports and follow-up services are provided	• client trust in worker, contributing to willingness to disclose needs Older person/carer capacity may vary according to vulnerability factors, cultural values and beliefs in relation to care, and access to interpreters and assistive technologies where required.

This element is only relevant to clients whose cases remained open over time, although clients whose cases were opened and closed in one day could also be referred to My Aged Care and/or other programs or organisations.

While it is clear that referrals were provided to a range of organisations (see Section 3.3.3.1 above), very little qualitative data was collected about the nature of referrals to services or organisations other than My Aged Care. Processes to ensure that clients did not have to repeat their stories within employing organisations were not investigated. In some cases, Connectors not only provided information about other programs and services but encouraged their use, particularly where clients were initially reluctant or needed immediate interim service supports while waiting for a My Aged Care assessment or for aged care services to become available. However, whether warm referrals were provided is not clear. It was also clear that Connectors advocated for clients where required, to ensure that they were able to access rights and entitlements from government agencies such as Centrelink. For referrals to My Aged Care, Connectors provided tailored and ongoing support, and followed up over time to ensure that the process was proceeding. For these reasons, the overall program has been rated as 'Good' for referrals to other programs and services and 'Excellent' for referrals to My Aged Care.

There is clear evidence that all the contextual factors identified for this element did affect not only referrals themselves, but also the outcomes of those referrals. The availability of culturally appropriate services and programs was of particular significance.

Table 30. Value for Investment rubric effectiveness criterion – Element: Outcomes for older people and carers: Clients develop capacity to engage with the Aged Care System and exercise as much choice and control as is possible

CRITERION: EFFECTIVENESS				
Element: Outcomes for older people and carers: Clients develop capacity to engage with the Aged Care System and exercise as much choice and control as is possible				
Inadequate	**Adequate**	**Good**	**Excellent**	**Contextual factors**
Client lacks the information and capacity to engage with My Aged Care or the aged care system No apparent change in the capacity of the older person or carer to engage with My Aged Care or the aged care system over time	Client provides informed consent in relation to each service and each stage in the process Clients demonstrate increasing understanding over time of what they need to do, to access services and entitlements	Satisfactory AND: Client understands the operations of My Aged Care and the aged care system sufficiently for their needs Older persons and carers demonstrate increasing capacity to engage with My Aged Care or the aged care system over time, or to request further assistance as required	Good AND: Client has the information and capacity to exercise such choice and control as is possible in engaging with My Aged Care or the aged care system, with occasional support as required	Capacity to consent and capacity to exercise choice and control will vary with vulnerability factors, cultural values and beliefs in relation to care; access to assistive technologies where required; and the supporting organisation's policies, procedures and resources that support or enable client choice and control

Provision of information about the aged care system, and My Aged Care as its entry portal, is of course a central element of the Connector role, both through direct service delivery and through community education and awareness raising (see next element about the latter). Client interviews demonstrated that many had felt increased capacity to engage with My Aged Care as a result of Connector support. Clients spoke of their Connector helping them to understand the process of accessing support, and what information that My Aged Care would require from them. Some reported increased confidence to engage with My Aged Care as they knew what to expect in the assessment conversation. Some clients also stated that they felt confident to engage the support services following their My Aged Care assessment, and that they knew they could (and felt comfortable to) reach out to the Connector should they need further support in the future.

Given that the information about older person/carer capacity is from interviews and therefore a smaller proportion of the overall client base, we have rated the overall performance of the program as 'Adequate to Good'.

There is evidence that the contextual factors of client vulnerability and cultural values and beliefs in relation to care did affect capacity to consent, and capacity to exercise choice and control. Evidence was not available to evaluate the degree to which access to assistive technologies and the employing organisation's policies, procedures and resources supported client choice and control.

3.5.2.2 Touchpoints

Table 31. Value for Investment rubric effectiveness criterion – Element: Outcomes for Touchpoints

CRITERION: EFFECTIVENESS				
Element: Outcomes for Touchpoints: Key stakeholders (community/faith leaders, GPs, CALD organisations) increase their capacity to provide accurate and timely information about My Aged Care to CALD communities				
Inadequate	Adequate	Good	Excellent	Contextual factors
Stakeholders are not aware of the program Stakeholders are aware of but do not trust the program Stakeholders do not engage with Connectors	Stakeholders engage with Connectors to discuss the program Stakeholders have increased understanding about the aged care system, and how they can better support and advocate for older person within their communities Stakeholders are willing to initiate discussion with older person (and their family/carers) about future planning	Stakeholders invite Connectors to present at community or professional meetings Stakeholders refer older person to Connector and/or My Aged Care	Stakeholders partner with Connectors to jointly deliver information Stakeholders make warm referrals for older person to Connector	Connector holds specialist knowledge of the aged care system and its requirements Time and resources are allocated for Connector to develop relationships with key stakeholders and provide community education Stakeholders and Touchpoints have time and resources to allocate to learning about, and supporting, the program

Connectors spent approximately the same amount of time on community development and community awareness raising as they did on direct client support. Community education sessions were reported to increase community understanding of the aged care system in general and in some (but not all) cases resulted in a spike in referrals into the EnCOMPASS Connector program (see Section 3.2 above). However, some focus group or interview participants called for increased promotion of the program, suggesting that there was still work to be done to increase community awareness. Some Connectors serviced more CALD communities than others and this increased demands on their time. Further, Touchpoints were often busy people and volunteers, and the extent to which they could support the program varied.

Some stakeholder groups were harder to engage than others: young leaders in newly arrived CALD communities seemed less aware of the needs of older people (although this might reflect the age structure of their communities) and GPs were sometimes difficult to engage. The latter is a chronic issue in community health and wellbeing initiatives and reflects demands on general practitioners' time rather

than any shortfall in the program. Given these circumstances, and acknowledging the short duration of the EnCOMPASS Connector program, the program overall was rated as 'Good' for this element. It is likely that some employing organisations would have warranted an 'Excellent' rating.

The Care Finder program, as a longer-term program, may be better positioned to develop strategies to reach the hard-to-reach groups identified above. However, it will also have to re-establish awareness and trust in CALD communities generally, because the navigation and support pathway will have changed.

There was clear evidence that Connector knowledge and expertise contributed to this development in stakeholder capacity, and that employing organisations did allocate time and resources for it. However, the other contextual factors affecting effectiveness relate to the time and resources that Touchpoints and other stakeholders could commit to the program, and this has been added to the rubric.

3.5.2.3 EnCOMPASS Connectors

Table 32. Value for Investment rubric effectiveness criterion – Element: Outcomes for EnCOMPASS Connectors

CRITERION: EFFECTIVENESS				
Element: Outcomes for EnCOMPASS Connectors: A variety of supports develop Connector competence and confidence				
Inadequate	Adequate	Good	Excellent	Contextual factors
Connectors do not have access to appropriate training, supervision and/or peer support Connectors have access but do not participate in appropriate training, supervision and/or peer support Connectors do not understand the aged care system and its requirements Connectors are not confident in important	The wider program provides appropriate training and information resources to enable effective performance Employing organisations provide effective supervision and support for Connectors Community of Practice (CoP) sessions provide access to peer support Connectors understand the aged care	Satisfactory AND: Employing organisations provide access to, and encourage participation in, additional training/professional development opportunities for Connectors Connectors contribute their own knowledge and experience within CoP sessions Connectors are confident in basic and advanced aspects of their work roles	Good AND: Connectors are competent and confident to support others (e.g., new Connectors, work colleagues, community organisations) to develop understanding and competence to navigate the aged care system	Support to develop Connector confidence and competence may vary with: • capacity of employing organisation to provide appropriate professional supervision • access to high quality internet for on-line capacity development • access to external expertise to support Connector learning

CRITERION: EFFECTIVENESS				
Element: Outcomes for EnCOMPASS Connectors: A variety of supports develop Connector competence and confidence				
Inadequate	Adequate	Good	Excellent	Contextual factors
aspects of their work roles	system and its requirements Connectors are confident in their basic work roles			

Connector expertise and confidence was developed through professional development programs, the Community of Practice, and learning on the job. The latter incorporated learning from colleagues and learning by trial and error. Access to program-provided professional development was generally good for those who started at the beginning of the program, and was adapted, but not as good, for those who started later. Access to training and the Community of Practice was better for full-time rather than part-time workers, and of the part-timers, access was better for those with greater flexibility to rearrange their schedules to participate. Notice of meetings was not always long enough. Training in a key area – understanding of My Aged Care – was inadequate, meaning that workers had to learn through trial and error. By the end of the data collection period for this evaluation, most Connectors were sufficiently knowledgeable and confident to support others in improving their understanding of how to access the aged care system, if not the details of how My Aged Care worked or the intricacies of the aged care system. Overall, the program is rated as 'Adequate' on provision of capacity building, and 'Good' for the expertise and confidence of Connectors.

In relation to the contextual factors: data was not collected about the quality of supervision or about access to additional training provided by employing organisations. However, some Connectors discussed this capacity building support during interviews, noting the value of having an experienced manager who could provide supervision and guidance as well as access to additional training where needed. There were also a few examples of Connectors having inadequate supervision which made it more difficult for them to perform their roles. Access to high speed internet was not an issue in the EnCOMPASS Connector program, which operated in metropolitan and major rural areas. However, it could be more of an issue in other rural and remote areas in the Care Finder program.

Table 33. Value for Investment rubric effectiveness criterion – Element: EnCOMPASS Connectors

CRITERION: EFFECTIVENESS				
Element: EnCOMPASS Connectors: The right staff are employed and are able to perform well				
Inadequate	Adequate	Good	Excellent	Contextual factors
Connectors do not demonstrate core	Connectors demonstrate basic competencies	Connectors demonstrate core competencies at a good level, and competence	Connectors demonstrate high levels of expertise	Competency, retention rates, work satisfaction and motivation are likely to vary according to:

CRITERION: EFFECTIVENESS				
Element: EnCOMPASS Connectors: The right staff are employed and are able to perform well				
Inadequate	**Adequate**	**Good**	**Excellent**	**Contextual factors**
competencies when employed Low retention rates/ high attrition of Connectors	Retention rates are comparable to other programs in the employing agencies Low work satisfaction for Connectors contributes to low to adequate motivation on the job	improves over time Retention rates are good compared to other programs in the employing agencies Work satisfaction levels are comparable to other programs in employing agencies Connectors are motivated to perform well in their roles	Retention rates, work satisfaction and motivation are high compared to other programs in the employing agencies	• duration of employment contracts • management styles • organisational culture

The program did not develop a single statement of core competencies for EnCOMPASS Connectors. Individual sites were responsible for developing their own criteria and selecting staff against them. Employment practices appeared to vary across sites, with some prioritising qualified staff and others prioritising experience with, and/or membership of, the CALD communities in question. Future programs may consider developing a statement of core competencies. However, it would appear that Connectors were appropriately skilled and, where they did not already have it, developed necessary knowledge for the role, suggesting at least a 'Good' rating. Data was not collected about work satisfaction or retention rates, and consequently no rating can be given for those. Monitoring of these indicators would, however, be useful for future programs.

3.5.3 Efficiency and productivity

Table 34. Value for Investment rubric efficiency and productivity criterion – Element: Productivity

CRITERION: EFFICIENCY AND PRODUCTIVITY				
Element: Productivity: Program resources are used to maximise productive delivery and effectiveness				
Inadequate	Adequate	Good	Excellent	Contextual factors
Work planning does not address productivity Poor coordination of, or access to,	Work roles across the agency are clear, well organised and support worker	Adequate AND: Connectors are supported to consider how they can adapt their work	Good AND: Organisational systems analyse productivity and effectiveness and provide feedback	Efficiency and productivity are likely to vary according to: • the ethos of the employing

support functions within the employing agency Connectors are expected to be 'all things to all people', across a range of functions which do not contribute, or contribute indirectly, to program outcomes	efficiency and effectiveness Program resources are used to buy in complementary skills or roles to enable productivity and effectiveness	practices to maximise productivity and effectiveness	for continuous improvement	organisation, allocation of other organisational resources to support efficiency, and productivity of service delivery staff

The time and task snapshots identified that less than 14% of Connectors' available time was recorded as not having been spent on direct program activities (see Appendix 8, Section 5.8.6). It is possible that some of the time was spent on program tasks but was not recorded. Working effectively within an organisation requires some proportion of time to be allocated to whole of agency activities, and this proportion seems very reasonable. Conversely, the time and task data also demonstrated that other staff within the employing agency contributed to program activities (Appendix 8, Section 5.8.6). Meanwhile, the agency expenditure data demonstrated that program funds were used towards a range of other staff, including bicultural workers, project support workers, managers and administrative staff. Together, these factors imply that program resources were directed to functions that contributed directly to program outcomes. However, expenditure within and across staffing and other costs varied widely across employing organisations, in ways that this evaluation is not able to explain. It is possible (and indeed likely) that efficiency also varied widely. No data was available on whether employing organisations specifically analysed efficiency (or effectiveness) or used feedback from that analysis to improve productivity. Overall, the program has been rated as 'Adequate' for program resource use.

Direct evidence was not collected in relation to agency ethos, although it remains logical to assume that this would affect efficiency. Qualitative evidence suggests that the contributions of other staff – particularly bicultural workers – contributed directly to the quality of outcomes for clients, and thus to productivity.

Table 35. Value for Investment rubric efficiency criterion – Element: Relational efficiency and capital

CRITERION: EFFICIENCY				
Element: Relational efficiency and capital: Relationships within and outside of the organisation contribute to efficiency and effectiveness				
Inadequate	Adequate	Good	Excellent	Contextual factors
Connectors work in isolation from other staff in the agency, and/or in	Connectors have appropriate networks and relationships within and outside	Connectors have a wide range of networks and relationships and can draw on those	Strong, trusting relationships within the employing organisation, and across a variety of	Relational efficiency and capital are likely to vary according to:

CRITERION: EFFICIENCY				
Element: Relational efficiency and capital: Relationships within and outside of the organisation contribute to efficiency and effectiveness				
Inadequate	**Adequate**	**Good**	**Excellent**	**Contextual factors**
isolation from other services Relationships with other services or organisations do not achieve intended outcomes, and barriers are not addressed	the employing organisation Relationships are effective but largely one way: they depend on Connectors to make the initial contact to address issues Relationships enable intended outcomes for most clients	to address a variety of issues External workers and stakeholders are comfortable and confident to initiate contact to address issues	organisations and levels of systems, enable creative solutions to problems for older persons and carers Stakeholders and external organisations report strong and valuable relationships with the program and invest time to maintain those relationships	• the size of the CALD community overall and the size of the specific CALD communities served • the size of the local/regional service delivery system • existing social capital and networks within CALD communities and within the service system

Relationships within organisations clearly contributed to Connectors' expertise (see Section 3.4.3.1) and to problem solving. Taken alongside other staff undertaking direct work in the program, these factors contributed to effectiveness, and potentially to efficiency. Positive relationships with CALD community members, groups and organisations contributed to both community awareness and to referrals, both into Connectors and out from them to other programs and services (see Section 3.4.3 above). The overall rating for the program was therefore 'Good'.

No data was collected about the possible effects of size of CALD communities on relational capital. Larger communities are likely to have more groups and organisations than small ones, increasing the chances of developing relationships which may provide inroads into communities: it remains possible that this may improve efficiency and/or effectiveness. Increasing the number of distinct communities served by an individual Connector was found to increase workload, which has the potential to decrease effectiveness.

There was evidence, however, that an inadequate number of multicultural support services in the local service system undermined satisfaction with, and potentially the effectiveness of, support services (see Section 3.3.4.2). This supports the final contextual factor for this element.

Table 36. Value for Investment rubric efficiency criterion – Element: Allocative efficiency

CRITERION: EFFICIENCY				
Element: Allocative efficiency: Resources are allocated such that expected functions are undertaken and can achieve intended outcomes				
Inadequate	**Adequate**	**Good**	**Excellent**	**Contextual factors**
Resources are not allocated to enable the range of functions required by the program to be maintained, or to match the right resources and services, at the right intensity, to the right clients	Resources are allocated in such a way as to enable the range of functions to be maintained at a basic level Resources are allocated strategically (for example, with higher resourcing to increase community awareness early in the program to enable referrals)	Satisfactory AND The balance/mix of Connector activities achieves moderately high equity and moderately high effectiveness	Good AND: The balance/mix of Connector activities achieves both high equity and high effectiveness	

3.5.4 Overall value for investment

The grant to FECCA for the EnCOMPASS Connector program overall was $9.74 million (exclusive of GST). The value created through the grant included:

- linkages to My Aged Care and other required services, resulting in increased ability to remain at home for those receiving home support services, reduced stress and improved quality of life for those receiving home support services, and reduced pressure on family members where home support services were provided. This also provides indirect value to the Commonwealth Government in that it improved access for a vulnerable community to an important area of service provision;
- information and referral services to a much wider group of CALD older people and carers. In total, over 7,000 people were reached by the program. While less is known about direct outcomes in this area, they included improved understanding of current and future options for at least some of those served, and likely increased access to some current programs and services;
- increased understanding of the Australian aged care system for Touchpoints and CALD organisations, strengthening their capacity to support older people and their families;
- tailored information resources for multiple CALD communities in all states and territories. These resources could be updated with Care Finder information later;
- increased understanding of the requirements for effective navigator programs in CALD communities, and of the time required to undertake particular aspects of the navigation role. This is of direct relevance to the Care Finder program and thus of value to Primary Health Networks and the Department of Health and Aged Care, but also to FECCA for future navigator programs as well as in their advocacy role;

- a period of paid employment for EnCOMPASS Connectors, also providing them with experience and skills to apply for future related employment. These individuals may also continue to provide an informal information resource in their own communities and networks;
- development of the rubric for assessing the quality of navigator services for CALD older people, which can be used or adapted for future programs and which may provide guidance on the sorts of data required for program evaluation.

4 Discussion

Eighteen refined program theories and the determination of the program's value of investment have answered the following overarching question:

For whom, in what contexts, in what respects and to what extent has the EnCOMPASS Connector program worked (and not worked), how and why, at what cost, and creating what value?

Support provided to clients was provided via four incremental stages, including the engagement of the client, working with different levels of older person / carer readiness (to engage with the aged care system), making the connection to My Aged Care work, and getting the most out of aged care services.

Engagement in the client's own language and by a worker who understood their own culture was found to create high rapport with older persons and/or carers, and such rapport was particularly critical when an older person / carer's readiness to engage with the aged care system was low but their need was high, or when client complexity was high. Rapport with a bicultural Connector was less important for clients whose readiness was already high (and complexity lower) and those whose need was currently low. Clients in these latter groups did not require the same level of skilful and intensive support from a Connector who understood their culture.

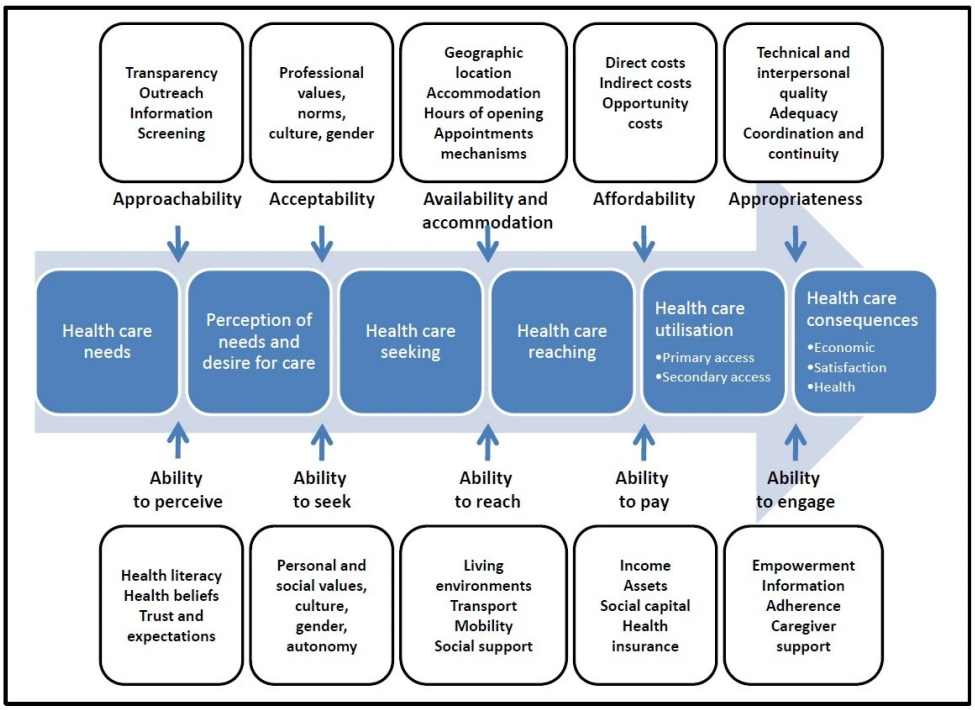
Connector support provided to clients was enabled by key elements of program implementation. Broadly, these elements encapsulated three areas: 1) Connector capacity building, which incorporated formal training, on-the-job learning and peer communities of practice; 2) implementation planning, which incorporated flexibility of KPIs and staff time, and co-design of culturally appropriate approaches; and 3) stakeholders with reach to older persons from CALD communities, which incorporated the expertise and networks of employing organisations, links with other CALD organisations, health professionals' 'buy in' to the program, community leaders' engagement, and clients becoming program champions.

It was common for Connectors, Managers and Touchpoints to speak positively of the EnCOMPASS Connector program, saying it was a highly valued and much needed program. The program in and of itself (within its own remit and distinct from the system it is designed to connect to) was considered to be highly effective. Clients who were interviewed were less likely than the above workers to know the EnCOMPASS Connector program by its name, or that it was a 'program'. Older persons and carers usually identified the Connector as a person providing a service to them. It was therefore critical for the evaluators to know the name of the relevant Connector to orient an interview. Even with this orientation, some clients had trouble distinguishing, or did not see the point in distinguishing, the service provided by the Connector from the broader aged care system. Most valued the support of the Connector through the (often difficult) process of connecting with My Aged Care and aged care services, but some clients felt that in the end and overall, the Connector support was only as valuable as the quality of the resulting services. However, others could and did distinguish between the two and valued the support irrespective of the longer-term outcome.

4.1.1 Formal theory on health care accessibility

The *Conceptual framework of access to health care* (Levesque et al., 2013) has been used to interpret the synthesised findings of the evaluation. This framework, shown in Figure 15, conceptualises health service access as a dynamic interplay between demand-side (client) and supply-side (health system) factors. As described further below, health service demand comes from an individual's capacity to demand care, including their ability to perceive, ability to seek, ability to reach, ability to pay, and ability to engage. Corresponding dimensions on the supply (health service) side are the approachability, acceptability, availability and accommodation, affordability, and appropriateness of services.

Figure 15. Conceptual framework of access to health care



The EnCOMPASS Connector program was found to be effective in increasing the ability of older persons and carers to perceive, seek, reach, and engage with My Aged Care and aged care support services. For example, support from a Connector increased an individual's ability to perceive need for care by providing information and encouragement and respectfully challenging beliefs, in order to increase readiness to engage with the aged care service system. For those with high need but low readiness for services, the Connector worked to build trust and rapport by speaking the same language or seeking the support of a bicultural colleague who did. This, together with being proactive and responsive as well as persistent, enabled the Connector to approach the client with respect for their culture and with warmth, and to communicate clearly. The client felt respected and understood, so they engaged with the Connector and bought in to the program. In the context of high rapport, the client was able to experience time and personalised attention, and respect for cultural beliefs, while gently being challenged with information and encouragement to accept aged care services. In response, the older person or carer's awareness of services and acceptance of need (ability to perceive and engage) were increased.

The program worked differently for older persons and/or carers with social or medical complexity who were in need of services. Rapport was again critical for the Connector to prepare the client for contact with My Aged Care, by being honest about the process being long and frustrating, providing practical and emotional support for key meetings and phone calls with My Aged Care (such as by practising with the client what to say), and then by checking progress, troubleshooting and ensuring the process was underway. In response, the client felt assured knowing that the Connector was across everything, felt

buffered from harsh, unclear and inflexible interactions with My Aged Care, knew what was coming next, and felt encouraged and confident to speak up, and to see the My Aged Care registration and assessment processes through. These are all examples of increasing individual ability and are positive outcomes of the program; however, these outcomes were merely interim/incremental outcomes in the access pathway to aged care services.

Service approachability is about people being able to identify from the organisation that some form of service exists, can be reached, and would be likely to have an impact on the health of the individual. Different factors, such as levels of transparency, information regarding available treatments and services, and outreach activities could contribute to make the services more or less approachable.

Service acceptability is determined by cultural and social factors that make it possible for people to accept the aspects of the service, such as the sex or social group of providers, and the judged appropriateness for the persons to seek care. It can be affected by social and cultural practices that could make the service unacceptable to some people. It can also be affected by practical factors (such as requirements to move furniture for cleaners).

Availability and accommodation refer to the fact that health services (either the physical space or those working in health care roles) can be reached both physically and in a timely manner. Availability constitutes the physical existence of health resources with sufficient capacity to produce services.

Affordability reflects the economic capacity for people to spend resources and time to use appropriate services. It results from direct prices of services and related expenses in addition to opportunity costs related to loss of income.

Appropriateness denotes the fit between services and clients' needs, the timeliness of the service provided, the amount of care spent in assessing health problems and determining the correct treatment, and the technical and interpersonal quality of the services provided. Access is not just about being able to find a service, but also being able to choose acceptable and effective services.

The EnCOMPASS Connector program was found to be approachable. However, My Aged Care was found to be non-transparent and inflexible for clients, and for Connectors too, who were required to learn by trial and error (through erroneous and inefficient dealings with My Aged Care). There was no outreach by My Aged Care, no safety net, and no one following up. So Connectors did this for clients who they thought would have otherwise fallen through large cracks.

Some clients achieved positive outcomes by being assisted to connect with My Aged Care and have services set up that were approachable, acceptable, available, affordable and appropriate *enough* to warrant keeping them. In some cases, Connectors were able to lightly influence the provision of services by recommending that the older person / carer chooses a service known to be of better quality, or by negotiating with service providers about client needs. However, it was found that in most cases the Connector had no influence over services. Some clients made it clear that they had traded off the pros and cons of the services, and decided that they were not (due to low acceptability or affordability, for example) worth the effort and expense of keeping them.

It is clear that significant effort and resources have gone into the design and implementation of the EnCOMPASS Connector program to maximise its accessibility. The program, within its own remit, has performed well on both the demand- and supply-side dimensions of access. This was largely due to a focus on community engagement and development around the program; co-design of promotional activities; having the Connectors hosted by multicultural organisations which provided ready networks, trust and available resources to support implementation of the program; and flexibility of its implementation budget and KPIs.

The EnCOMPASS Connector program was found to create positive value for older people, carers, EnCOMPASS Connectors and, through knowledge generation, organisations providing navigator services and funders of such services. Yet neither Connectors nor clients could routinely rely on, safely predict or

guarantee (or assure older persons / carers) that their lives would be improved by engaging with the EnCOMPASS Connector program because of its inability to significantly influence the supply side (of My Aged Care and aged care services). For older people and carers needing support to live their lives, service boundaries are arbitrary. Focusing solely on changing individuals 'abilities, and not changing the accessibility of the system itself, has a high risk of continuing to fail a sizeable proportion of clients. Viewing and addressing the system as a whole is likely to be more in line with client perspectives. The following recommendations are in line with a system-wide approach.

4.2 Recommendations

This section answers the fifth and final evaluation question:

5. What lessons and implications can be drawn from the program for scaling of effective Connector programs for CALD older persons and their carers?

This realist evaluation of the EnCOMPASS Connector program has found that system-wide improvement would provide best outcomes for older people and carers. The following recommendations are aligned to different actors within the Care Finder program and broader system to ensure a comprehensive approach.

4.2.1 Recommendations for program implementers

4.2.1.1 Provide comprehensive training opportunities for aged care navigators

Program funders should continue to provide training opportunities covering areas such as cultural safety, co-design, women's health, intersectionality, dementia awareness and person-centred approaches. In addition, further training opportunities should be offered to support navigators' skills in report writing, designing and delivering community events and community engagement, and working with clients whose expectations are hard to meet. More comprehensive and practical training on My Aged Care should also be provided to support navigators to understand the My Aged Care assessment processes more thoroughly to ensure they have the insight and confidence to support and guide their clients through the registration and assessment processes.

4.2.1.2 Provide peer-learning and engagement opportunities for navigators

Program funders should continue to provide regular, structured Community of Practice peer-learning opportunities to support navigators to build peer networks and learn from each other's experiences. To support engagement with the Community of Practice the facilitators should vary the meeting days and times to increase accessibility for part-time workers and those outside of dominant time zones. Providing ample advance notice (e.g., 4 weeks' advance notice) for meetings is also essential to ensure navigators can prioritise them and schedule community events and client meetings around them. It is also recommended that meetings focus on shared/common issues that can be workshopped as a group, and meetings should be long enough to allow enough time for all participants to contribute.

4.2.1.3 Provide flexible KPIs to support a place-based approach

Program funders should continue to commission the program with flexible KPIs in place to ensure the navigators can work in a flexible and responsive manner based on the needs of their local communities. Funders should also work closely with employing/host organisations to ensure they understand why flexible KPIs are in place as well as the importance of not placing internal KPIs onto the role as this may detract from navigators' ability to build the necessary trust within their communities to foster engagement with the program.

4.2.1.4 Commission organisations that are known and trusted by CALD communities

Program funders should seek to commission organisations who are trusted and respected by local CALD communities. These organisations should have existing networks into CALD communities.

Whilst not optimal, where the organisation does not have existing connections with local CALD communities it is imperative to provide the organisation with the time and resources needed to build such networks.

4.2.1.5 Retain existing EnCOMPASS Connector staff and transition them to Care Finder roles

The program implementers should investigate the possibility of retaining staff when programs transition. In the case of the EnCOMPASS Connector program, this would ensure the relationships built to date are not lost and that the Care Finder or other program staff would have existing relationships with CALD communities.

4.2.1.6 Evaluate at the whole of program level

Monitoring and evaluation processes and indicators should be developed at the whole of program level to enable consistency and aggregation of findings across the program. Contribution of data to monitoring and evaluation processes should be a requirement for all employing organisations.

4.2.2 Recommendations for employing organisations

4.2.2.1 Understand the need for culturally safe practice, respect the flexible KPIs and support connectors to work in a flexible manner

Employing organisations should understand and support culturally safe practice and recognise the need for time to be spent to build trust within the local CALD communities. This will ensure that employing organisations understand the importance of working under flexible KPIs to support trust building within local CALD communities.

The employing organisation should work intensively with navigators in the early stages of the program to build their comfort around working without directive KPIs and provide guidance and support that reiterates the need to be flexible and adaptable to local needs.

The organisation should also develop ways of assessing navigator performance that is not dependent on KPIs (such as the number of clients seen) as this may detract from the flexibility to perform the role in the manner most suitable for the local communities.

4.2.2.2 Recruit the right navigators and support them to develop skills and connections

Employing organisations should look to recruit and retain staff who have existing CALD networks within their local community and, where possible, staff who are from the same culture and speak the same language as the main local CALD communities. They should also look to employ staff who have experience in aged care or working with CALD communities. Additionally, employing organisations should have the workforce capacity to provide internal mentoring and support to navigators from people who are highly experienced in the field and/or who work in similar roles. Lastly, employing organisations should support navigators to engage with their local CALD networks by providing warm introductions and endorsements.

4.2.3 Recommendations for Care Finder navigators

4.2.3.1 Prioritise and enhance stakeholder networks

Navigators should continue to prioritise the building of networks with stakeholders who will support them to connect with CALD communities. Navigators should make a concerted effort to work with CALD service providers to build trust that the navigator's host organisation will not take clients from them and

that clients can be safely referred. Navigators should also budget funding to ensure community leaders are appropriately remunerated for their time and expertise.

4.2.3.2 Prioritise and enhance program promotion

Navigators should continue to promote the program amongst CALD communities, continually looking for opportunities to enhance the frequency and reach of promotion. Navigators should also use national networks (such as PHNs) to promote the program to GPs and other health professionals who are networked nationally.

Navigators should prioritise promotion of program to groups who had lower engagement with the EnCOMPASS Connector program, such as newly arrived communities.

4.2.4 Recommendations for My Aged Care

4.2.4.1 Increased integration with My Aged Care

My Aged Care should investigate ways of integrating Care Finder with My Aged Care, to provide navigators with increased recognition and authority within My Aged Care, including access to the My Aged Care portal to allow tracking of referrals.

4.2.4.2 Improve the My Aged Care phone system

My Aged Care should improve the functioning of their phone system to reduce the number of dropped calls and have processes in place where if a call is dropped the My Aged Care worker calls the client back immediately so they do not have to re-start their assessment process with a new assessor. My Aged Care should also change how their phone number is listed on caller-ID so it is not displayed as a private number. This would allow CALD clients to save it in their phone and then recognise the caller and not avoid answering calls for fear of them being scams. My Aged Care should also employ a process whereby they send a text message (in the client's preferred language) to older persons / carers, providing advanced notice for phone calls and letters.

4.2.4.3 Improve the transparency of My Aged Care assessment questions and process

My Aged Care should provide more transparency around assessment questions, processes and criteria. Information should be available to navigators and clients about the assessment process, including a list of assessment questions to help older people to prepare for their assessment and feel more comfortable to undertake the process.

4.2.4.4 Improve the cultural safety and responsiveness of My Aged Care and its staff

My Aged Care should immediately review and improve the cultural appropriateness of the service as a whole. All staff should be provided with cultural competency and safety training as well as training in appropriate interpreter use.

All communications (including phone calls and letters) with CALD clients should be in the client's recorded first language. Client files should be reviewed in advance of calls and where a client's preferred language is not English, My Aged Care staff should engage an interpreter to ensure their first interaction with the client is in their preferred language. Letters from My Aged Care should be sent to clients in their preferred language, not in English.

My Aged Care should prioritise the employment of staff from CALD backgrounds and increase the diversity of languages spoken by My Aged Care staff.

4.2.5 Recommendations for the aged care service system

4.2.5.1 Increased capacity, availability and transparency of aged care service provision

The aged care service system should investigate and plan for increasing the number and spread of Home Care Package providers and community health service providers to increase older persons' access to

services and reduce wait times. Service providers should be required to increase transparency regarding costs of services and co-pay requirements.

4.2.5.2 Increased capacity and availability of culturally diverse aged care service providers

The system should support the establishment of more CALD service providers and increased diversity of languages spoken by staff working in aged care services to enhance accessibility.

5 Appendices

5.1 Appendix 1: Hypothesised program theories

5.1.1 For older persons (OP) and their carers

Hypothesised program theory 1

Context

OP (and their family/carers) are 'ready to engage' with the system

Connector offers personalised care and support (focusing on what matters to the older person and their family) with dignity and compassion

Connector holds specialist knowledge of the aged care system and its requirements

Connector's approach is underpinned by cultural competence (Connector is bilingual and works within multicultural organisation with cadre of bilingual workers). (n.b. service may not work as well when the Connector needs to broker through interpreter services)

Intervention

1:1 support

Comprehensively trained EnCOMPASS Connectors available to provide culturally appropriate, intensive support and one-on-one case management to older persons of CALD backgrounds

Mechanism

OP (and their family/carers) build on their own capabilities

OP (and their family) have increased awareness of types of support available, specific to their circumstances

Connector gains 'buy in' as a trusted bicultural worker within the OP's eco-system of care

Outcome

Coordinated care and support across multiple episodes and over time to develop OP's capability to engage with the Aged Care System

OP exercises choice and control in engaging with the aged care system.

Hypothesised program theory 2

Context

OP (and their family/carers) are 'ready to engage' with the system

OP is offered timely, culturally appropriate information through a trusted cultural network/organisation

Intervention

Network of Support Navigators working collaboratively to solve age-related community problems and acting as a wider referral pathway for hard-to-reach older persons to EnCOMPASS Connector

Mechanism

OP wants to reduce burden on their family and proactively steer the direction of their future care options

Outcome

OP (and their family/carers) consent to meet with the EnCOMPASS Connector

OP exercises choice and control in engaging with the aged care system

Hypothesised program theory 3

Context

OP has strong pride in independence and/or holds cultural values that family should care for elders

Connector is culturally competent, has knowledge of OP's cultural values

Intervention

1:1 support

Comprehensively trained EnCOMPASS Connectors available to provide culturally appropriate, intensive support and one-on-one case management to older persons of CALD backgrounds in the community

Mechanism

OP (and their family/carers) feel the Connector treats them with respect for their culture, with dignity and compassion

Outcome

OP (and their family/carers) consent to meet with the EnCOMPASS Connector

OP (and their family/carers) readiness to engage with the system is increased.

Hypothesised program theory 4

Context

OP has strong pride in independence and/or holds cultural values that family should care for elders

OP is experiencing social isolation exacerbated by COVID-19, i.e., not participating in social activities outside of home and/or older person is socially isolated due to living in a regional area

Therefore, older person is harder for Connector to reach as does not (currently) have adequate social capital (social interactions, networks) to access timely information about aged care

Intervention

Network of Support Navigators working collaboratively to solve age-related community problems and acting as a wider referral pathway for hard-to-reach older persons to EnCOMPASS Connector

Mechanism

Resistance to relinquishing independence and/or fear of strangers undertaking care roles

Outcome

Connector relies on Navigator Network referral
OP will require more intensive support from Connector to increase readiness to engage with the system

Hypothesised program theory 5

Context

OP living with dementia

OP experiencing social isolation as cultural values may affect family/carer's attitudes to seek support due to stigma, therefore harder for Connector to reach

Intervention

Network of Support Navigators working collaboratively to solve age-related community problems and acting as a wider referral pathway for hard-to-reach older persons to EnCOMPASS Connector

Mechanism

OP's family/carer reluctant to seek assistance/support

OP may experience confusion or be unable to recall information provided to them

Outcome

Connector relies on Navigator Network referral

OP and family/carers will require more intensive support from Connector to increase readiness to engage with the system

Hypothesised program theory 6

Context

OP has experienced trauma (e.g., migrated as a refugee) or may hold fear of institutional care arrangements (mistrust of government)

Connector is culturally competent, has knowledge of family's cultural values, and has specialist knowledge of trauma informed care

Intervention

1:1 support

Comprehensively trained EnCOMPASS Connectors available to provide culturally appropriate, intensive support and one-on-one case management to older persons of CALD backgrounds in the community

Mechanism

OP (and their family/carers) feel the Connector treats them with respect for their culture, with dignity and compassion

OP (and their family/carers) more open to receiving information about Aged Care services in Australia

Outcome

OP (and their family/carers') readiness to engage with the system is increased

Hypothesised program theory 7a

Context

OP and family/carers seek information in response to acute crisis (social or medical)

Intervention

Network of Support Navigators working collaboratively to solve age-related community problems and acting as a wider referral pathway for hard-to-reach older persons EnCOMPASS Connector

Mechanism

OP (and their family/carers) decision-making is reactive to circumstances of crisis. OP may be feeling fear or worry about the future

Outcome

Navigator Network referral to Connector

Hypothesised program theory 7b

Context

OP referred to Connector following crisis

Intervention

1:1 support

Comprehensively trained EnCOMPASS Connectors available to provide culturally appropriate, intensive support and one-on-one case management to older persons of CALD backgrounds in the community

Mechanism

OP (and family/carer) feel reassured by case management approach to dealing with crisis

Outcome

OP (and their family/carers') readiness to engage with the system is increased

Hypothesised program theory 8

Context

Health/aged care decision-making is not made by older person alone, it is done collectively

OP (and family) migrated to Australia, unfamiliar with Australian social support services system

Connector is culturally competent, has knowledge of family's cultural values and approach to decision-making with respect to elder care with financial implications

Intervention

1:1 support

EnCOMPASS Connector facilitates access to Services Australia information about financial support

Mechanism

OP (and their family/carers) feel the Connector treats them with respect for their culture

OP's family concerns about the costs associated with accessing aged care services are allayed

Outcome

OP's family/carers have increased knowledge of the financial supports/subsidies available in Australia

OP's family/carers become more ready to engage with the aged care system

Hypothesised program theory 9

Context

OP experiencing dementia; cultural values may affect OP's family/carer attitudes to seeking support due to stigma

Connector has competencies to provide navigation to appropriate services for older person experiencing dementia

Intervention

1:1 support

Comprehensively trained EnCOMPASS Connectors available to provide culturally appropriate, intensive support and one-on-one case management to older persons of CALD backgrounds in the community

Mechanism

OP family/carers feel the Connector treats them with respect for their culture, with dignity and compassion

Family more open to receiving information and seeking care support on behalf of themselves and OP

Outcome

Family's knowledge/awareness of how to navigate care and respite support options for dementia is increased

Connector facilitates warm referral to specialist navigation for dementia for older person (and their family/carers)

5.1.2 For cultural networks and organisations with reach to older persons from CALD communities

Hypothesised program theory 10

Context

CALD community organisations/networks have capacity and mandate to support older person interests, are resourced by Connector with sectoral knowledge/skills to provide relevant and timely capacity building

Intervention

Develop Navigator Network

Key community leaders, faith leaders, community Touchpoints and health professionals have their understanding and capacity built in relation to ageing, aged care services, role of navigators

Mechanism

CALD community organisation/network awareness of aged care system and services increased

Bridging capital among network members grows through capacity building processes

Outcome

Network of Support Navigators working collaboratively to solve age-related community problems and acting as a wider referral pathway for hard-to-reach older persons to Special Support Worker/ EnCOMPASS Connector

Hypothesised program theory 11

Context

Connector works for multicultural service provider and has good network/ local knowledge of groups, organisations, suppliers and services

Connector has specialist knowledge of the aged care system and its requirements

Intervention

Develop Navigator Network

Key community leaders, faith leaders, community Touchpoints and health professionals identified and organised into Navigator Network

Mechanism

Networking generates bridging capital which 'brings the network alive'

Network members and community leaders have buy in about the Connector's role

Outcome

Capacity of CALD community organisations/networks to provide accurate and timely signposting about Aged Care to CALD communities is increased

Greater integration across service boundaries

Hypothesised program theory 12

Context

CALD community organisations/networks participate in tailored capacity building activities

Intervention

Training for Navigator Network

Ongoing training for Navigator Network

Mechanism

Increasing knowledge and skills, Network members are on 'the same page' about aged care options for CALD community members

Outcome

Building community capacity for culturally appropriate service provision and/or co-ordination

5.1.3 For Touchpoints

Hypothesised program theory 13

Context

GP is a trusted source of information for CALD community members to support decision-making about health and ageing

GPs who work with multicultural communities participate in townhall/network events

Intervention

Townhalls & Navigator Network

Community partner builds relationships with local community health professionals to bring them into the Navigator Network

Mechanism

GP awareness of aged care processes increased

Outcome

GP willing to initiate discussion with older person (and their family/carers) about future planning

GP refers older person to Connector and/or Network of Support Navigators.

Hypothesised program theory 14

Context

Community/faith leader is a trusted source of information for CALD community members to support decision-making about family matters/care responsibilities

FECCA/community partners have relationships with community leaders

Intervention

Townhalls & Navigator Network

Townhall events for communities who are not already involved in the Navigator Network

Mechanism

Increase in CALD community leaders 'buy in' to the Navigator Network and the need to build capacity of community in Aged Care service knowledge

Outcome

Increased understanding among CALD community/faith leaders about how they can better support and advocate for older person within their communities

Community/faith leaders engage with Navigator Network

5.1.4 For Connectors

Hypothesised program theory 15

Context

Connectors aware of personal skill gap or need to enhance professional competencies through training

Intervention

Training for Connector: Training workshop with EnCOMPASS Connectors to build common understanding of project framework, principles and methods, and to standardise core competencies

Ongoing training, capacity building and networking for EnCOMPASS Connectors

Mechanism

Knowledge gaps in specialist skills addressed

Outcome

Connectors communicate consistent and high-quality signposting to support capacities of individuals and communities to navigate My Aged Care

Connector offers personalised care and support (focusing on what matters to older person and their families) with dignity and compassion

Connector holds specialist knowledge of the aged care system and its requirements

Connector's approach is underpinned by cultural competence, demonstrates respect

Hypothesised program theory 16

Context

Connectors actively participate in Community of Practice streams

Intervention

Connector Community of Practice: Four Community of Practice Streams meet bi-monthly on the following:

1. Co-design and communication
2. Community development and engagement
3. Consumer Journey
4. Connector Competencies

Mechanism

Connector increases awareness of what good practice looks like

Outcome

Connectors have an increased understanding of their role and how competencies are demonstrated across different community settings

5.2 Appendix 2: Client and carer interview schedule

Introduction

Hello and thank you for agreeing to talk to me today about your experience with the EnCOMPASS Connectors program.

My name is Kerryn O'Rourke/Liz Meggetto, I work for Charles Darwin University, and I will be facilitating the discussion today.

You have been invited to participate in this interview because your views and experiences as a client/carer in the EnCOMPASS Connectors program are crucial for understanding how the program works. The information you provide will help improve the program and other similar programs.

You have seen the participant information and consented to be here. Just to cover some important points before we start:

- I will be recording the discussion, no one will see this recording except me and the other university researchers on the team.
- I will not tell FECCA, the Commonwealth Government or anyone else that you have participated
- You will not be identified in any reports
- If we use quotes from this discussion, we will remove any details that may identify you

These things are required of us to make sure we are doing the research ethically.

Please feel free to be honest and frank. We acknowledge that the program works differently for different people and it's really helpful for us to hear a range of different views and experiences.

The interview will take about half an hour. You don't have to answer every question and you can ask me to stop at any time.

(If both client and carer participating) - Please try to speak one at a time so that the voice recorder doesn't miss anything.

Do you have any questions of me before we start?

Interview questions for client/family member:

1. How did you come to know about the Connector Program? Who referred you? How do you know them?
2. Were you looking for support for yourself or someone else?
3. Did you feel ready for aged care support? Or did the Connector help you feel less or more ready?
4. What did your Connector do? Can you tell me the story of what they did and how they worked with you?
5. Did they use your language or interpreters? How was that for you? Why?
6. What decisions did you (or you and your family) make after receiving the information/support? Why do you think you made these decisions?
7. If relevant – what was it about your connector that made you trust them/what they were saying/doing? Why?
8. Did working with the Connector change your mind/thinking about anything? How, why? Or how did you feel in your heart or in your mind when the Connector was working with you?

I'm trying to get inside your head or understand your thoughts a little, if that makes sense?

9. Have you registered with My Aged Care? What assistance has the EnCOMPASS Connectors program/the Connector provided for that process? How did they do this?
10. Has anything else (other than the EnCOMPASS Connectors program or the Connector) helped you to access My Aged Care?
11. Has anything made it hard for you to access My Aged Care? Can you describe that for me?
12. Has the EnCOMPASS Connectors program provided any other kind of support to you or your family?
13. What has changed, is anything better or worse since the Connector worked with/supported you?

    Prompts: assessment for aged care service eligibility, establishing a plan, access to services.
14. If you could change something about the EnCOMPASS Connectors program to make it work better for people and their families/carers, what would you change?

5.3 Appendix 3: Connector focus group/interview schedule

Introduction

Hello and thank you for coming along to this discussion about the EnCOMPASS Connectors program.

Before we start, I would like to acknowledge the traditional owners of the land we meet on today and pay my respects to elders past, present and emerging.

My name is Kerryn O'Rourke/Liz Meggetto, I work for Charles Darwin University and I will be facilitating the discussion today.

You have been invited to participate in this evaluation discussion because your views and experiences working in the program are crucial for understanding how the program works. The information you provide will help the Commonwealth Government improve the program and other similar programs.

You have all seen the participant information and consented to be here. Just to cover some important points before we start:

- I will be recording the discussion, no one will see this recording except me and the other university researchers on the team.
- I will not tell FECCA, the Commonwealth Government or anyone else that you have participated
- You will not be identified in any reports
- If we use quotes from this discussion, we will remove any details that may identify you.

These things are required of us to make sure we are doing the research ethically.

We ask that you respect the process and each other, by keeping what is shared here, confidential.

So please feel free to be honest and frank. We acknowledge that the program works differently for different people and it's really helpful for us to hear a range of different views and experiences.

The focus group will take one hour. We won't have any breaks in the hour but if you wish to leave the discussion to take a break or if you don't want to participate anymore, you can leave at any time.

I have about 9-10 questions for you. You don't have to answer every question. To those of you who have participated in our focus groups before, there is some deliberate repetition. Feel free to answer again, perhaps with another answer or story.

I will keep a check on the time to make sure we can cover all the questions.

Please try to speak one at a time so that the voice recorder doesn't miss anything.

Do you have any questions of me before we start?

Questions

1. Can you please tell me how long you have been employed as a connector
2. Thinking about the training you have had to date; how did it help improve your capability in the role? (follow up prompt if needed to expand on the initial part - What was it about the training and/or support that helped or didn't help?)
3. Was there any other support that you needed?
4. How have the Community of Practice meetings supported you to develop in your role? What was it about them that helped or didn't help?
    - for those who haven't participated, what is it about the CoPs that has stopped you from participating? Is there something that would make you more likely to participate and why?

5. Thinking about your work with clients - What strategies or approaches have you found most effective in engaging CALD older people and their carers? Can you give me an example? What made you use this strategy/approach?
6. When a strategy or approach has worked well, how did you know it worked well? What was the immediate outcome? Can you give me an example, perhaps share a story of how it worked, to get that outcome?
7. Have you had any people make contact with, then not work with you, or stop the process? What do you think was going on there?
8. If you could change something about the EnCOMPASS Connectors program to make it work more effectively where you are, what would you change and why?
9. If I have any further questions, may I contact you again in the coming months?

Generic follow up questions

- Can you tell me more about that?
- We're really interested in how that may have changed your thinking, can you tell me more about that?
- What was it about that thing that helped or didn't help?
- Can you tell me how that changed your thinking?
- Did it work like that for all of you, or has some experienced that differently?

5.4 Appendix 4: Manager focus group/interview schedule

Introduction

Hello and thank you for coming along to this discussion about the EnCOMPASS Connectors program.

Before we start, I would like to acknowledge the traditional owners of the lands we are on today and pay my respects to elders past, present and emerging.

My name is Kerryn O'Rourke/Liz Meggetto, I work for Charles Darwin University and I will be running the focus group discussion today.

You have been invited to participate in this discussion because your views and experiences from managing the EnCOMPASS Connectors program are crucial for understanding how the program works.

The information you provide will help the Commonwealth Government improve the program and other similar programs.

You have all seen the participant information and consented to be here. Just to cover some important points before we start:

- I will be recording the discussion, no one outside of the university evaluation team will see or hear the recording.
- I will not tell FECCA, the Commonwealth Government or anyone else that you have participated
- You will not be identified in any reports
- If we use quotes from this discussion, we will remove any details that may identify you

These things are required of us to make sure we are doing the research ethically.

We ask that you respect the process and each other, by keeping what is shared here, confidential.

So please feel free to be honest and frank. We acknowledge that the program works differently for different people and it's really helpful for us to hear a range of different views and experiences.

The focus group will take around one hour. We won't have any breaks in the hour but if you wish to leave the discussion to take a break or if you don't want to participate anymore, you can leave at any time.

I have about 10 questions for you. You don't each have to answer every question. I will keep a check on the time to make sure we can cover all the questions.

Please try to speak one at a time so that the voice recorder doesn't miss anything.

Do you have any questions of me before we start?

Questions

1. What community organisation are you a part of, and what is your management role?
2. Can you tell me about your involvement with the EnCOMPASS Connectors program?
3. What do you feel the program has done well to help you support older people from CALD communities to access aged care services? Has there been anything missing? Something that may have helped you further.
4. What do you think it is about how the connectors work that helps get these outcomes?
5. What has been the value in having the touchpoints/community leaders involved in the program? How/why has this been valuable?
6. What do you think have been the benefits of having the connector work within your agency? Do you think this has helped them to get the outcomes they have? How do you think it helped?

7. There are lots of ideas about how best to provide information to CALD communities about aged care and the supports it can provide. What have you seen in the EnCOMPASS Connectors program that you think has worked well so far? Why/how?
   What hasn't worked well? Why/how?
   What else could be done? Why/how?
8. If you could change something about the EnCOMPASS Connectors program to make it work more effectively in your area, what would you change and why?
9. What else do you think we need to know, to really understand how the EnCOMPASS Connectors program has worked in your community so far?
10. If I have any further questions, may I contact you in the coming months?

Generic follow up questions

- Can you tell me more about that?
- We're really interested in how that may have changed your thinking, can you tell me more about that?
- What was it about that thing that helped or didn't help?
- Did it work like that for all of you, or was it different for any/some of you?
- Why/how?

Thank you for your time and contributions.

5.5 Appendix 5: Touchpoint focus group/interview schedule

Introduction

Hello and thank you for coming along to this discussion about the EnCOMPASS Connectors program.

Before we start, I would like to acknowledge the traditional owners of the land we meet on today and pay my respects to elders past, present and emerging.

My name is Kerryn O'Rourke/Liz Meggetto, I work for Charles Darwin University and I will be facilitating the discussion today.

You have been invited to participate in this evaluation discussion because your views and experiences working with the EnCOMPASS Connectors program are crucial for understanding how the program works.

The information you provide will help the Commonwealth Government improve the program and other similar programs.

You have all seen the participant information and consented to be here. Thank you for that. Before we start, I'll just confirm with you:

- I will be recording the discussion, no one will see this recording except me and the other university researchers on the team.
- I will not tell FECCA, the Commonwealth Government or anyone else that you have participated
- You will not be identified in any reports
- If we use quotes from this discussion, we will remove any details that may identify you

These things are required of us to make sure we are doing the research ethically.

Do you have any questions about any of this so far?

We ask that you respect the process and each other, by keeping what is shared here, confidential.

So please feel free to be honest and frank. We acknowledge that the program works differently for different people and it's really helpful for us to hear a range of different views and experiences.

The focus group will take around one hour. We won't have any breaks in the hour but if you wish to leave the discussion to take a break or if you don't want to participate anymore, you can leave at any time.

I have about 7-8 questions for you and you don't have to answer every question, and I will keep a check on the time to make sure we can cover all the questions.

Please try to speak one at a time so that the voice recorder doesn't miss anything.

Do you have any questions of me before we start?

Questions

1. What community network/organisation are you a part of, and what is your role?
2. Can you tell me about your involvement with the EnCOMPASS Connectors program?
3. What do you consider the outcomes of the EnCOMPASS Connectors program have been for older people and their families?
4. What do you feel the program has done well to help you support older people to access My Aged Care? Has there been anything missing? Something that may have helped you further.

5. There are lots of ideas about how best to provide information to CALD communities about aged care and the supports it can provide. What have you seen in the EnCOMPASS Connectors program that you think has worked well so far? What hasn't worked well? What else could be done?
6. What do you see as your role in the program?
7. Have you participated in the events run by the connecters? What did you gain from them?
8. Why do you participate in the events the connectors run?
9. Why do you think touchpoints like yourself are valuable to the program? How do you add value?
10. person What has the program or Connector done that is working well?
11. Can you share a story about when the program has worked well or made difference for an older and/or their carer?
12. Can you share a story about when the program has not worked well?
13. If you could change something about the EnCOMPASS Connectors program to make it work more effectively in your area/community, what would you change and why?
14. What else do you think we need to know, to really understand how the EnCOMPASS Connectors program has worked in your community to date?
15. If I have any further questions, may I contact you in the coming months?

Generic follow up questions

- Can you tell me more about that?
- We're really interested in how that may have changed your thinking, can you tell me more about that?
- What was it about that thing that helped or didn't help?
- Did it work like that for all of you, or was it different for any/some of you?
- Why/how?

5.6 Appendix 6: Time and task data collection tool

Information and instructions

We are collecting this information to be able to calculate the time needed for a Connector's different roles. For work with older persons and carers, we will also work out whether the time needed varies for clients with more complex situations. This information will inform planning for future programs like this one.

For this, we need a COMPLETE record of one week's work in the EnCOMPASS Connectors program at your agency.

Select ONE, one week period between the 24th of October and the 13th of November 2022. Weeks start on Monday and finish on Sunday, to include work Connectors do on weekends.

Complete only ONE snapshot form per agency. If more than one Connector works at your agency, please enter information from all Connectors into the same page and submit one file. Identify different Connectors as Connector 1, Connector 2 etc.

We will NOT use this information to assess the performance of any individual worker or agency. Only aggregated (added together) data will be provided to FECCA and the Department of Health and Aged Care.

We will NOT use this information to assess the time taken for individual clients. Only aggregated (added together) data will be used in analysis.

ALL work you do during the chosen week should be recorded (e.g., client work, community education work, administration, meetings). Take a note of the time you start each task. Then enter each task into the sheet as you complete it. This will avoid forgetting things or recording too little time for them.

Each task should be recorded separately on its own row. This is so that we can analyse the information.

Please include the work you do for ALL of your clients. Client consent is NOT needed for this data because no client information is being entered. EVERY client-related task should have a unique Client Number with it.

For Client Numbers: Where clients have consented for their data to be provided in the monthly report for the evaluation, copy and paste their unique identifier number into this document. This will allow us to analyse the time taken for clients with more complex needs. If the client has not consented for their data to be provided for the evaluation, please generate a number and put an asterisk after it (e.g. 123456*).

The total time recorded for the week should equal the total time worked by Connectors in the week.

An explanation of each item is below. It provides examples of what the different items mean.

The sheet named "Data" is where you record the information.

Some columns have drop-down lists. Click on an empty box to bring up the arrow for drop down lists. The arrow will appear on the right, next to the box. Click on the arrow to see the list. Click on your selected option to make it appear in the box.

Name your file as [your site name_state/territory_snapshot2] and send to rreali@cdu.edu.au by Monday 14 November 2022. Thank you.

Explanation of categories on Data collection template

Name of agency

The organisation you work for (so we can calculate the number of organisations who provide data).

Week the snapshot spreadsheet is completed

Select the week you are capturing data for from the drop-down list. Choose a week that is "closest to typical" as you can. (i.e.. No Connectors on leave, no planning days for the agency.)

Number of days the Community Connectors in your agency normally work per week

The total number of days the Connectors in your agency are contracted to work per week (e.g., 5 days, 3.5 days). For most sites, this will be 5 days.

Number of full (7.6hour) days worked by Connectors in your agency this week (e.g. 3.5 days)

Number of whole days all Connectors in your agency worked in the week for which you are recording data (e.g. 5 days, 2.5 days). Add part days together. Add time for both/all Connectors together.

Connector number

If there is more than one connector in your organisation number yourselves and indicate which connector is completing each row. This information will not be used to monitor individual performance. It will help us understand why there might be multiple tasks occurring at the same time.

Tasks (Drop down list)

- Initial enquiry: May be with client, family member, touchpoint etc.
- First meeting with client: Older person and/or family member (or other support person). This includes face to face meetings, virtual meetings (e.g., skype, Zoom) or over the phone.
- Subsequent meeting with client: Any meeting with the client after the first face to face meeting. This includes face to face meetings, virtual meetings or over the phone.
- Follow up work for client: E.g., phone calls to services, organising referrals, finding information, booking interpreters
- Travel time for client meetings: May be taking a client to a meeting or service provider, or travelling to client house/agreed meeting place. Include travel both ways.
- Attending 'external' meetings with client: Time spent in meetings with the client and other service providers (e.g., My Aged Care, GP, other services). Does NOT include travel time.
- Case notes / documentation for client: Completing all documentation for clients - case notes or other records
- Other work for individual clients: Please describe briefly in "Notes" column
- Planning/organising community education/engagement: Planning time only. E.g., planning information sessions for community members or training for touchpoints such as co-design workshops, community capacity building event and Town Halls, or other strategies. Record your time only in this column. May be individual work or planning meetings with others.
- Developing materials for community education/engagement: E.g., developing training materials, writing information materials, meetings with graphic designers or translators
- Providing community education/engagement: E.g. time spent in community meeting at which you provide information, or in a radio station doing interview
- Travel time for community education/engagement: Travel time to attend a planning session or a community education event. Include travel both ways.
- Planning/organising other community development: E.g., collaborative work with other agencies to develop new programs/services, supporting a community group to develop a new program
- Implementing other community development: E.g. time spent working with other agencies to implement new programs/services, supporting a community group to implement a new program
- Travel time for other community development: Travel time to attend planning or implementation of other community development activities. Include travel both ways.
- Attending network meetings: Includes EnCOMPASS Connectors Community of Practice and other inter-agency networks or groups and other meetings within your agency
- Travel time for network meetings: Travel time to attend network meetings. Include travel both ways. Leave blank if network meeting was on-line and no travel was required.
- Professional development sessions attended: Any training or professional development you attended for your own learning
- Other tasks (please specify in notes): Other tasks required for your job, e.g., attending staff meetings.

Client Number

Where clients have consented for their data to be provided in the monthly report for the evaluation, copy and paste their unique identifier number into this document. This will allow us to analyse the time taken for clients with more complex needs. If the client has not consented for their data to be provided for the evaluation, please generate a number and put an asterisk after it (e.g. 123456*).

Day

The day of the week on which the task was undertaken (e.g., Monday)

Time started

The approximate time you started the task (to the nearest 5 minutes). Please use the clock time format, e.g. 10:00 for 10am, 02:00 for 2pm.

Time taken (minutes) - excluding any breaks

The length of time taken on the task in this day, in minutes (e.g., "35"; or "120" if the task took 2 hours) - excluding any break time taken during the task.

Other staff from your agency involved?

Were any other staff members from your organisation involved in this task on this day? (Only staff who actually worked on it on the particular day should be recorded . Other workers might include another Connector, a bi-lingual worker, or another team member to whom a warm referral was made)

Number of other staff from your agency involved

How many staff, NOT including yourself, worked on the task on this day? E.g., If there was a planning meeting with yourself and 3 other staff involved, record "3".

Other staff member(s) role(s)

E.g., EnCOMPASS Connector (if there are two Connectors in your agency), Team manager, Bi-lingual worker

Total time taken for all other staff members involved on this task (minutes)

The total amount of time the other team member(s) spent on the task in this day. If one team member spent 30 minutes and one spent an hour, record 90 minutes.

Notes

Include any "Other" activities for direct client work, community education or community development here.

Data collection template

Name of agency	Week this spreadsheet was completed (click on the below cell to see drop down list of options)	Total number of days the Connectors in your agency normally work per week	Number of full (7.6hour) days worked by Connectors in your agency this week (e.g., 3.5 days)	Total number of current clients 'on the books' during the snapshot week (registered with your agency & not yet closed)	Total number of clients supported during the snapshot week

Connector number	Task	Client Number	Day	Time task started	AM/PM	Time task taken (minutes) - excluding any beaks taken while doing this task	Other staff from your agency involved?	Number of other staff from your agency involved	Other staff member(s) role(s)	Total time taken for all other staff members involved on this task (minutes)	Notes
	EXAMPLE - Initial enquiry	*123456*	*Monday*	*9:15*	*AM*	*20*	*Yes*	*1*	*Bi-lingual worker*	*20*	*Face to face enquiry*

5.7 Appendix 7: Staff costs data collection tool

Introduction

Thank you for providing staffing costs for the EnCOMPASS Connectors program evaluation

Please follow these instructions:

1. Enter the required information in the fields in the next sheet.
2. Save the file as State, agency name, staff costs
3. Email the file to rreali@cdu.edu.au by Monday 14 November 2022.

State/Territory	Site or agency name	Staff role	FTE	Staffing cost including superannuation & oncosts per 12 months		Of $189,915 provided for the program, indicate proportion for:	%
		E.g. Connector 1	*0.5*	*$42,000*		Connector staffing	
		E.g. Connector 2	*0.2*	*$42,000*		Other staffing	
		E.g., Manager	*0.1*	*$26,000*		Other program costs	
		E.g., Bilingual project officer	*0.2*	*$17,000*			

5.8 Appendix 8: Report of quantitative data analysis

Key findings from the below analysis have been brought forward into the report against the relevant program theories.

5.8.1 Summary of main findings

Participating sites provided data about clients and their careers, support activity provided to clients and community group sessions throughout 2022, detailed snapshots of activities of Connectors over two weeks, and information about costs. This data was analysed to understand relationships such as between client characteristics, support provided, and client outcomes. The main findings from this analysis are summarised below.

5.8.2 Client characteristics and complexity

- Around 70% of clients have challenges with English and required an interpreter or bilingual worker in at least some settings. Around 55% of clients spoke an Asian language and 38% were of Asian ethnicity, while 35% have a background as a refugee.
- Around two-thirds of clients have at least one impairment, and 96% have at least one health issue. Almost all clients (93%) were eligible for Medicare.
- Among clients where overall complexity could be assessed, 52% were rated as medium complexity (with three or four health issues, impairments, or other issues that may increase their support needs), 39% high complexity (five or more issues), and only 9% low complexity (fewer than three issues).
- Client referrals came from a variety of sources, with self-referrals being the single largest source (28% of clients), followed by carers (17%).

5.8.3 Support provided to clients by sites

- Each client received an average of 1.4 occasions of support during 2022, with 78% of clients receiving one occasion of support and only 5% of clients receiving more than five occasions of support.
- Clients who were born in Australia/New Zealand or who have been in Australia for less than ten years were less likely to receive more than one occasion of support compared to clients born elsewhere or who have been in Australia for longer.
- There are also some variations in the proportion of clients who received more than one occasion of support by ethnicity and language spoken, with people of most Asian ethnicities / languages less likely than clients of all other ethnic or linguistic backgrounds combined to receive more than one occasion of support (South-East Asian being an exception). Clients who spoke northern European languages were less likely to receive more than one occasion of support, while clients who spoke southern European languages were more likely.
- Clients with only one health issue were less likely to receive more than one occasion of support compared to other clients.
- Around 44% of occasions of client support were face-to-face, with the remainder by other modes including phone and email. Around 61% of clients received at least one face-to-face occasion of support.
- Clients of South-East Asian ethnicity or who were born in Asia were less likely to receive face-to-face support than other clients, while clients born in the Americas were more likely to receive face-to-face support. Clients who had been in Australia for 20 years or more or who were not from a refugee background were less likely to receive face-to-face support.

- Clients who spoke a Northern European language were significantly more likely to receive face-to-face support while those who spoke a Southeast Asian language were less likely.[14]
- Clients with one health issue were more likely to receive face-to-face support than other clients.
- Clients of low or medium complexity were less likely to receive face-to-face support than all other clients.
- The average case duration was 22 days for clients with closed cases and 219 days for clients with open cases as of 31 December 2022, but it is not clear whether sites have consistently recorded closing dates for inactive clients, so case durations may be overstated for some clients where no closing date has been recorded.
- Among clients with closed cases, 53% were recorded as having their cases opened and closed on the same day.
- Among clients with closed cases, average case duration was statistically significantly shorter than other clients for those born in Australian/New Zealand (8 days), those with no health issues (5 days) and those with low complexity (12 days). Case duration was longer for those residing in Australia for 20 years or more (35 days), clients with medium complexity (32 days) and those referred to sites by other organisations (52 days). Average case duration for clients with high complexity (30 days) was not significantly different from the average duration for all other clients.
- Among clients with open cases at the end of 2022, there are substantially more variations in average case durations across client characteristics, but it is difficult to know whether these variations relate to client characteristics or are a consequence of incomplete data.

5.8.4 Community outreach

- A total of 720 community outreach (group) sessions were reported as being led or attended by participating sites between January and November 2022. Around half of these sessions were for 'community outreach', i.e., to connect with older people who may need support.
- There does not appear to be a clear relationship between community outreach sessions and inward referrals to sites. There are some instances where a site received a relatively large number of inward referrals soon after a community outreach session, but there are also many other instances where this did not occur.
- On average, a site received around one inward referral per week in weeks where no outreach sessions were held, compared to 3.6 referrals in the seven days following a "townhall" session and 2.9 referrals in the seven days following other types of sessions. However, the pattern of outreach sessions and inward referrals is very variable across sites and across time so it is difficult to be sure of the extent to which referrals were caused by community outreach sessions.

5.8.5 Client outcomes

- 48% of clients are recorded as being referred to My Aged Care, 34% referred to another service, and 18% have no referral recorded as of 31 December 2022.
- The proportion of clients referred to My Aged Care is greater for clients with open cases than with closed cases (58% open vs 27% closed), and the opposite is true for clients referred to other services (26% open vs 51% closed).
- Clients with higher complexity were more likely to be referred to My Aged Care and for their case to remain open at the end of 2022, while clients with lower complexity were more likely to be referred to another service and for their case to be closed.

[14] Most clients who spoke a Southeast Asian language were supported by a single site, and almost all support provided by that site was by phone. Thus, this result may reflect the service models of agencies serving different groups of clients, rather than client characteristics.

- Clients who were referred to My Aged Care were likely to receive more occasions of support from sites during 2022 while clients referred to other services were likely to receive fewer occasions of support.
- Clients were likely to be either referred to My Aged Care or have no referral recorded by the end of 2022 if their case had been closed and was of longer duration, while clients with shorter duration cases were more likely to be referred to other services.

5.8.6 Allocation of connector time (task and time snapshots)

- Connectors spent around 36% of their available time on tasks related to client support, i.e., meetings, follow-ups, and travel. Within this time, client meetings account for 34% of connector time, while other tasks directly associated with that support (i.e., follow-up and case notes or documentation) accounted for 46% of time.
- Around half of clients who received support in the snapshot weeks had one support task recorded and half had more than one task recorded (up to a maximum of seven tasks).
- A greater proportion of clients (78%) received other forms of support from connectors in the snapshot weeks than had a meeting with a connector (45% of clients). Only 6% of clients had more than one meeting with a connector recorded in the snapshot weeks.
- External meetings that connectors attended with clients (median 90 minutes) tended to take longer than first meetings with clients (median 60 minutes), which in turn tend to take longer than subsequent meetings with clients (median 35 minutes). However, recorded meeting times vary from 10 minutes to 240 minutes.
- While not statistically significant, there was a positive correlation between the support time provided by connectors to clients in the snapshot weeks and client complexity. The median support time provided to the highest complexity clients was nearly double that provided to lower complexity clients.
- Connectors also spent around 32% of their available time on community outreach tasks, i.e., community education and other community development. Within this time, providing education accounted for 28% of connector time, while planning, organising, and developing materials accounted for 64% of time.
- Travel did not take a significant amount of connector time, accounting for only 8% of the total time that connectors spent on client support and 9% of the time spent on community outreach activities.
- Allocation of connector time to types of tasks varied considerably across sites during the snapshot weeks. Some sites spent little time on client support in those weeks, due to community activities taking most of the reported connector time. Other sites spent more time on client support, although the greatest reported proportion of connector time spent on client support was 66% across sites for both snapshot weeks combined, indicating that all Connectors spent some time on tasks other than client support.
- Across all sites, about 14% of available connector time (based on actual connector days worked) in the snapshot weeks was not associated with recorded tasks. This unallocated proportion of time varied across sites, with 67% of sites reporting tasks equivalent to at least 80% of available connector time, while 19% of sites did not account for more than half of available connector time.
- Agency staff members who were not connectors are also recorded as contributing to a significant number of tasks, with total time recorded for non-connector staff in both snapshots equal to 54% of the total time recorded for connectors. In most sites and for most types of tasks, the total time recorded for non-connectors was less than half of the total time recorded for connectors, but there are some cases where non-connector time is greater than connector time. Non-connectors were more likely to be involved with community outreach tasks than with client support, and 45% of total non-connector time across sites was for community outreach tasks, versus 25% for client support.

5.8.7 Agency costs

- Across sites, there is substantial variation in reported costs across connectors, other staff, and all other costs such as overheads. Reported payments to Connectors ranged from around one-third to 100% of total costs. All but two sites reported allocating some funding to other costs aside from staffing, with this proportion ranging from 2% to 56% of funding.
- It appears that some sites have reported costs over 12 months that are substantially less than the funding that was provided, but the reasons for this are not clear.
- Across all sites that provided this information, the median cost per FTE is around $93,000 for Connectors, $114,000 for managers, and $75,000 for bilingual support workers, although there is a relatively wide range of reported costs per FTE for each of these roles, and particularly for managers. In most cases the reported FTE numbers for roles other than Connectors are low, with an average of 0.20 FTE managers per site and 0.25 FTE bilingual support managers per site, across sites that reported costs for such roles.

5.8.8 Overview and data sources

The following analysis is based on data collected by participating sites between January and December 2022 and provided to the evaluation team:

Older person and carer demographics: Characteristics of clients registered with participating sites. Analysis of clients relates only to the subset of clients who have given permission for their information to be shared with the evaluation team.

- *Outward referrals:* Records of all clients referred to My Aged Care and other agencies.
- *Occasions of support:* Details of support provided to all individual clients including the number and type of support sessions.
- *Group sessions:* Summaries of the number and types of community outreach and other groups sessions provided by sites.
- *Time and task snapshots:* Detailed records of activities undertaken by Connectors during two snapshot weeks in May/June and October/November.

5.8.9 Client demographics

5.8.9.1 Characteristics of registered older persons

Characteristics of the 1,038 clients registered with sites up to December 2022 and who have given permission for their information to be shared with the evaluation team are summarised in Figure 1.[15]

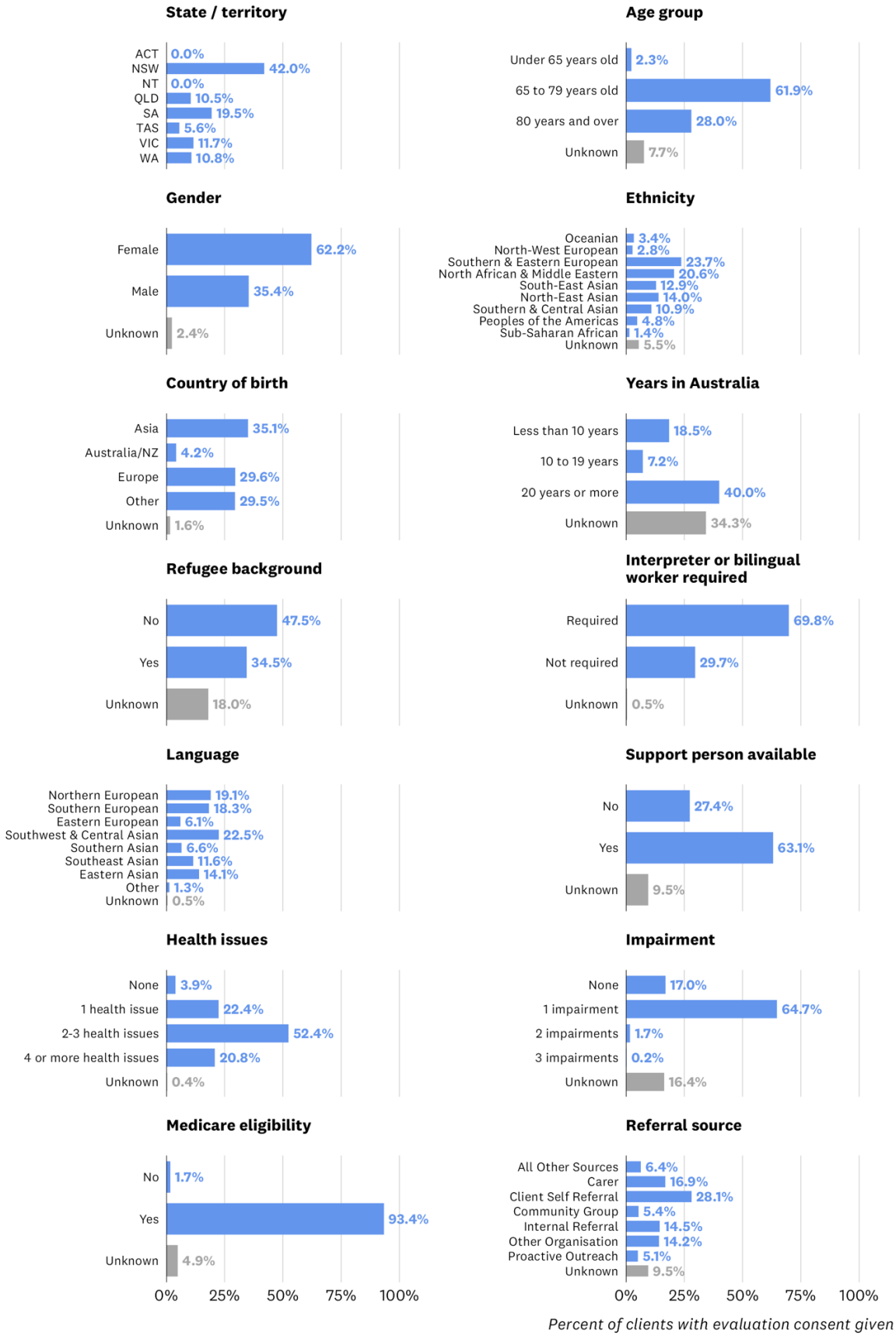
- Almost all older persons are aged 65 and older persons. Among those whose age is recorded, around two-thirds are aged between 65 and 79, and one-third are aged 80+.
- There are 1.75 times as many female older persons as male older persons.
- Around 38% of older persons were of Asian ethnicity and 27% were European. Around 55% of older persons spoke an Asian language.[16]

[15] It is not possible to calculate the proportion of all clients captured in this sample or assess whether the sample is representative, because the evaluation team only had access to data about clients who gave permission for their data to be shared.

[16] The ethnicity and language classifications shown in
Figure 1 are based on ABS level 1 ethnic and language groups. These groupings put Middle Eastern languages in the Southwest & Central Asian language category, but people of Middle Eastern ethnicity are included in the North African & Middle Eastern ethnic group. This is the main reason why the proportion of clients that speak an Asian language is substantially higher than the proportion of clients of Asian ethnicity.

- Around 96% of older persons have at least one known health issue and around 73% have two or more health issues.
- Around two-thirds of older persons have at least one known impairment. Due to the way that this data was collected, older persons with multiple impairments may have been recorded as having one impairment, thus the number of older persons with more than one impairment is probably understated. In addition, impairment status was not recorded for around 16% of older persons.
- Around 70% of older persons required an interpreter at least in some settings.
- Almost all older persons are eligible for Medicare – of those with eligibility recorded, around 98% are eligible.
- Around 35% of older persons are recorded as having a background as a refugee.
- Almost two-thirds of older persons have a support person available who can assist them.
- The number of years in Australia was not recorded for around 34% of older persons. Of those whose year of arrival was recorded, 60% have been in Australia for 20 years or more, while around 28% have been in Australia for less than ten years.
- Self-referral was the largest single source of referrals, accounting for 28% of older persons, with carers accounting for a further 17%.

Figure 1 Demographics of older persons who have given permission for their information to be shared with the evaluation team.



5.8.9.2 Complexity index

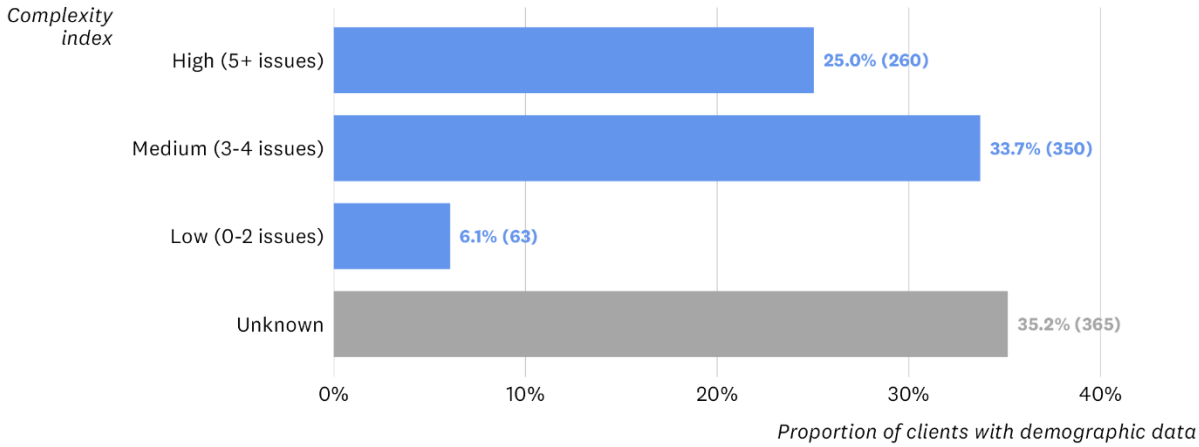
Based on some client characteristics, a 'complexity score' was defined for older persons that is intended to reflect how much support they are likely to require. Table 1 shows how a client's complexity score was calculated based on their characteristics. Potential scores range from zero to seven.

Table 1. Calculation of client complexity scores.

Characteristic	Score
Support person available	Yes = 0 / No = 1
Interpreter required	No = 0 / Yes = 1
Refugee background	No = 0 / Yes = 1
Health issues	None = 0 / 2-3 issues = 2 / 4 or more issues = 3
Impairments	None = 0 / 1 or more = 1
Complexity categories	
Low complexity	Total score of 0, 1 or 2
Medium complexity	Total score of 3 or 4
High complexity	Total score of 5 or more

All characteristics necessary to calculate a client's complexity score were recorded for 673 older persons (65%) among the 1,038 older persons with some demographic data provided (Figure 2). Among the 673 older persons where a complexity score can be calculated, 91% are medium or high complexity, and only 9% are low complexity older persons.

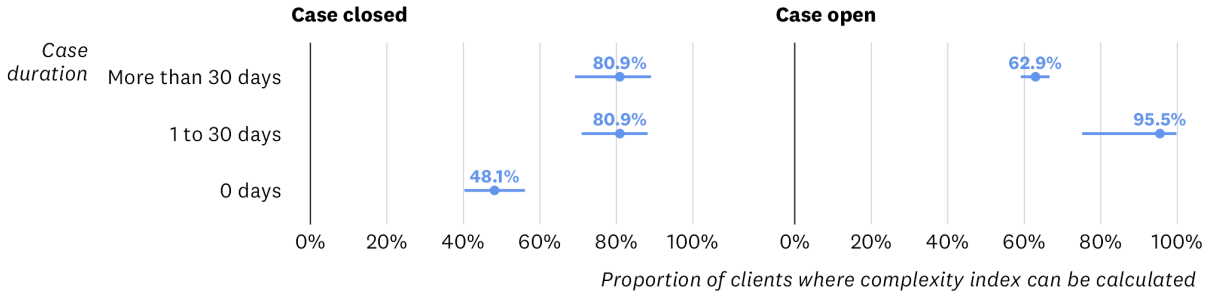
Figure 2 Distribution of client complexity scores.



Complexity scores can be calculated for older persons who have agreed to share their information with the evaluation team and who have provided information about the characteristics used to determine complexity (see Table 1 above). Among older persons with closed cases (i.e., where a case closing date is recorded), the proportion of older persons where complexity can be calculated is significantly lower for older persons where the case was opened and closed on the same day, but there is no difference in this

proportion for older persons with case durations from one to 30 days compared to those with case durations greater than 30 days (Figure 3 left panel). Among older persons with open cases (no case closing date recorded), the proportion of older persons where a complexity score can be calculated is significantly greater for older persons with a case duration of up to 30 days (as of 31 December 2022) compared to older persons where the case was open for longer (Figure 3 right panel).

Figure 3 Relationship between the proportion of older persons where a complexity score can be calculated and case duration (with 95% confidence intervals).

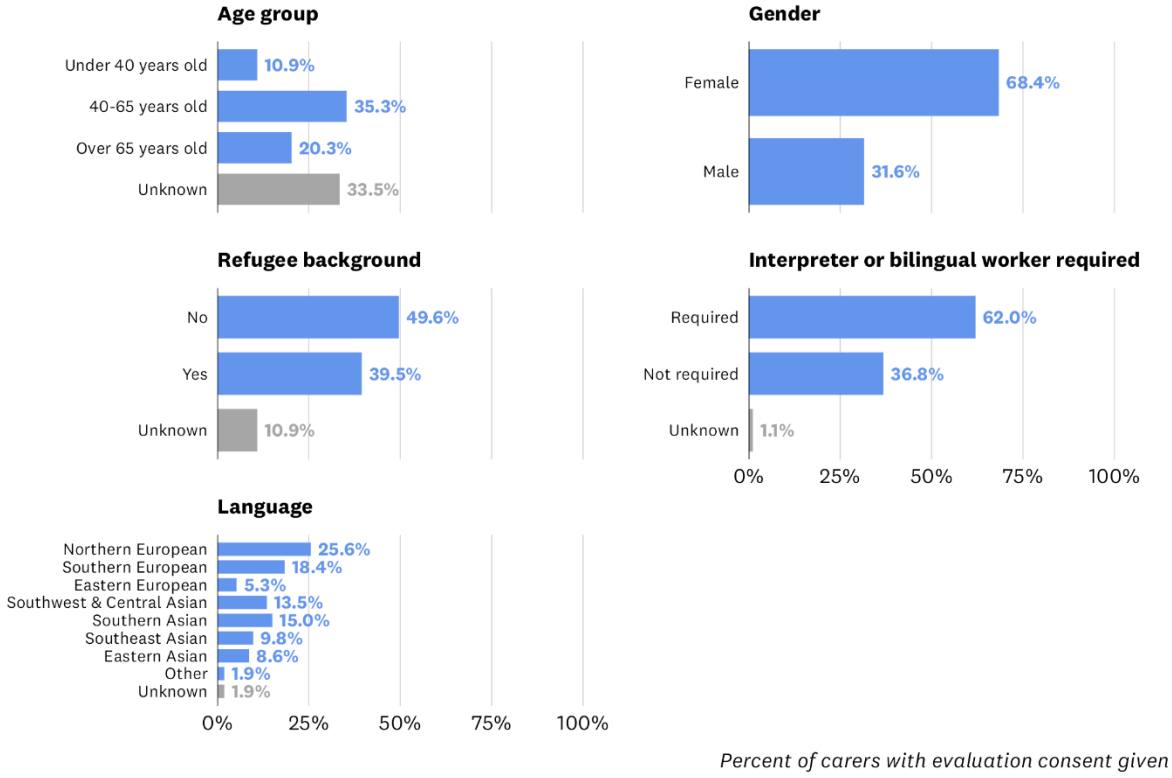


5.8.9.3 Characteristics of carers

Figure 4 summarises demographics of 266 carers registered with sites up to December 2022 and who have given permission for their information to be shared with the evaluation team. Less information was collected about carers than older persons.

- Carers tended to be younger than older persons. Of carers where age was recorded, around two-thirds were under 65 years old.
- The proportions of carers who were female and from a refugee background were similar to older persons, at around 68% and 40% respectively.
- Around 62% of carers are recorded as requiring an interpreter or bilingual worker, and around 47% were recorded as speaking an Asian language.

Figure 4 Demographics of carers who have given permission for their information to be shared with the evaluation team.



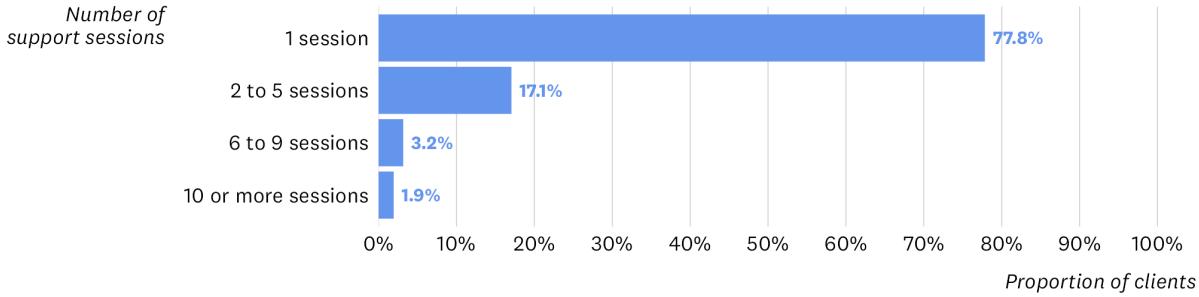
5.8.9.4 Summary of support provided and community engagement activity by sites

5.8.9.5 Occasions of support provided to older persons

Data provided by sites records information about 1,462 occasions of support during 2022 for older persons who gave permission for their information to be shared with the evaluation team. Overall, each client received an average of 1.4 support sessions but this ranges from 1 to 19 sessions across older persons. Most older persons are recorded as receiving one occasion of support, with less than 2% receiving 10 or more occasions of support (Figure 5).[17]

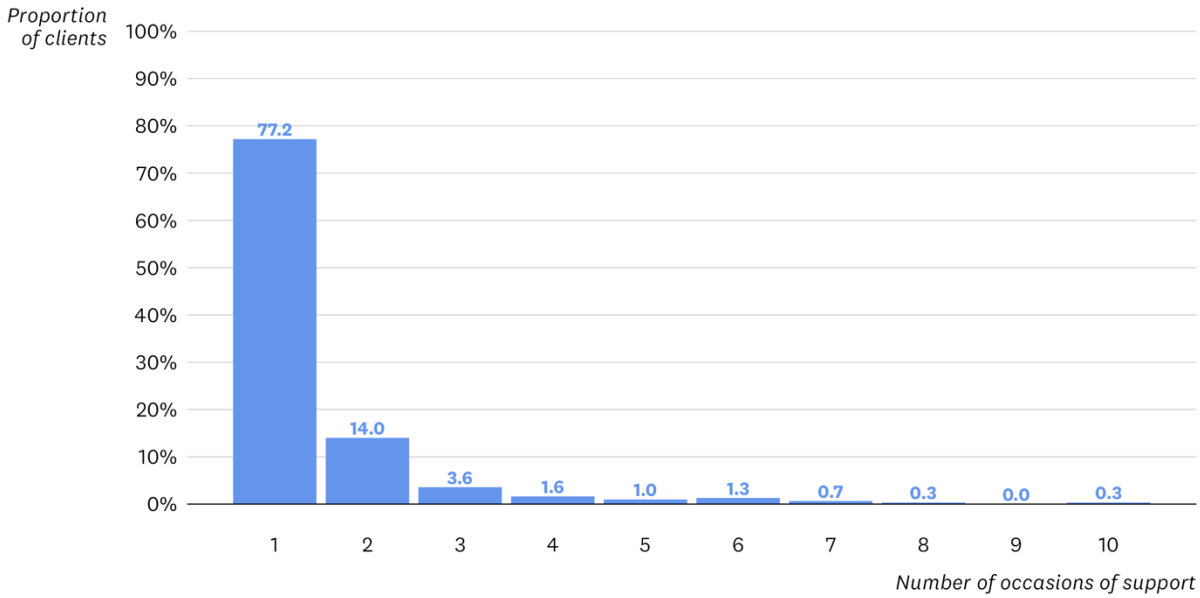
[17] The proportions shown in Figure 3 are only based on clients whose case is recorded as being first opened prior to December 2022, and the data on occasions of support for clients runs up to the end of December 2022. This is to reduce the distortion caused by clients who registered later in the year having less opportunity to receive support than clients who registered earlier. As discussed below, the average duration of client cases is around 3 weeks.

Figure 5 Number of support occasions recorded for all older persons with cases opened before 1 December 2022.



Among the 1,038 older persons included in this analysis, 307 (30%) are recorded as having a 'closed' case by 31 December 2022. For older persons with closed cases, 77% received one occasion of support and the greatest number of occasions of support recorded was 10 (Figure 6).

Figure 6 Number of occasions of support recorded for older persons with closed cases by 31 December 2022.



Given that most older persons received only one occasion of support, it is interesting to look at whether the proportion of older persons who received more than one occasion of support differs across groups of older persons Figure 7):[18]

[18] It should be noted that the comparisons in Figure 6 and similar figures below are for one client characteristic at a time, and to the extent that characteristics are correlated this may over- or under-state the importance of any one characteristic. For example, older clients also tend to have more health issues and impairments and these interactions are implicitly included in the comparisons in each of these characteristics. For each characteristic, statistical significance is shown in Figure 6 for a comparison of clients with that characteristic to all other clients without that characteristic. For example, the proportion of clients born in Australia/NZ who received more than one occasion of support is lower than all other clients including those whose country of birth is not recorded, and this difference is statistically significant at the 5% level.

- In general, older persons with one or more 'unknown' characteristics were less likely to have received more than one occasion of support. Such older persons may be less engaged with support providers than other older persons.

- Clients of Oceanian, North-East Asian or Southern & Central Asian ethnicity or who were born in Australia/NZ were less likely to receive more than one occasion of support than other older persons. People of Southern & Eastern European, South-East Asian or American ethnicity were more likely to receive more than one occasion of support than other older persons. Similar variations are also seen across languages spoken by older persons.

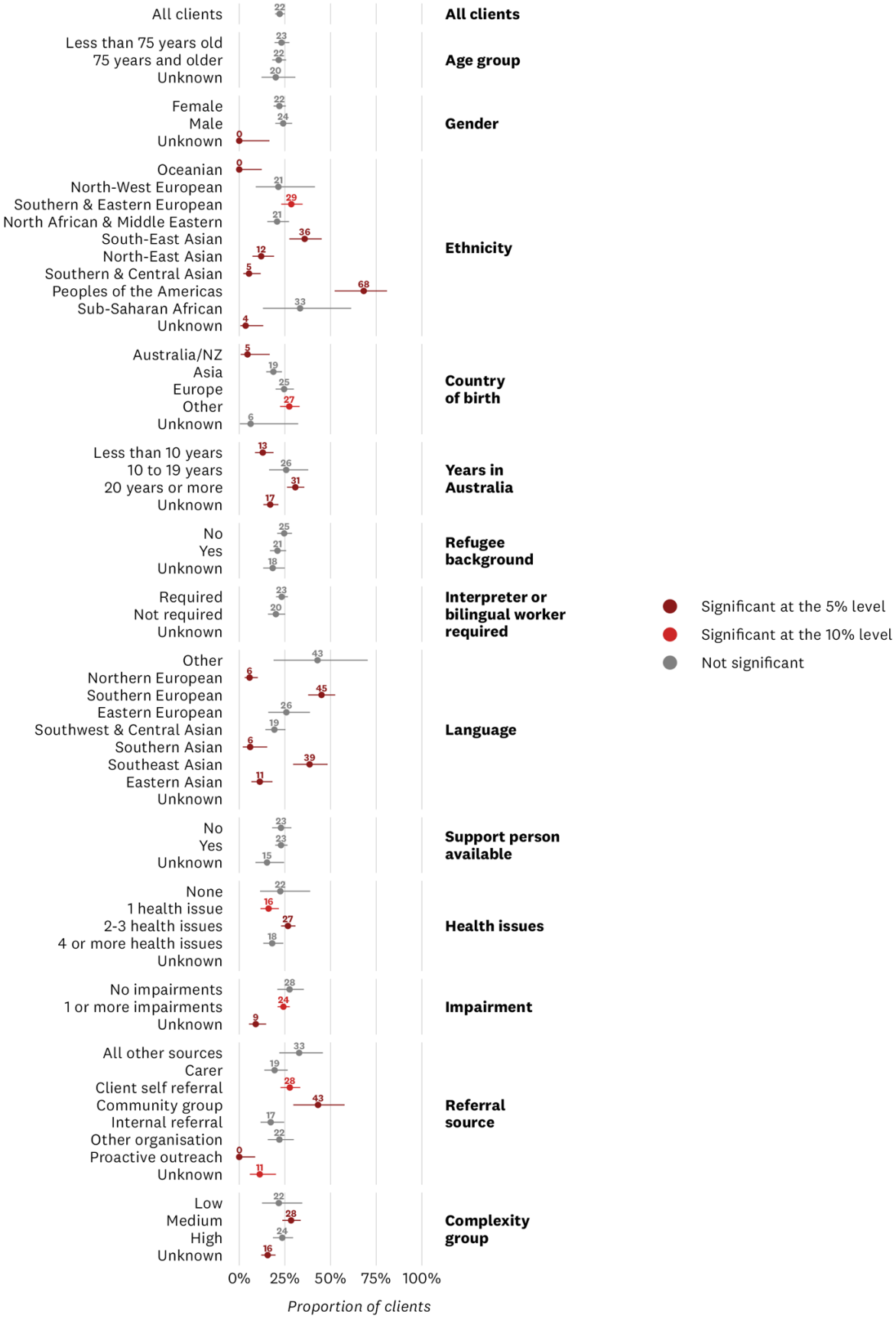
- Clients who have been in Australia for less than 10 years were less likely to receive more than one occasion of support, while older persons who have been in Australia for 20 years or more were more likely to receive more than one occasion of support.[19]

- Clients with one health issue were less likely to receive more than one occasion of support while older persons with 2-3 health issues were more likely.

- Self-referred older persons or those referred by community groups were more likely to receive more than one occasion of support, while older persons sourced from proactive outreach were less likely to receive more than one occasion of support.

[19] This may reflect the fact that clients who have been in Australia for 20 years or more tend to be older than clients who have been in Australia for less than 10 years. Among clients who have been in Australia for 20 years or more, 55% are aged 75 or older, compared to 38% of clients who have been in Australia for less than 10 years and this difference is statistically significant at the 1% level. However, clients who have been in Australia for 20 years or more were significantly less likely to have four or more health issues than clients who have been in Australia for less than 10 years (19% vs 41%) and there is no significant difference in the proportion of clients who are of high or medium complexity across these two groups.

Figure 7 Proportion of older persons who received more than one occasion of support, for older persons with cases opened before 1 December 2022.



5.8.10 Mode of support provided

Overall, 44% of occasions of client support are recorded as being face-to-face, with the remainder being by other modes including phone and email. Around 61% of older persons received at least one face-to-face occasion of support. Figure 8 compares the proportion of older persons who received at least one face-to-face occasion of support across client characteristics:[20]

- Clients of South-East Asian ethnicity or who were born in Asia were significantly less likely to receive face-to-face support than other older persons, while older persons born in the Americas were more likely to receive face-to-face support.

- Clients who had been in Australia for 20 years or more or who were not from a refugee background were significantly less likely to receive face-to-face support. This may reflect sites providing support in ways that best suit client needs, e.g., providing phone support to older persons who are less able to travel.

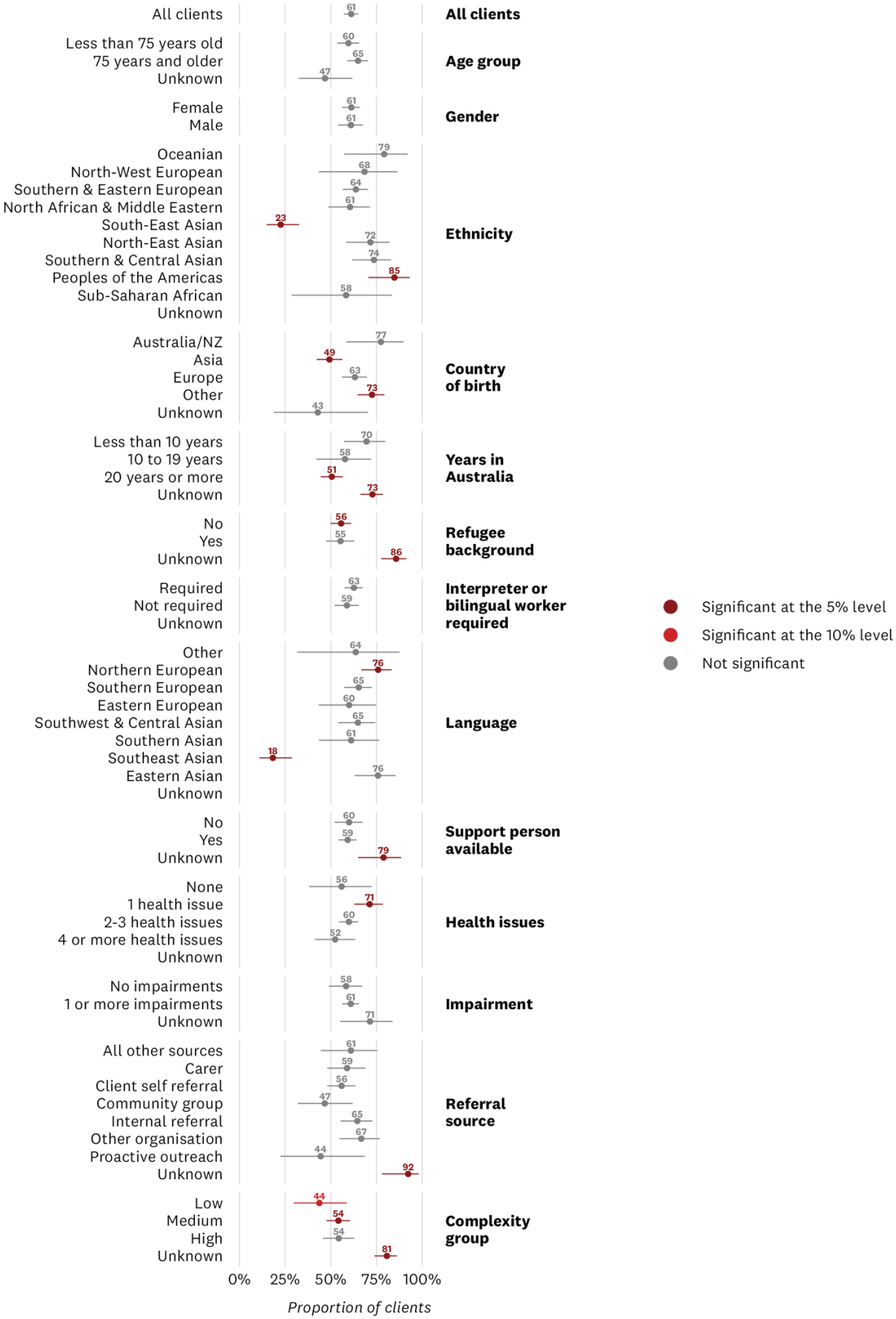
- Clients who spoke a Northern European language were significantly more likely to receive face-to-face support while those who spoke a Southeast Asian language were less likely.

- Clients with one health issue were more likely to receive face-to-face support than other older persons. This may reflect older persons with more health issues finding it harder to travel and needing phone support rather than face-to-face.

- Clients of low or medium complexity were less likely to receive face-to-face support than other older persons.

[20] As above, for each characteristic, statistical significance is reported for a comparison of clients with that characteristic to all other clients without that characteristic.

Figure 8 Proportion of older persons receiving face-to-face support by characteristics. Proportions for categories with fewer than 10 older persons have been suppressed.



5.8.11 Duration of support provided to older persons

The duration of support provided to older persons with closed cases can be calculated as the number of days between the recorded case opening and closing dates.[21] For older persons with open cases (i.e., no closing date is recorded), case duration was calculated from the client's case opening date until 31 December 2022. As above, older persons with cases opened during December 2022 are excluded from this analysis.

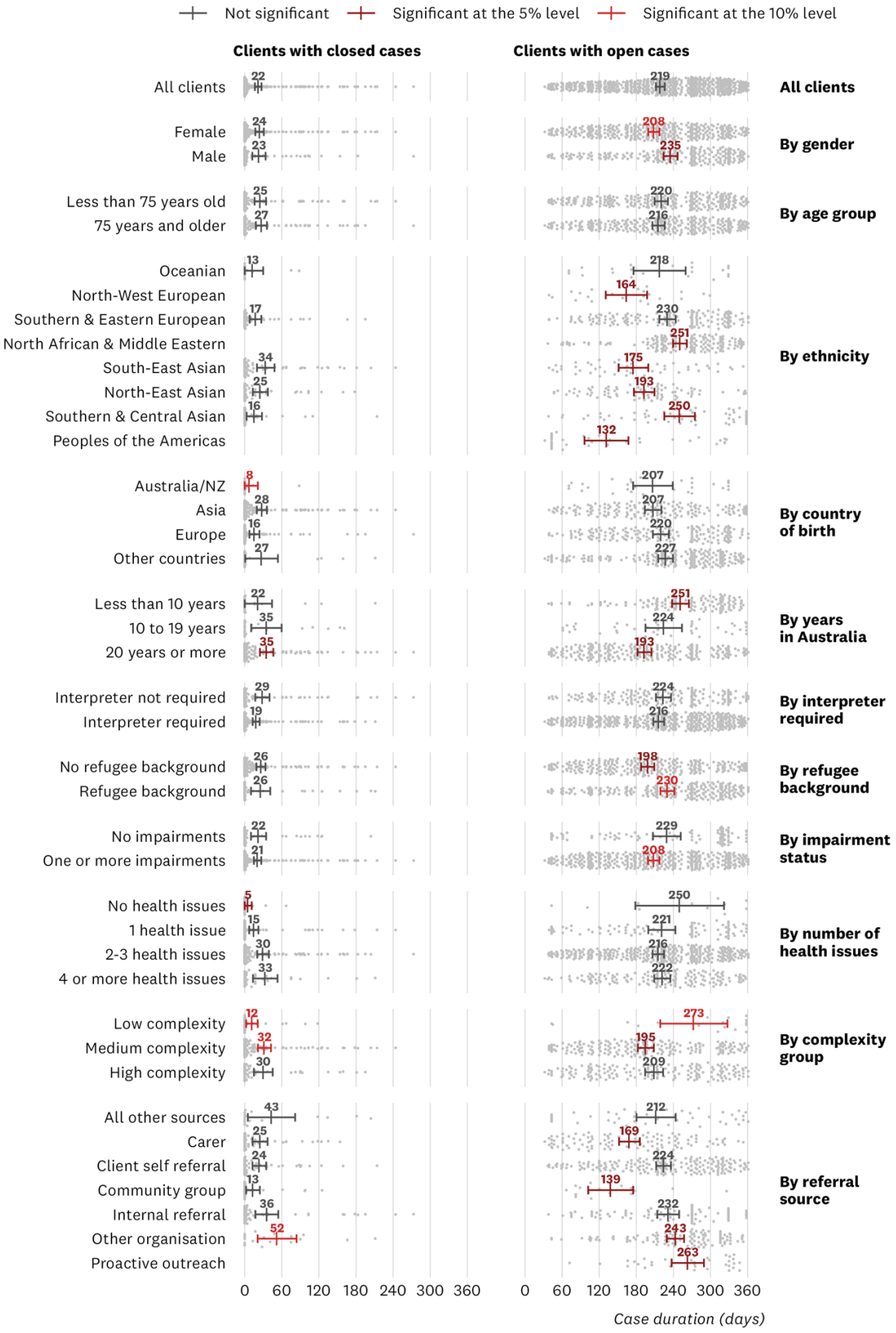
The average case duration was 22 days for older persons with closed cases and 219 days for older persons with open cases, but it is not clear whether sites have consistently recorded closing dates for inactive older persons, so case durations may be overstated for some older persons with 'open' cases with no closing date recorded.

Figure 9 shows case durations for individual older persons (grey dots) and the average case duration (red) for older persons with different characteristics. Among older persons with closed cases, 53% were recorded as having their cases opened and closed on the same day, which was treated as a case duration of zero days. For older persons with open cases, duration was calculated from the case opening date up to 31 December 2022, and older persons with no case opening date recorded are excluded from this analysis.

For each category of older persons, Figure 9 shows the statistical significance of a comparison of the mean duration of older persons in that category to all older persons with closed or open cases as appropriate. Among older persons with closed cases, there are significant differences in average case duration for some categories of country of birth, number of years in Australia, number of health issues, overall client complexity, and referral source. For older persons with open cases, differences are seen across gender, ethnicity, number of years in Australia, refugee background, impairment status, overall client complexity, and referral source.

[21] For clients with outward referrals to My Aged Care or other services, the case closing date may not be the same as the date of the referral, as some clients continue to need support after referral. However, referral dates are not recorded, so the time from when a client is first seen until they are referred is not known.

Figure 9 Distribution of case durations by client characteristics for individual older persons. Means and 95% confidence intervals are overlaid. Categories with fewer than 10 older persons have been suppressed.


Not significant
Significant at the 5% level
Significant at the 10% level
Clients with closed cases
Clients with open cases
All clients
Female
Male
Less than 75 years old
75 years and older
Oceanian
North-West European
Southern & Eastern European
North African & Middle Eastern
South-East Asian
North-East Asian
Southern & Central Asian
Peoples of the Americas
Australia/NZ
Asia
Europe
Other countries
Less than 10 years
10 to 19 years
20 years or more
Interpreter not required
Interpreter required
No refugee background
Refugee background
No impairments
One or more impairments
No health issues
1 health issue
2-3 health issues
4 or more health issues
Low complexity
Medium complexity
High complexity
All other sources
Carer
Client self referral
Community group
Internal referral
Other organisation
Proactive outreach
All clients
By gender
By age group
By ethnicity
By country of birth
By years in Australia
By interpreter required
By refugee background
By impairment status
By number of health issues
By complexity group
By referral source
0 60 120 180 240 300 360
Case duration (days)

5.8.12 Community outreach (group sessions)

A total of 720 group sessions were reported as being led or attended by participating sites between January and November 2022 (Table 2). Around half of these sessions were for 'community outreach', i.e., to connect with older people who may need support.

Table 2. Types of group sessions led or attended by all sites combined between January and November 2022.

Session type	Number of sessions	Proportion of all sessions
Community outreach[1]	369	51%
Other or unknown	189	26%
Support network engagement or training[2]	117	16%
Co-design	45	6
TOTAL	720	

[1] Community outreach includes 'community briefing', 'seniors expo' and 'townhall' sessions.

[2] Support network engagement or training includes 'community of practice', 'staff training', 'other training', 'steering committee', and 'support navigator network' sessions.

Figure 10 shows the monthly number of sessions led or attended by sites in each state. Throughout the year, there have been community outreach sessions in most months in most states. Across sites, there is considerable variation in the total number and types of group sessions reported, ranging from one session to 76 sessions (Figure 11).

Figure 10 Monthly number of group sessions led or attended by sites in each state.

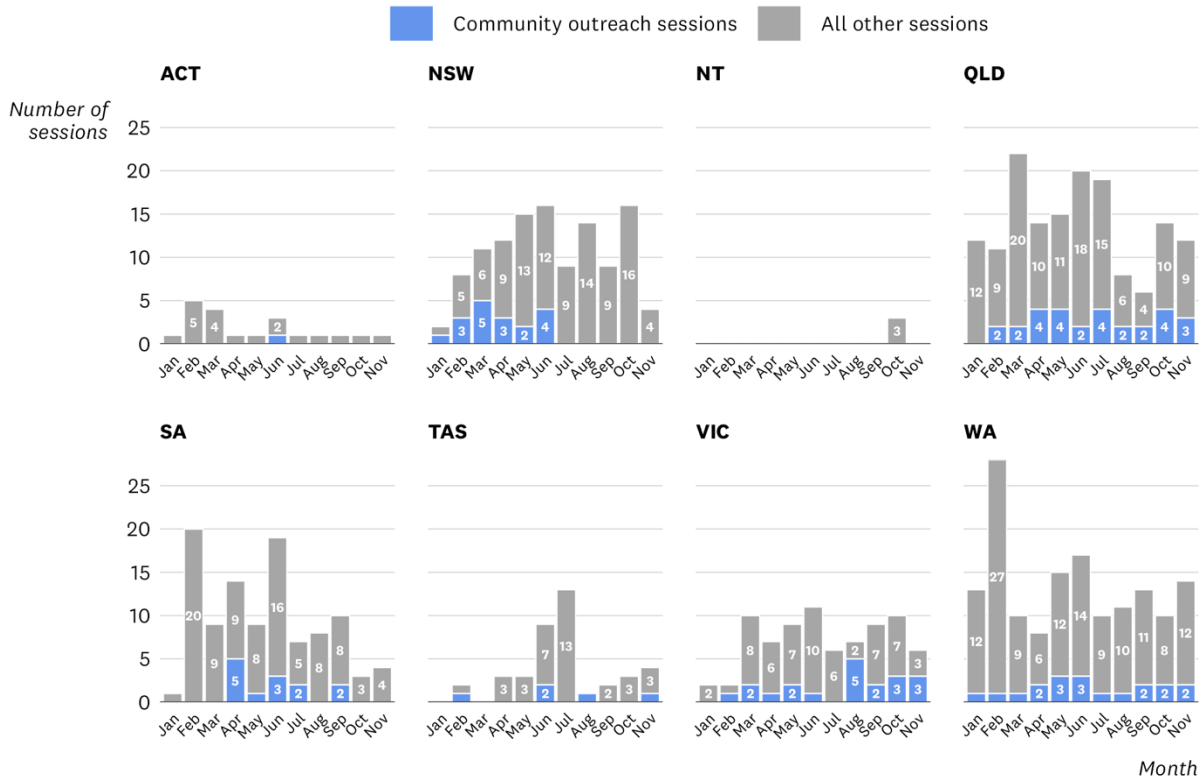


Figure 11 Total number of group sessions by site between January and November 2022.

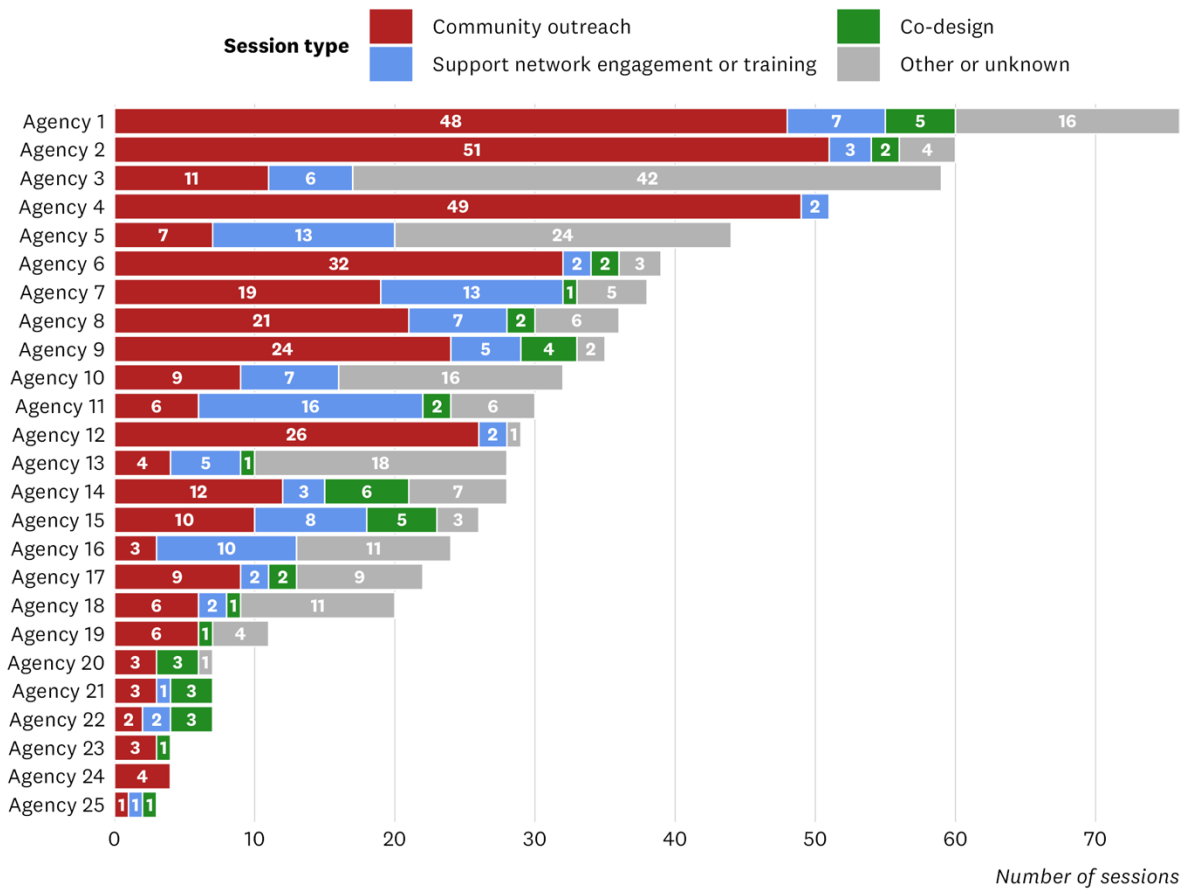
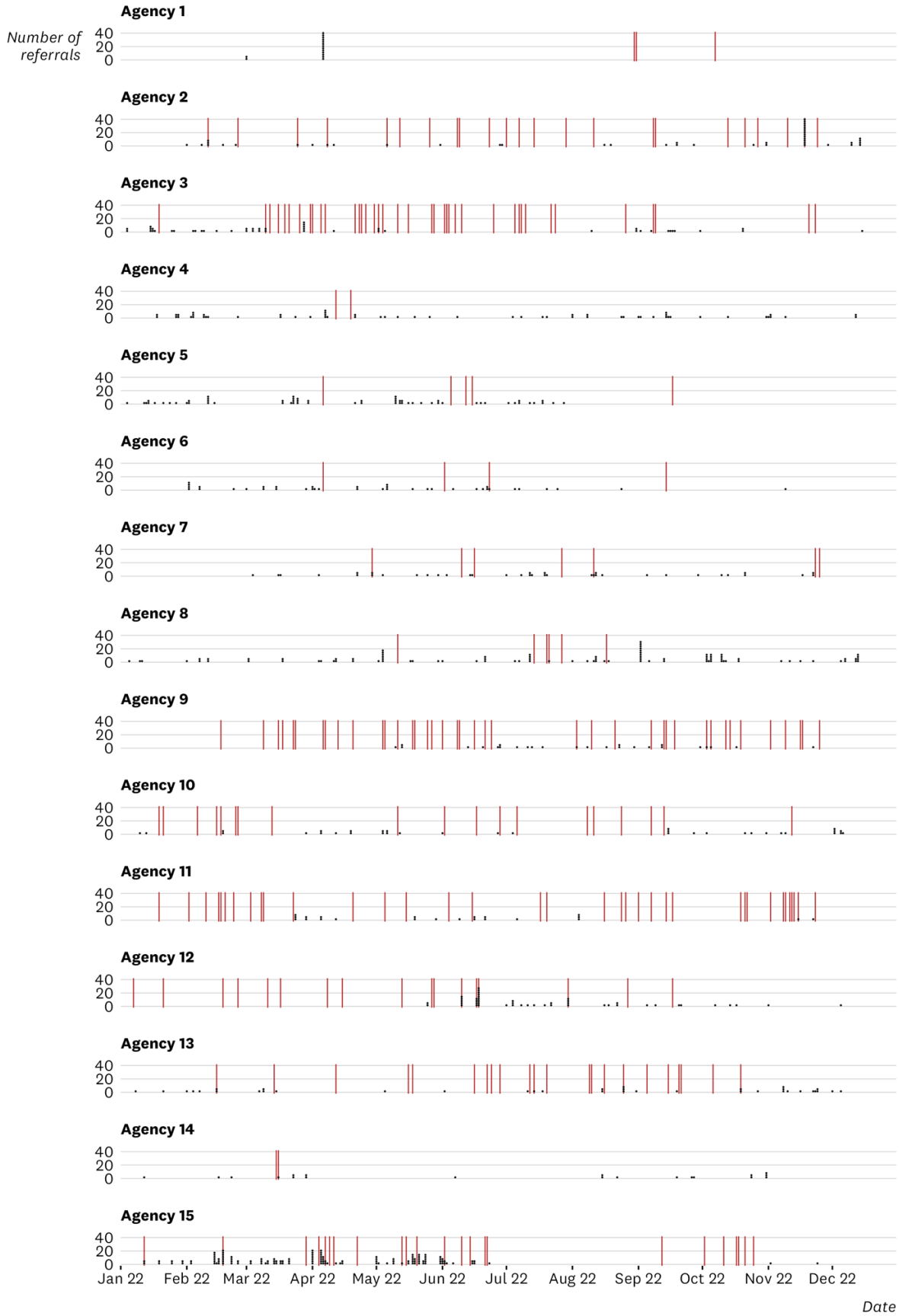


Figure 12 on the next page examines whether community outreach sessions led or attended by sites tend to lead to subsequent inwards referrals of older persons (including self-referrals). Dates of community outreach sessions are shown as red bars, and daily new client cases opened are shown as black dots. Only older persons who have given permission for their information to be shared with the evaluation team and who have a case opening date recorded are shown. Only sites that had at least two community outreach sessions and at least 20 inward referrals are shown.

This does not appear to show a clear relationship between community outreach sessions and inward referrals, but on average inward referrals to these sites tended to be higher in weeks when outreach sessions were held compared to weeks when no sessions were held. On average, a site received around one inward referral per week in weeks where no outreach sessions were held, compared to 3.6 referrals in the seven days following a “townhall” session and 2.9 referrals in the seven days following other types of sessions. However, as can be seen in Figure 11 the pattern of outreach sessions and inward referrals is very variable across sites and across time so it is difficult to be sure of the extent to which referrals were caused by community outreach sessions.

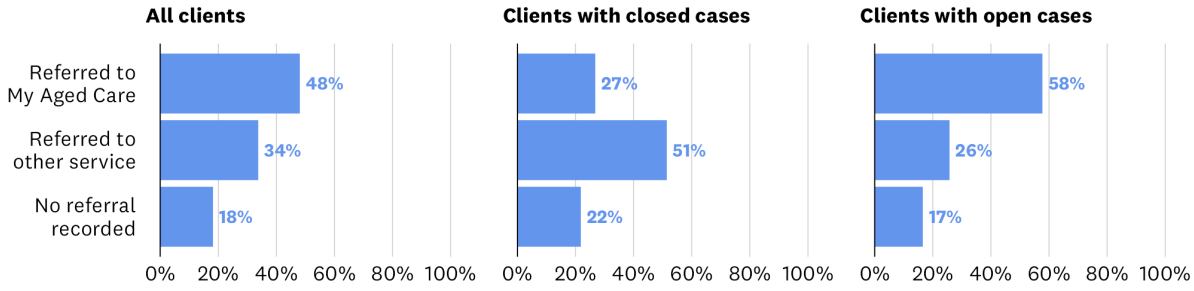
Figure 12 Community outreach sessions provided (red bars) and inward referrals of older persons (black dots), for sites with at least two sessions and at least 20 inward referrals.



5.8.13 Analysis of outcomes

Among all older persons who gave permission for their data to be used in the evaluation, 48% were recorded as being referred to My Aged Care, 34% referred to another service, and 18% had no referral recorded (Figure 13). The proportion of older persons referred to My Aged Care was greater for older persons with open cases (58%) than with closed cases (27%), and the opposite was true for older persons referred to other services (26% open vs 51% closed).

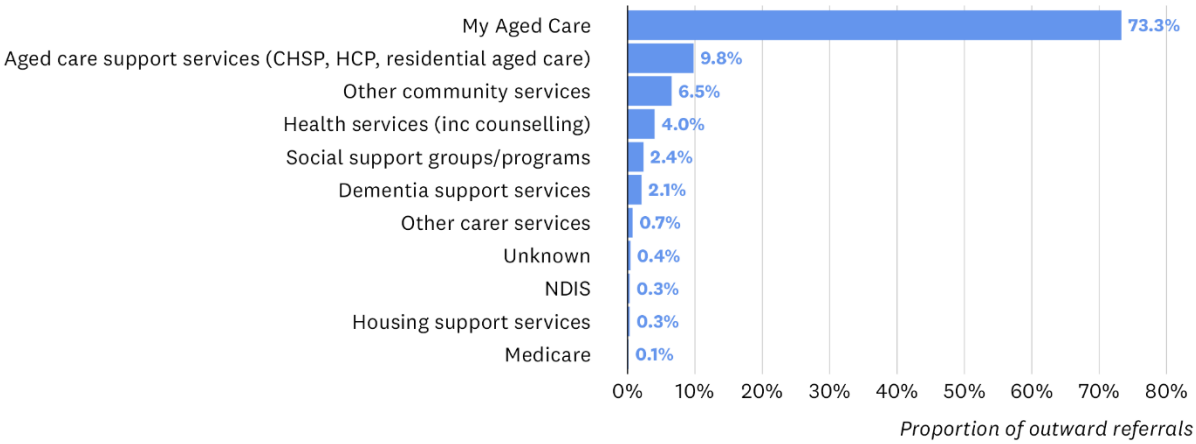
Figure 13 Types of outward referrals recorded for older persons, by case status.



5.8.13.1 Types of referrals

Among all outward referrals, 73% were to My Aged Care and the remainder were spread across a variety of types of other services including aged care support, health services, social support groups, and dementia support services (Figure 14).

Figure 14 Outward client referrals by type of service.



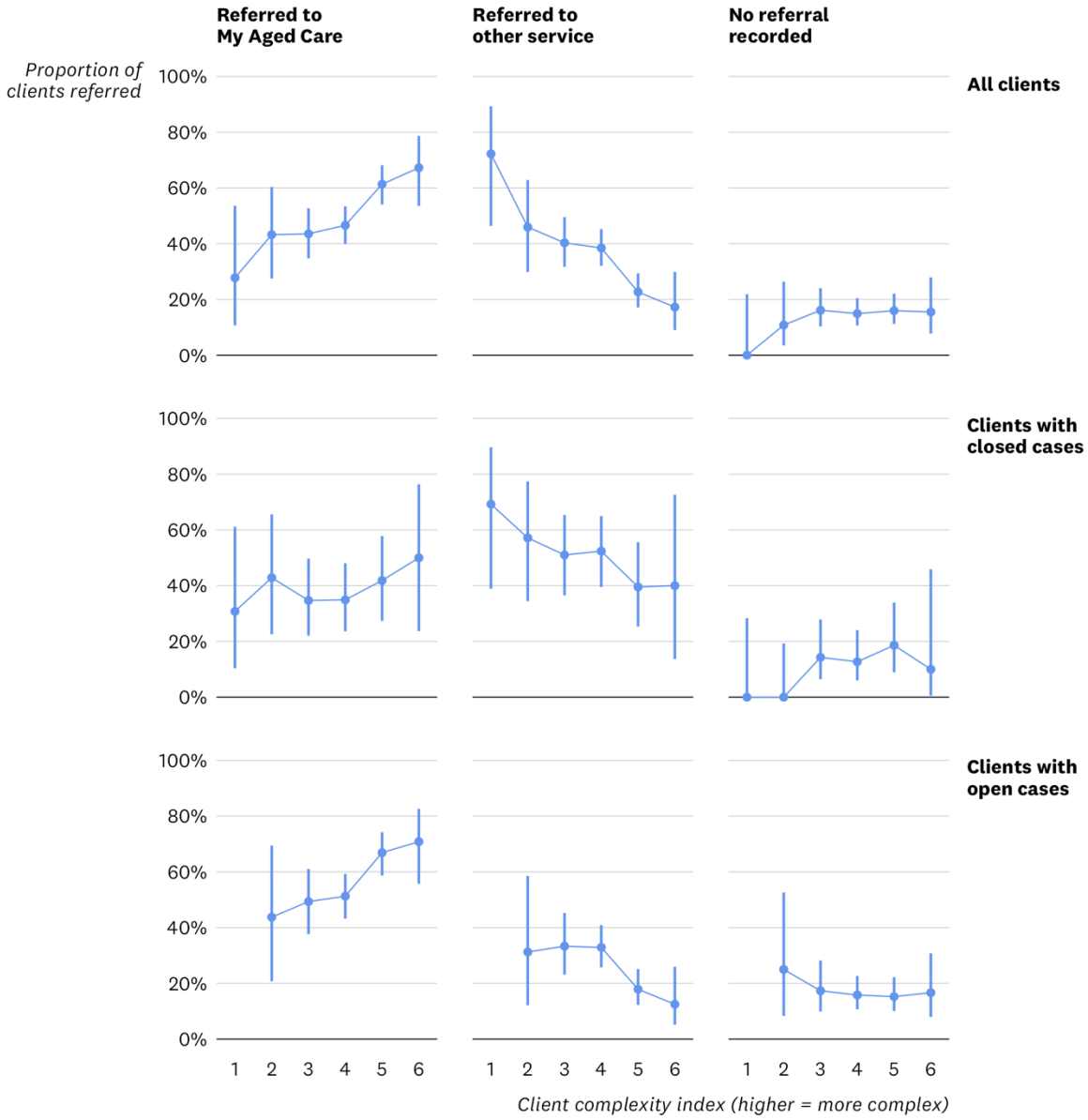
5.8.13.2 Referrals and client complexity

Figure 15 shows how client referral outcomes vary with the client complexity index (described above) and case status. Based on logistic regression analysis, there are statistically significant relationships at the 5% level between complexity and client referral outcomes for:

- Referrals to My Aged Care across all older persons (increases with complexity)
- Referrals to other services across all older persons (decreases with complexity)
- Referrals to other services for older persons with closed cases (decreases with complexity)
- Referrals to My Aged Care for older persons with open cases (increases with complexity)
- Referrals to other services for older persons with open cases (decreases with complexity).

Overall, this suggests that there is a relationship between client complexity and the likelihood of being referred to My Aged Care or another service and having an open or closed case by the end of 2022. Clients with higher complexity were more likely to be referred to My Aged Care and for their case to remain open, while older persons with lower complexity were more likely to be referred to another service and for their case to be closed.

Figure 15 Client referral outcomes by case status and client complexity index with 95% confidence intervals. Categories with fewer than 10 older persons are suppressed.



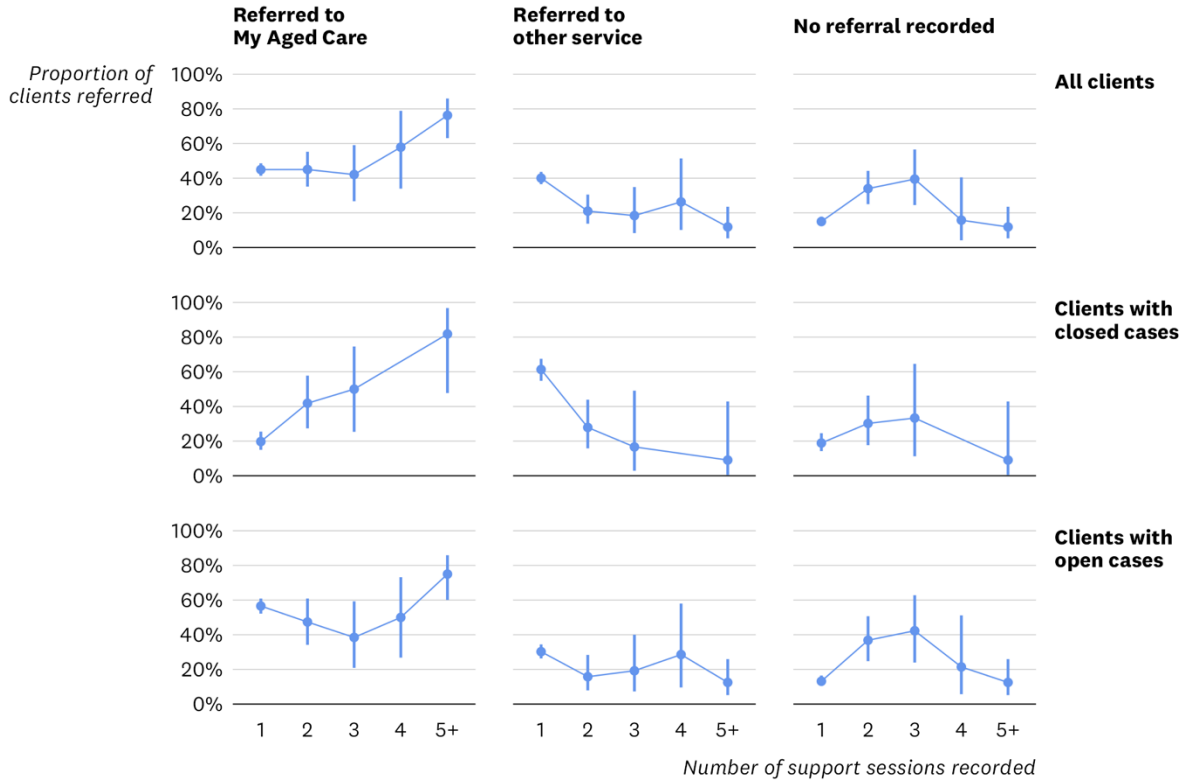
5.8.13.3 Referrals and number of support sessions

Figure 16 shows how client referral outcomes vary with the number of occasions of support provided to older persons and case status. As noted above, most older persons only have one occasion of support provided, thus it is more difficult to see how referral outcomes vary with the number of occasions of support. Based on logistic regression analysis, there are statistically significant relationships at the 5% level between number of support sessions and client referral outcomes for:

- Referrals to My Aged Care across all older persons (increases with number of sessions)
- Referrals to other services across all older persons (decreases with number of sessions)
- Referrals to My Aged Care for older persons with closed cases (increases with number of sessions)
- Referrals to other services for older persons with closed cases (decreases with number of sessions)
- Referrals to My Aged Care for older persons with open cases (increases with number of sessions)
- Referrals to other services for older persons with open cases (decreases with number of sessions)

Overall, this suggests that older persons who were referred to My Aged Care were likely to receive more occasions of support, and this is true for both older persons with closed and open cases as at the end of 2022. Similarly, older persons referred to other services were likely to receive fewer occasions of support. Overall, it appears that older persons who were ultimately referred to My Aged Care needed more support, on average, than older persons referred to other services. This may be due to differences in client characteristics and/or differences in the referrals process across services.

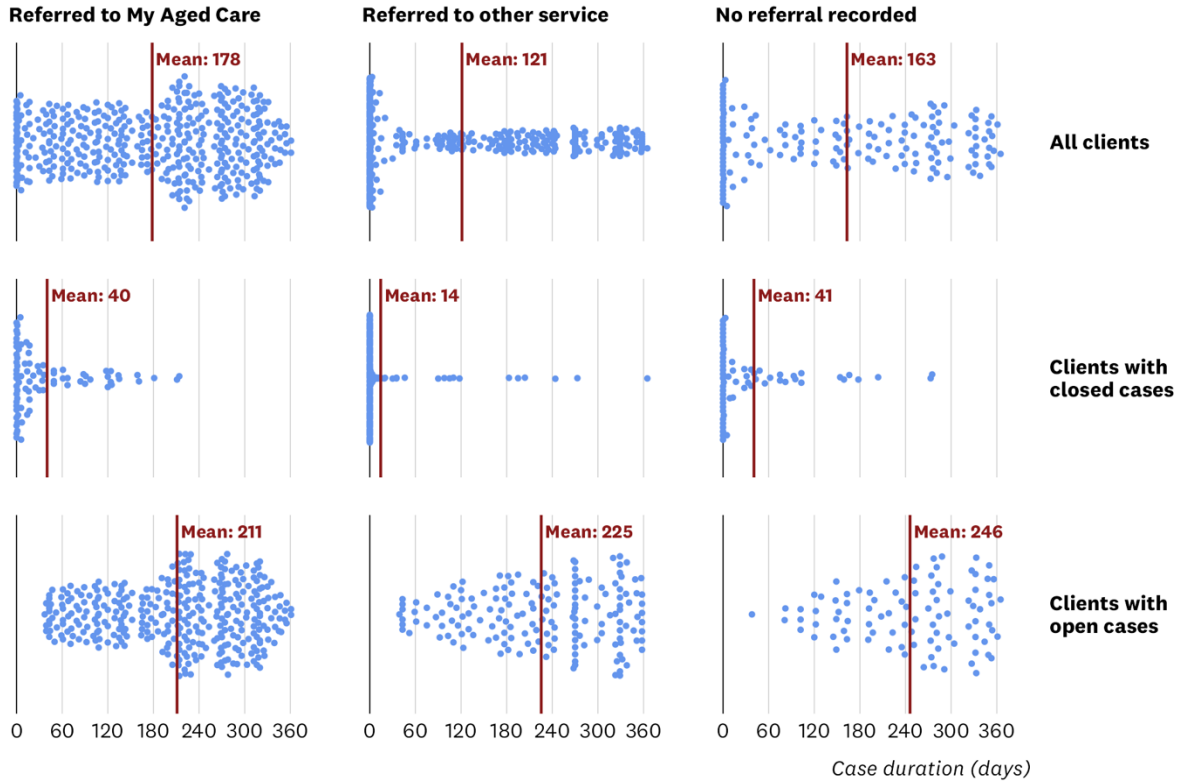
Figure 16 Client referral outcomes by case status and number of occasions of support recorded with 95% confidence intervals. Categories with fewer than 10 older persons are suppressed.



5.8.13.4 Referrals and case duration

Figure 17 shows relationships between client referral outcomes and case duration, by case status as at the end of 2022. As above, older persons with closed cases where the opening and closing date are the same are shown as a case duration of zero days, and case durations for older persons with open cases are calculated up to 31 December 2022.

Figure 17 Case duration by client referral outcomes and case status.



Based on logistic regression analysis, the following statistically significant relationships (at the 5% level) were found between case duration and client referral outcomes:

- Referrals to My Aged Care across all older persons increase with case duration
- Referrals to My Aged Care for older persons with closed cases increase with case duration
- Referrals to My Aged Care for older persons with open cases decrease with case duration
- Referrals to other services across all older persons decrease with case duration
- Referrals to other services for older persons with closed cases decrease with case duration
- No referral recorded for older persons with open cases increases with case duration
- No referral recorded for older persons with closed cases increases with case duration.

Overall, this suggests that older persons with longer duration, closed cases were likely to be either referred to My Aged Care or have no referral recorded while older persons with shorter duration cases were more likely to be referred to other services. Clients with longer duration cases that remained open at the end of 2022 were likely to be either referred to My Aged Care or have no referral recorded, but there is no statistically significant relationship between case duration and referrals to other services for older persons with open cases.

5.8.13.5 Time and task snapshot analysis

Two detailed snapshots of how Connectors and other staff members used their time were provided for one week in May/June 2022 and another week in October/November:

- ***Snapshot 1:*** 23 sites (82% of sites) provided data for various seven-day periods between 16 May and 12 June 2022. A total of 726 tasks were recorded. Client ID numbers were provided for 173 individual older persons associated with 301 task records (41% of tasks).
- ***Snapshot 2:*** 22 sites (79% of sites) provided data for various seven-day periods between 24 October and 13 November 2022. A total of 765 tasks were recorded. Client ID numbers were provided for 211 individual older persons associated with 404 task records (53% of tasks).

The analysis below is based on both snapshots combined. To aid interpretation, results are expressed on a weekly basis by averaging or aggregating the snapshots as appropriate.

5.8.13.6 Use of connector time

Across all sites that provided data for at least one snapshot, Figure 18 shows the average number of hours of Connector time recorded by each site in the snapshot week.[22] A full-time equivalent of 37.5 hours is shown for reference, however not all sites have employed a full-time Connector and in some cases Connectors did not work on all days in the snapshot week, while some sites report having more than one full-time Connector. This means that the differences across sites shown in Figure 18

[22] In this and all other figures in this section, the names of agencies are not shown to protect the confidentiality of their data and the agency numbers shown on the figure are not necessarily consistent across figures.

Figure reflect differences in hours worked by Connectors, as well as differences in recorded use of Connector time during the snapshot weeks.

Figure 18 Average Connector time recorded by sites in the snapshot weeks.

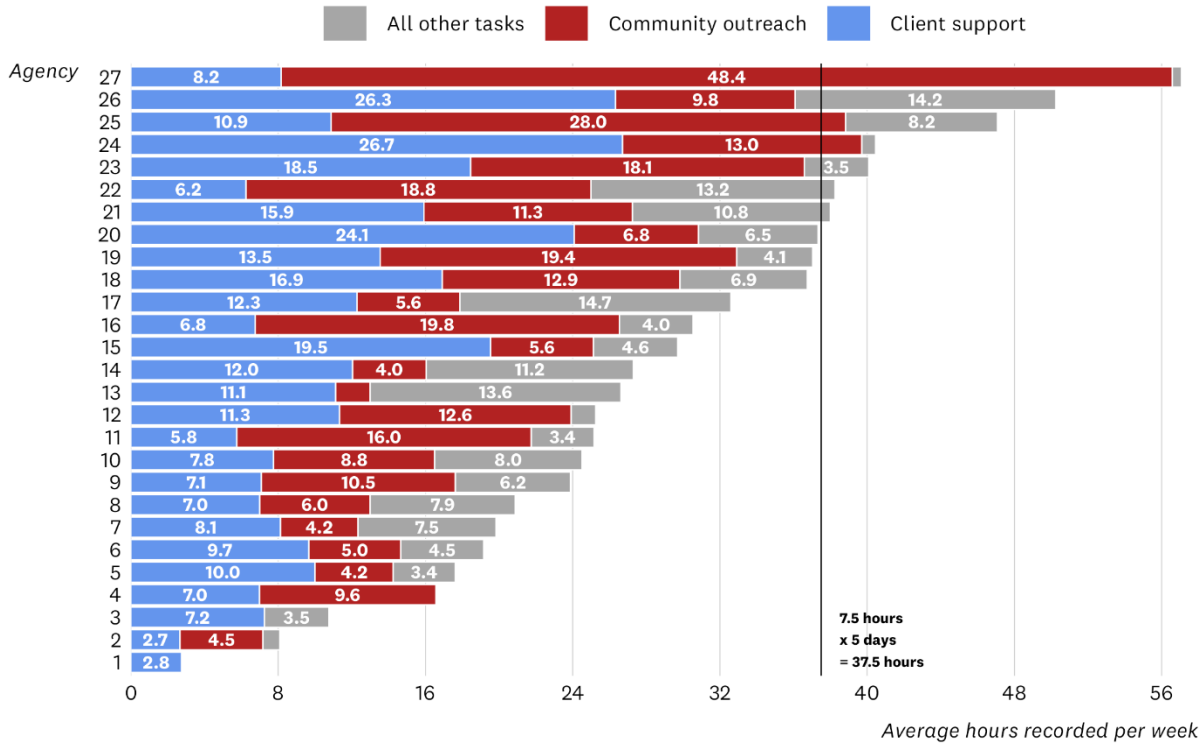


Figure 18 above shows there is substantial variation in the amount of Connector time recorded by sites in the snapshot weeks. The extent to which this is due to differences in the available working time of connectors, the amount of time spent on tasks, or incomplete recording of tasks is not clear. It is also apparent that in many sites, community outreach and other tasks took up a significant amount of time, in addition to client support.

Figure 19 Allocation of available Connector time to tasks (all sites combined).

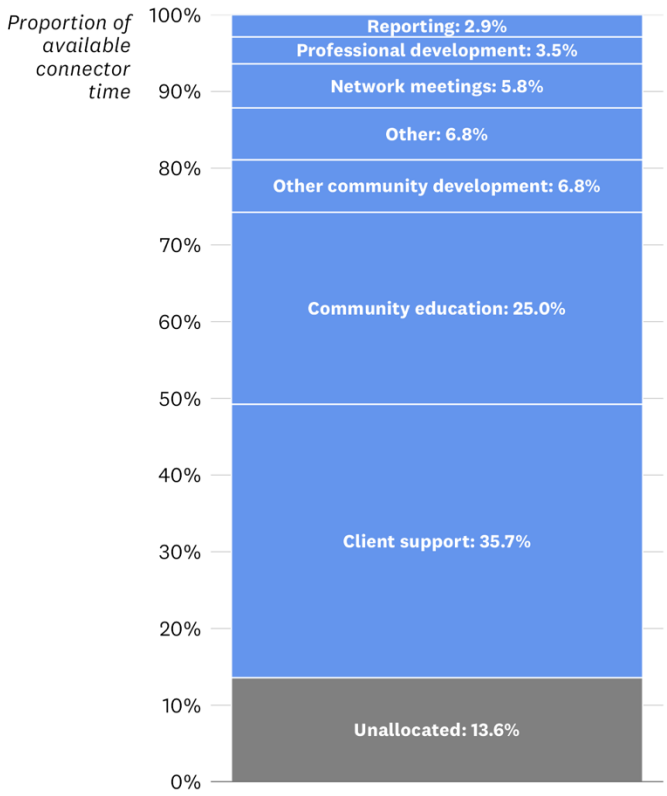
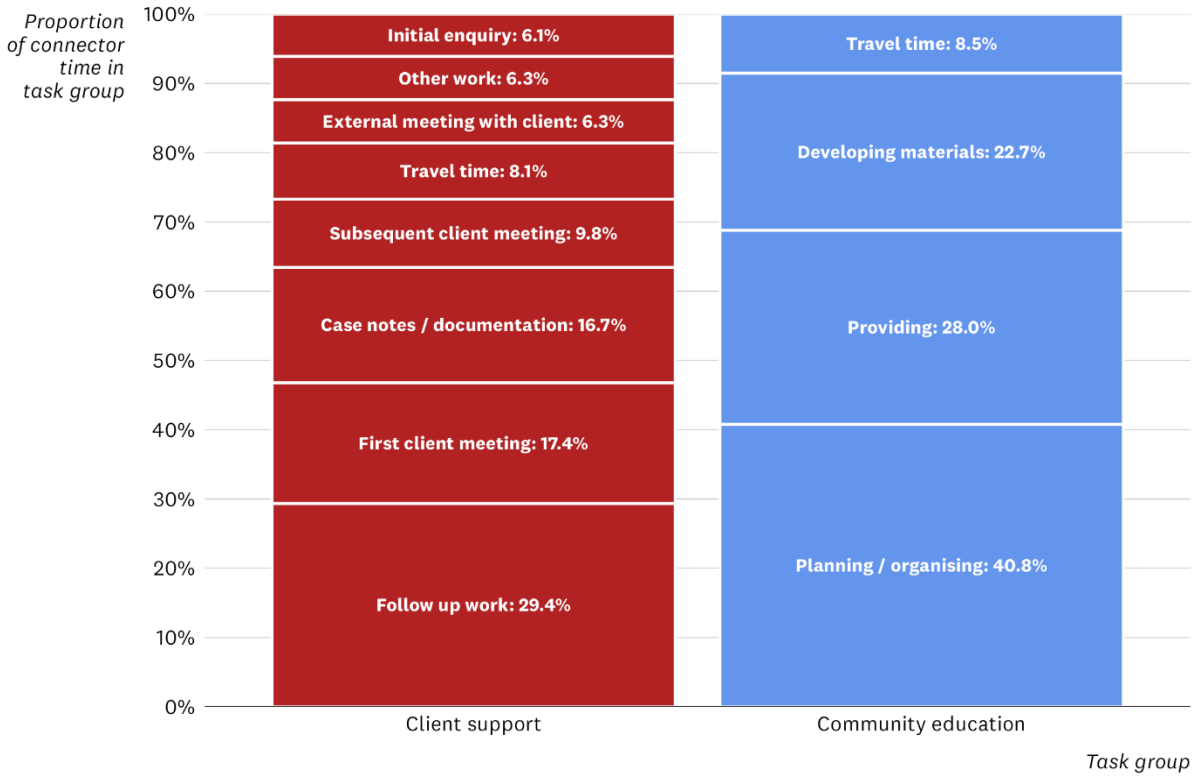


Figure 19 shows how available Connector time across all sites in the snapshot weeks was allocated to major groups of tasks. Available Connector time for each site was calculated based on the reported actual number of days Connectors worked during each snapshot week. In cases where the total time recorded for Connectors of a site is less than the available Connector time calculated for the site, the remaining time is shown as 'unallocated'. Thus the 'unallocated' time is the proportion of available Connector time that was not recorded in the time and task snapshots, but this does not necessarily mean that Connectors did nothing during that time.

Across all sites, recorded tasks in the snapshot weeks accounted for 86.4% of available Connector time, with 13.6% unallocated on average over the two snapshots. Across all sites that provided data, client support accounted for around 36% of available Connector time in the snapshot week. Community education and other community development tasks combined also accounted for about 32% of available Connector time. 'Other' time shown in Figure 19 consists of a variety of 'other tasks' and 'other administration/management' tasks recorded in the time and task snapshots.

Figure 20 provides more detail about the types of tasks done within the 'client support' and 'community education' categories in Figure 19. Client meetings (i.e., first, subsequent, and external meetings) account for 34% of time that Connectors spent on client support during the snapshot weeks. Other tasks directly associated with that support (i.e., follow-up and case notes or documentation) accounted for 46% of time that Connectors spent on client support. All other client support related tasks (initial enquiries, travel time, and other work) account for the remaining 20% of Connector time spent on client support. Within community education activities of Connectors, providing education accounted for 28% of time, while planning, organising, and developing materials accounted for 64% of time. For both client support and community education, travel accounted for a relatively small proportion of recorded Connector time (around 8%).

Figure 20 Detail of Connector time spent on client support and community education tasks.



During the snapshot weeks, there is considerable variation among sites in the allocation of Connector time across types of tasks. Figure 21 on the next page shows the reported allocation of available Connector time to different types of tasks by individual sites. Across sites, client support varies between 7% and 66% of available Connector time, with a median of 32%. Not all sites reported time for tasks such as other community development and professional development, most likely indicating that such tasks do not typically happen every week. The proportion of unallocated time across sites also shows the variation in the coverage of the time and task data that was provided. Five sites out of the 27 that provided data for at least one snapshot recorded tasks for less than half of the available Connector time, while 18 sites recorded tasks for at least 80% of available Connector time.

Figure 21 Allocation of available Connector time in the snapshot weeks across tasks by sites. Each dot is an individual site that provided data in at least one snapshot week.

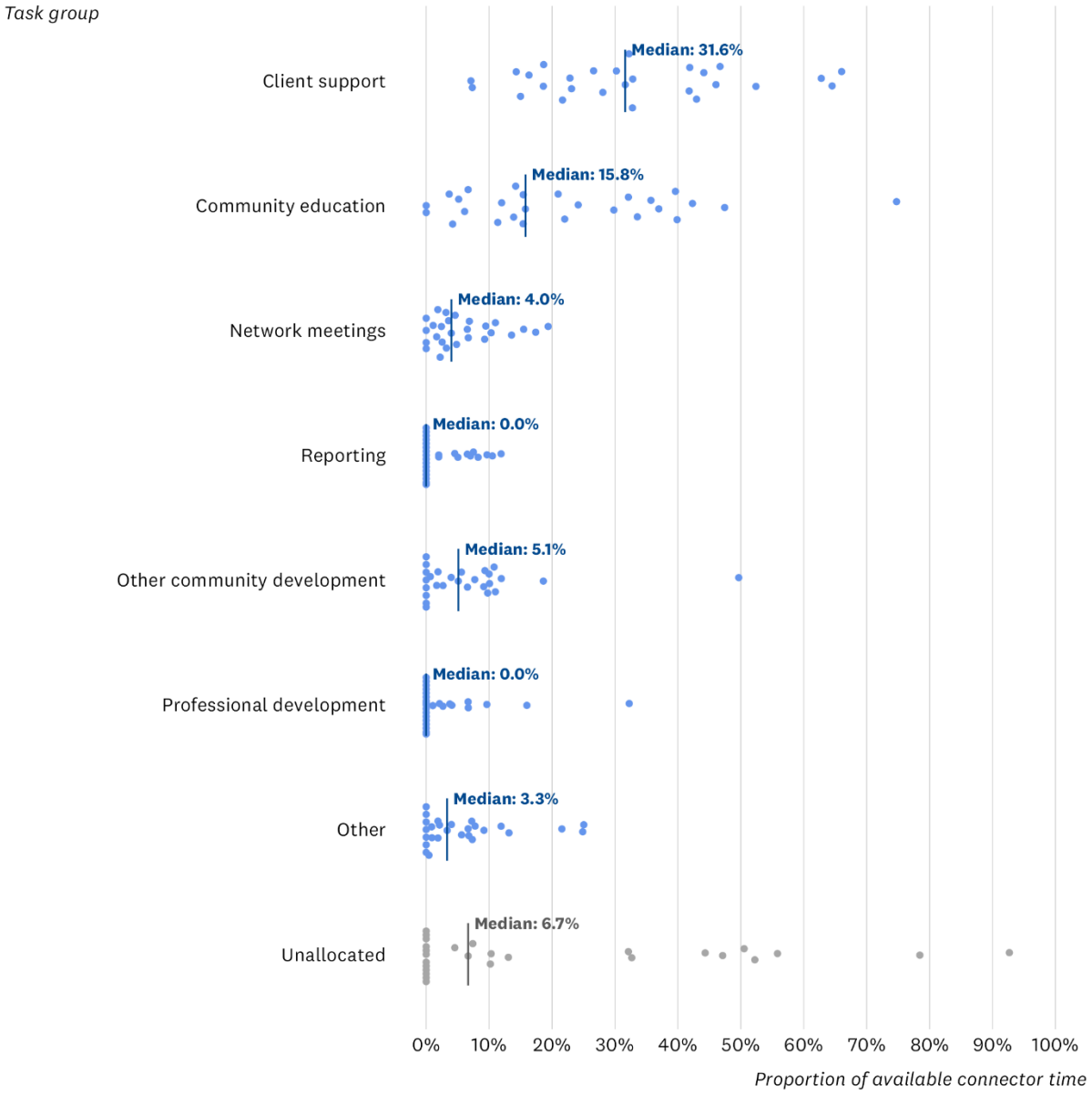
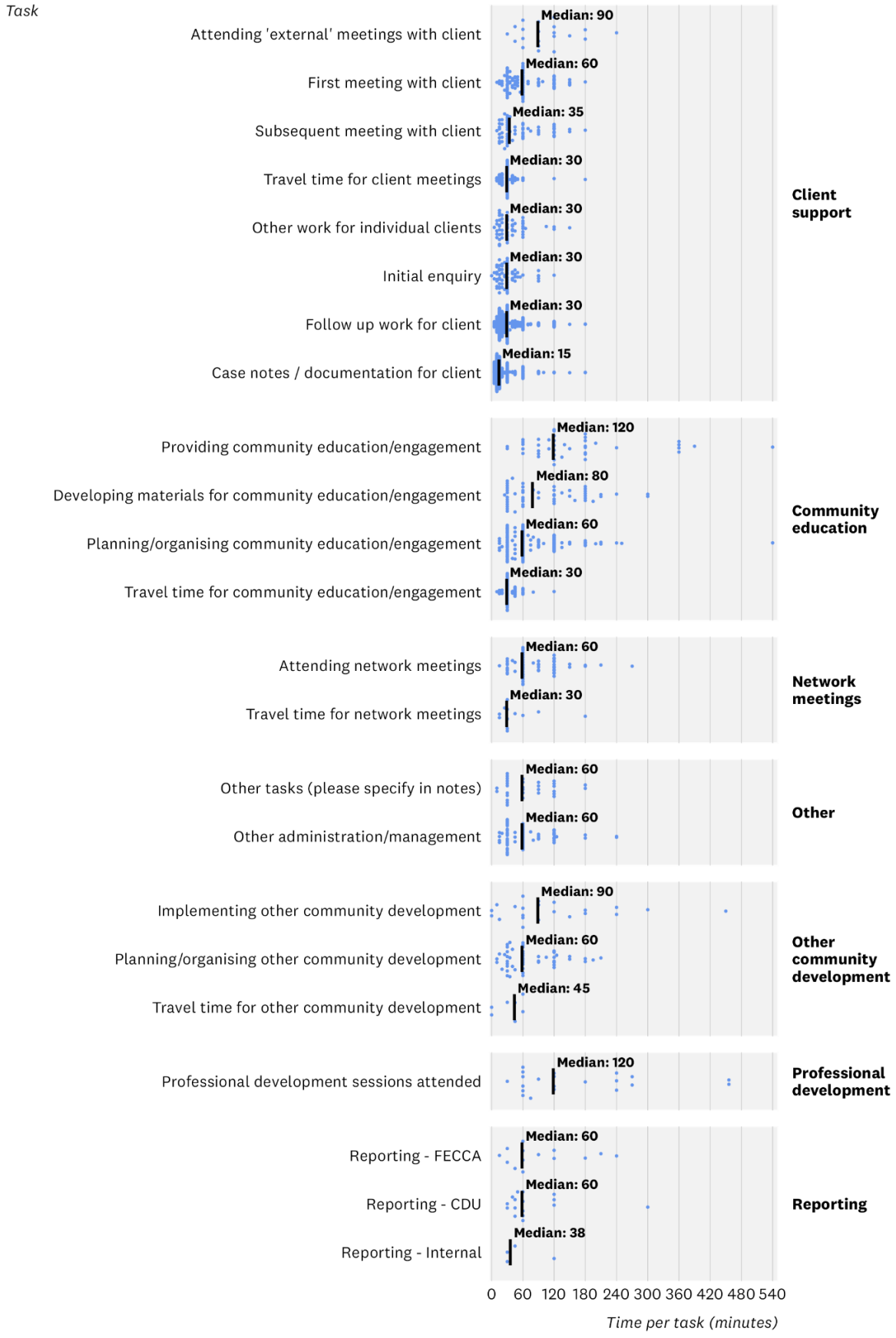


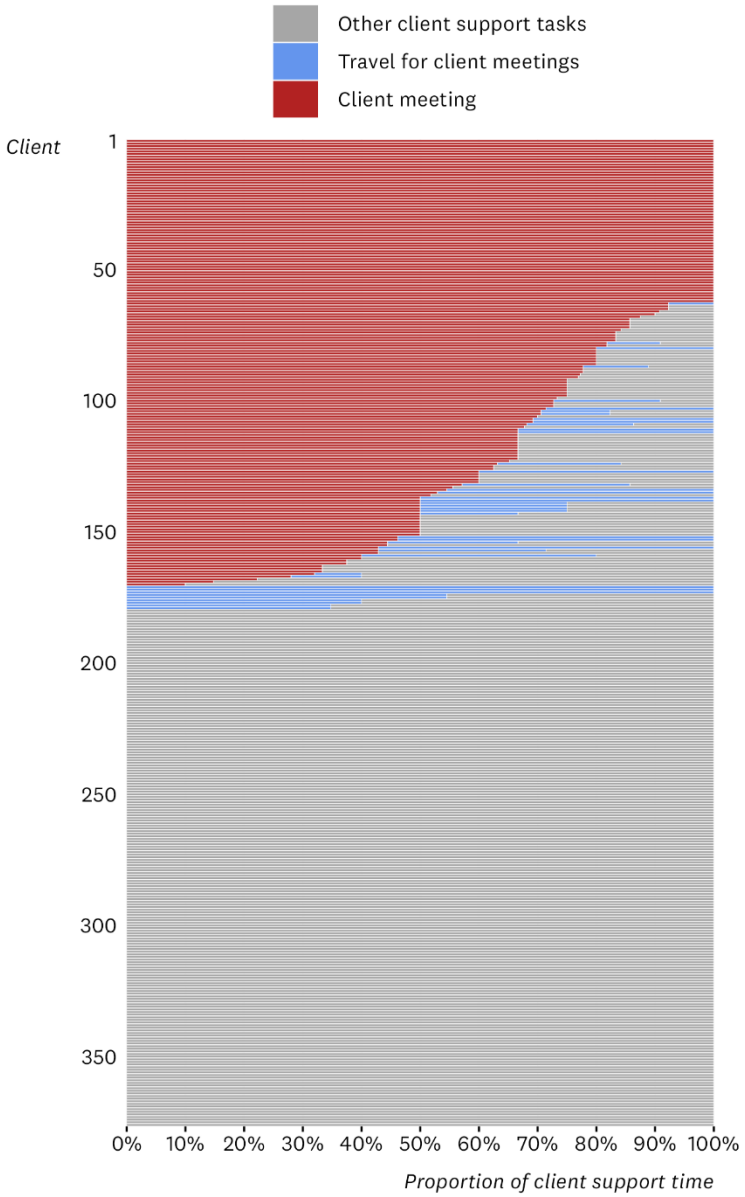
Figure 22 (on the next page) shows the variation in the time taken for individual tasks reported by individual Connectors. This shows that external meetings with older persons (median 90 minutes) tend to take longer than first meetings (median 60 minutes), which in turn tend to take longer than subsequent meetings (median 35 minutes), but within each of these categories there were relatively short and relatively long meetings. Where travel was required for client meetings, the reported time varied between 10 and 180 minutes, with a median of 30 minutes. Professional development and providing community education tasks were less frequently recorded, but some of these tasks took a significant amount of Connector time (6 to 9 hours in a few cases).

Figure 22 Reported duration of individual tasks done by Connectors in the snapshot week. Each dot is an individual task recorded by an individual Connector.



5.8.14 Connector support time received by older persons

Figure 23 Breakdown of client support time received by individual older persons in the snapshot week.



Connector time received by individual older persons can be analysed for client support tasks associated with the 376 individual older persons with ID numbers in the combined set of time and task snapshots. For each of these individual older persons, Figure 23 shows how the recorded Connector time that they received was divided among meetings, travel, and other tasks.

Among these older persons, 170 (45%) had a meeting with a Connector during the snapshot week (including external meetings). For all but 19 of those 170 older persons, the meeting itself took at least half of the support time provided to the client in the snapshot weeks.

Connectors also did other tasks for 296 (79%) of these older persons, and for 197 older persons (52%), other tasks accounted for all the Connector time the client received during the snapshot weeks.

It is unclear why travel time was recorded for some older persons where no meeting was recorded; this could reflect a data quality issue or incomplete recording of tasks.

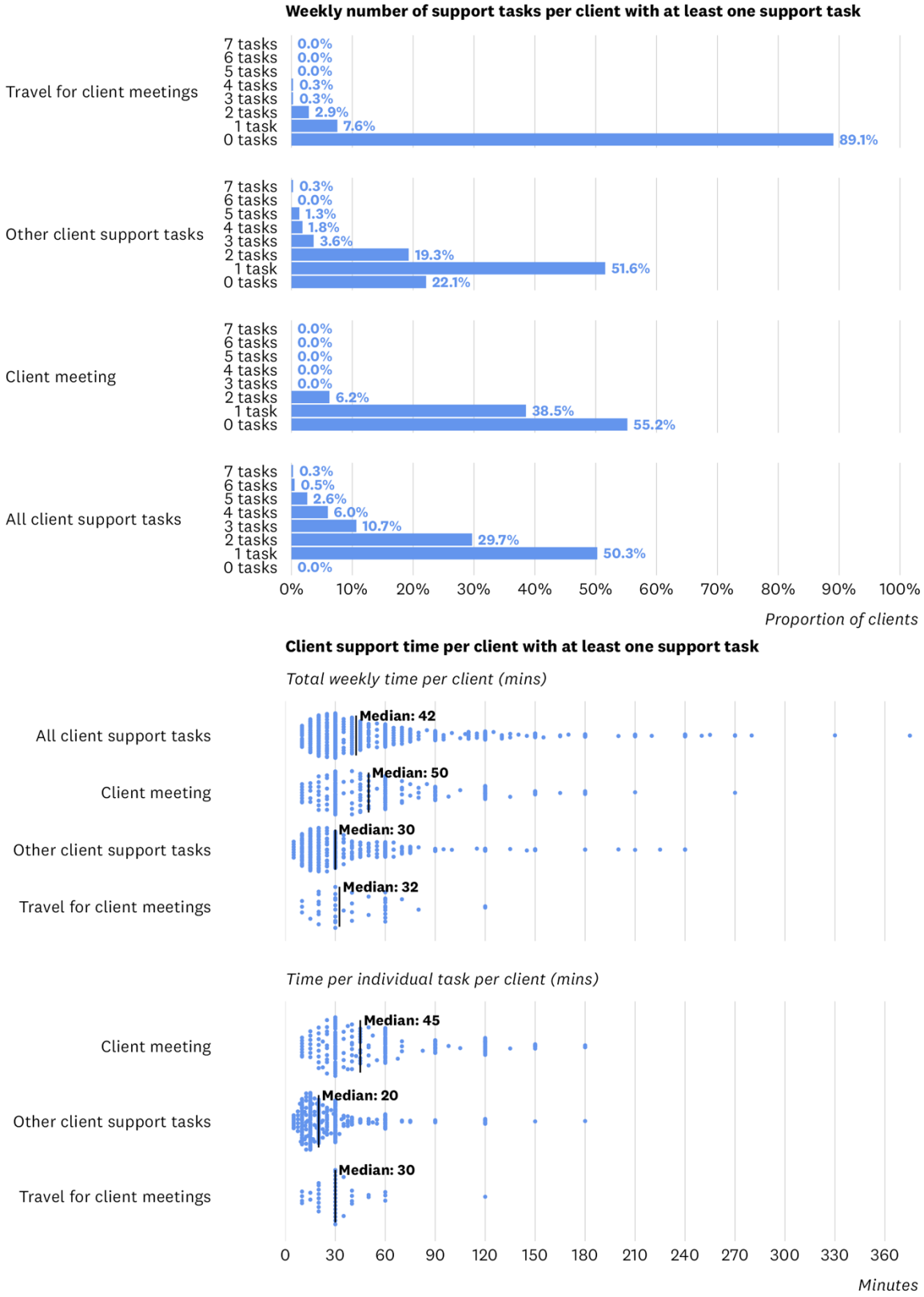
Figure 24 on the next page shows more detailed analysis of the number and duration of Connector support tasks provided to the 376 older persons with ID numbers recorded during the snapshot weeks, across all sites combined. This shows:

- Around half of these older persons received one support task and half received more than one task.[23]

[23] Clients are only included in the time and task snapshot data if support was provided to them, thus no clients are recorded as receiving zero support tasks. In reality, some clients registered with agencies will not be provided with support in any given week.

- Only 6% of these older persons received more than one meeting in a week.
- Around 78% of these older persons received other forms of support aside from meetings and travel related to meetings. For 26% of older persons, this other support involved more than one recorded task in a week.
- The total weekly Connector support time provided to each client ranged from 5 to 375 minutes, with a median of 42 minutes. One hour or more of Connector support time in a week was provided to 42% of older persons, and 17% of older persons received two hours or more of support time. Around 36% of older persons who received one hour or more of Connector support time during a snapshot week were new older persons who were recorded as having their first meeting with a Connector during that week. In comparison, around 11% of older persons who received less than one hour of Connector support time during a snapshot week were new older persons. This reflects that first meetings with older persons were generally longer than subsequent meetings (see Figure 22 above).
- Total weekly meeting time provided to each client during the snapshot weeks ranged from 10 minutes to 270 minutes, with a median of 45 minutes. One hour or more of meeting time was provided to 22% of older persons.
- Total Connector time spent on other support tasks (aside from meetings and travel) for these older persons ranged from 5 minutes to 240 minutes, with a median of 30 minutes. Other support tasks took one hour or more of Connector time for 20% of older persons.

Figure 24 Analysis of the weekly number and duration of support tasks for older persons.



5.8.14.1 Use of non-Connector time

Time for other staff members aside from Connectors was recorded for 31% of tasks recorded by all sites during the two snapshot weeks combined. It was more common for other staff members to be involved in community outreach and network meetings tasks than with client support or other tasks (Figure 25).

Figure 25 Proportion of tasks with other staff time recorded

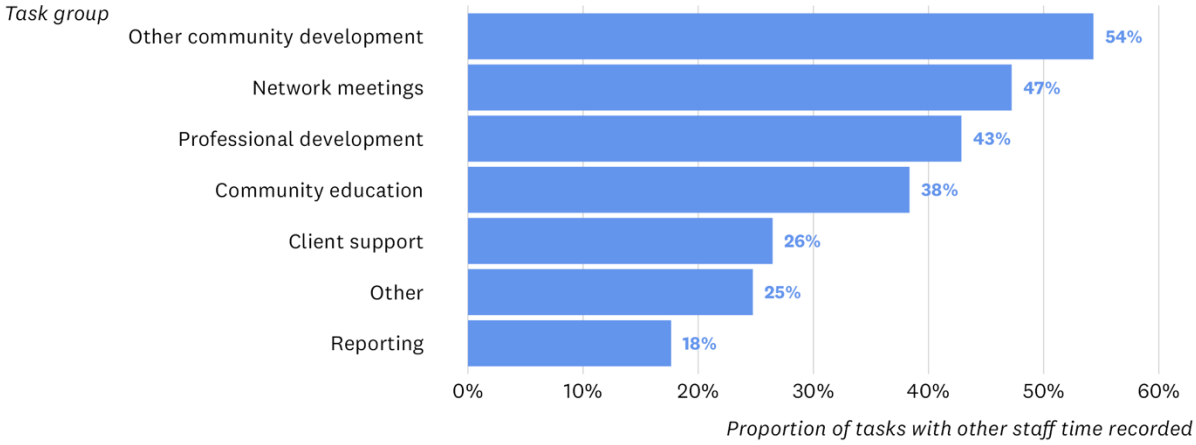
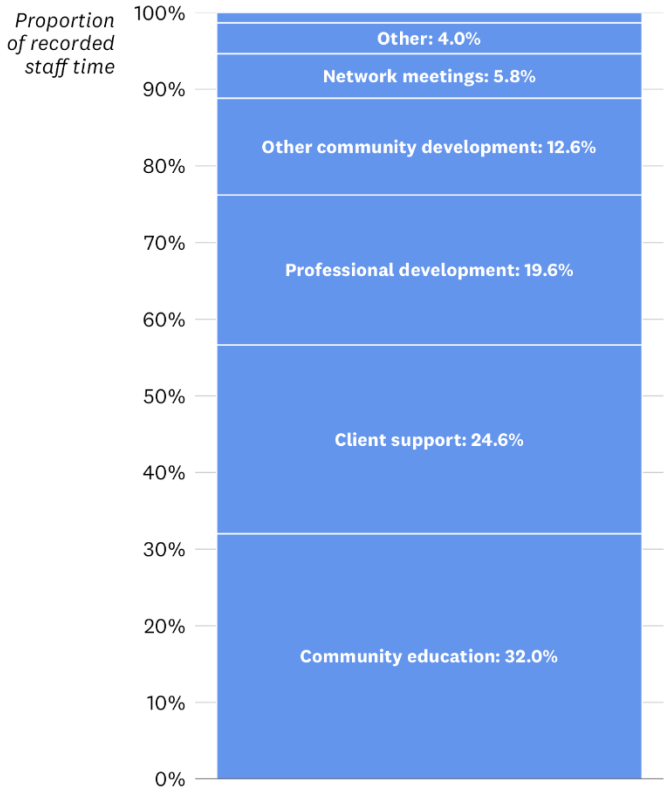


Figure 26 Allocation of non-Connector time to tasks (all sites combined).

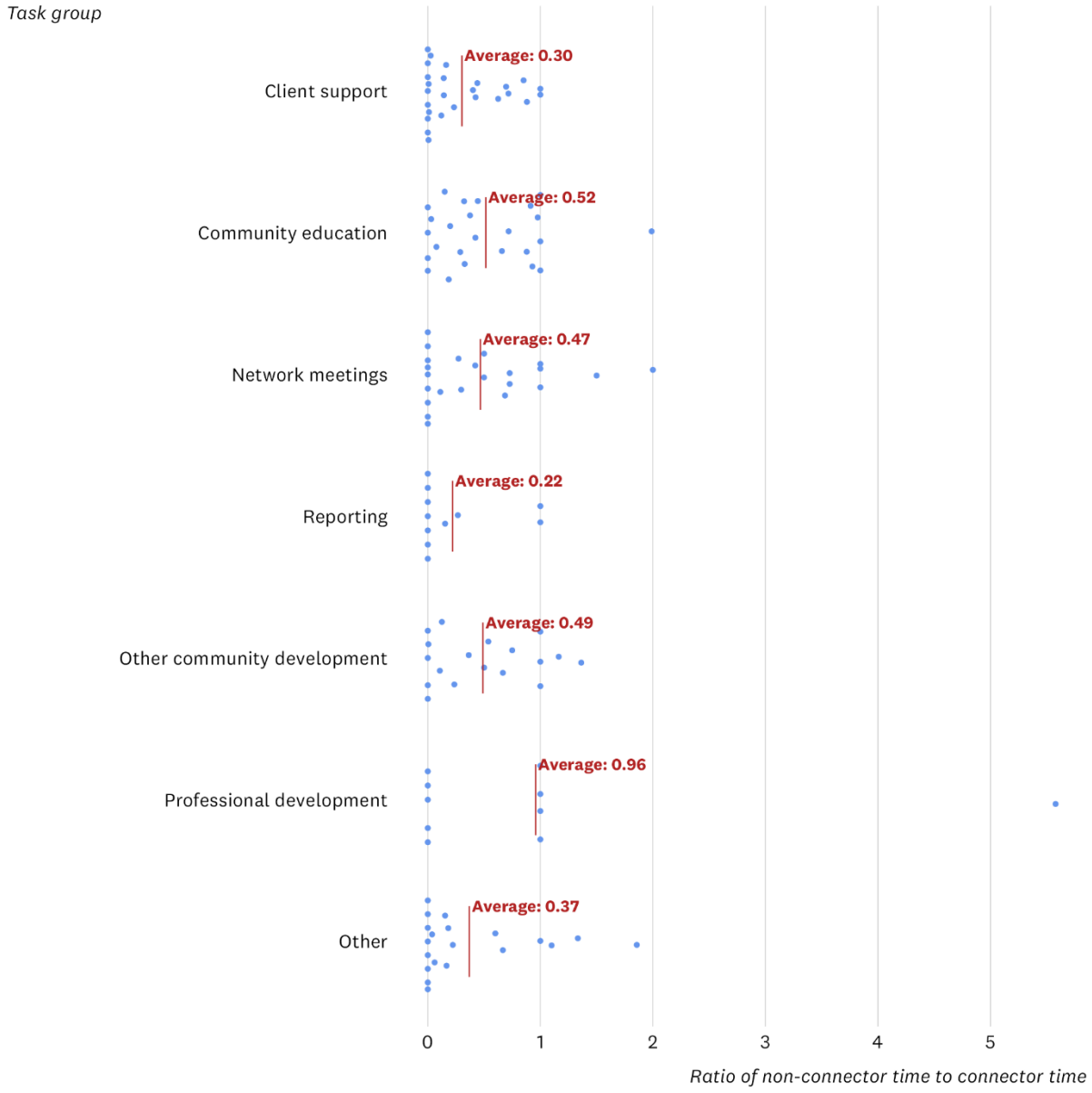


Across all sites combined and both snapshots, around 45% of the recorded non-Connector time was for tasks relating to community education and development, and 25% was for client support tasks (Figure 26). While it was relatively common for non-Connectors to be involved in network meetings and professional development, the total amount of non-Connector time recorded for such tasks was relatively small, most likely reflecting that not all sites did such activities during the snapshot week (see Figure 21 above).

Figure 27 on the next page shows the ratio of total recorded non-Connector time to Connector time during the snapshot weeks for each site, broken down by type of task. In most cases the ratio is less than one, indicating that total Connector time was greater than non-Connector time, for a given type of task performed by staff of a site. However, there are some cases where the time contributed by non-Connectors was greater than Connectors (i.e., a ratio of greater than one). Most examples of this are for network meetings, community education and community development.

All but two sites that provided data in at least one snapshot reported some non-Connector time during the snapshot week(s). Five sites reported total non-Connector time that was less than 10% of total recorded Connector time, but one site reported non-Connector time that exceeded the amount of total Connector time.[24] This suggests that the role of non-Connector staff was quite varied across sites.

Figure 27 Ratio of recorded total non-Connector time to Connector time for each site during the snapshot weeks, by type of task. Each dot is an individual site.



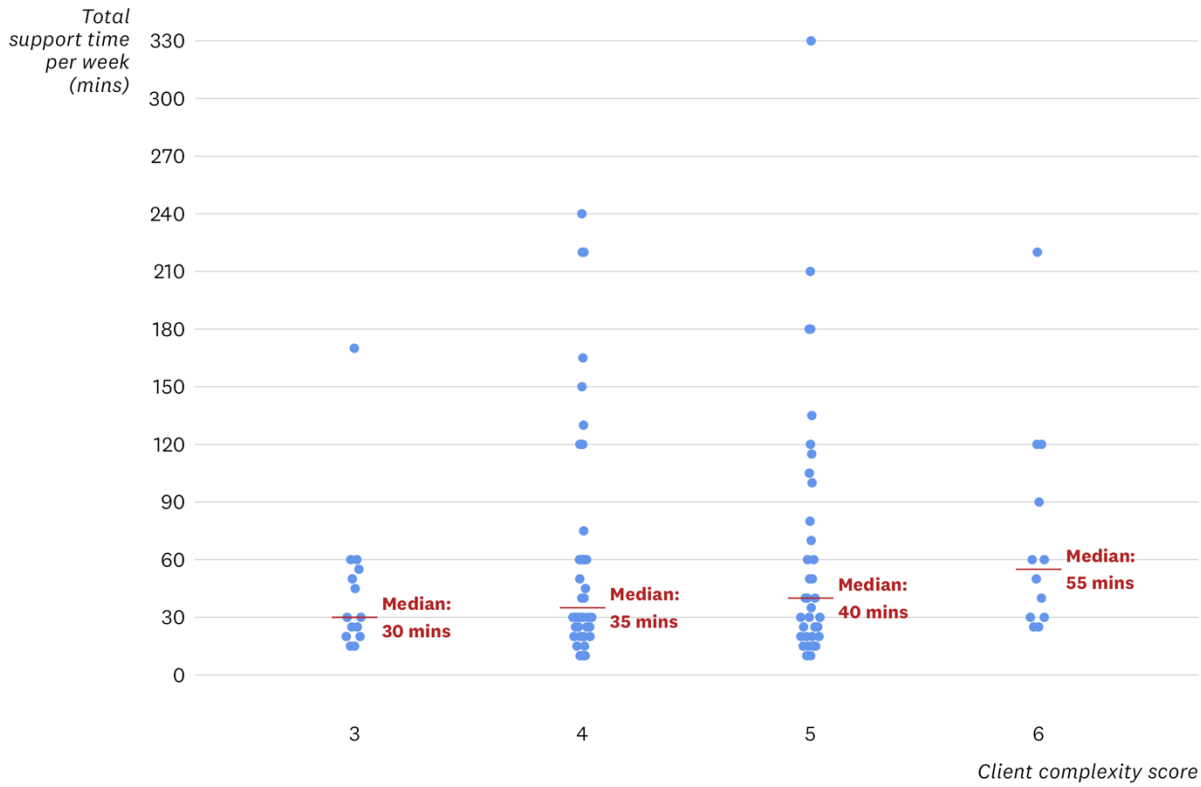
5.8.14.2 Connector support time provided by client complexity

Across both snapshots combined, records of support time provided to 99 individual older persons could be matched to older persons who had given permission for their personal data to be shared with the evaluation team and where sufficient data was available to allow the client's complexity score to be

[24] This was due to the site recording two professional development sessions during the November snapshot that involved a total of 30 non-Connector staff.

calculated (as defined above).[25] Figure 28 Figure shows how weekly support time provided to older persons varied with client complexity.[26] This is suggestive of an increasing relationship between client complexity and support time, with median time provided to older persons with a complexity score of six almost double that provided to older persons with a complexity score of three. However, among older persons with each complexity score, there is a wide range of support time provided, and the correlation between support time and complexity score is not statistically significant (Kendall's rank correlation p-value 0.25).

Figure 28 Connector time provided to older persons during the snapshot weeks, by client complexity index.



Comparing the 'medium' (complexity score of three or four) and 'high' (complexity score of five or more) complexity groups of older persons defined above, median support time was 30 minutes for the medium group and 40 minutes for the high group, but there is no statistically significant difference in the average support time provided to these two groups.

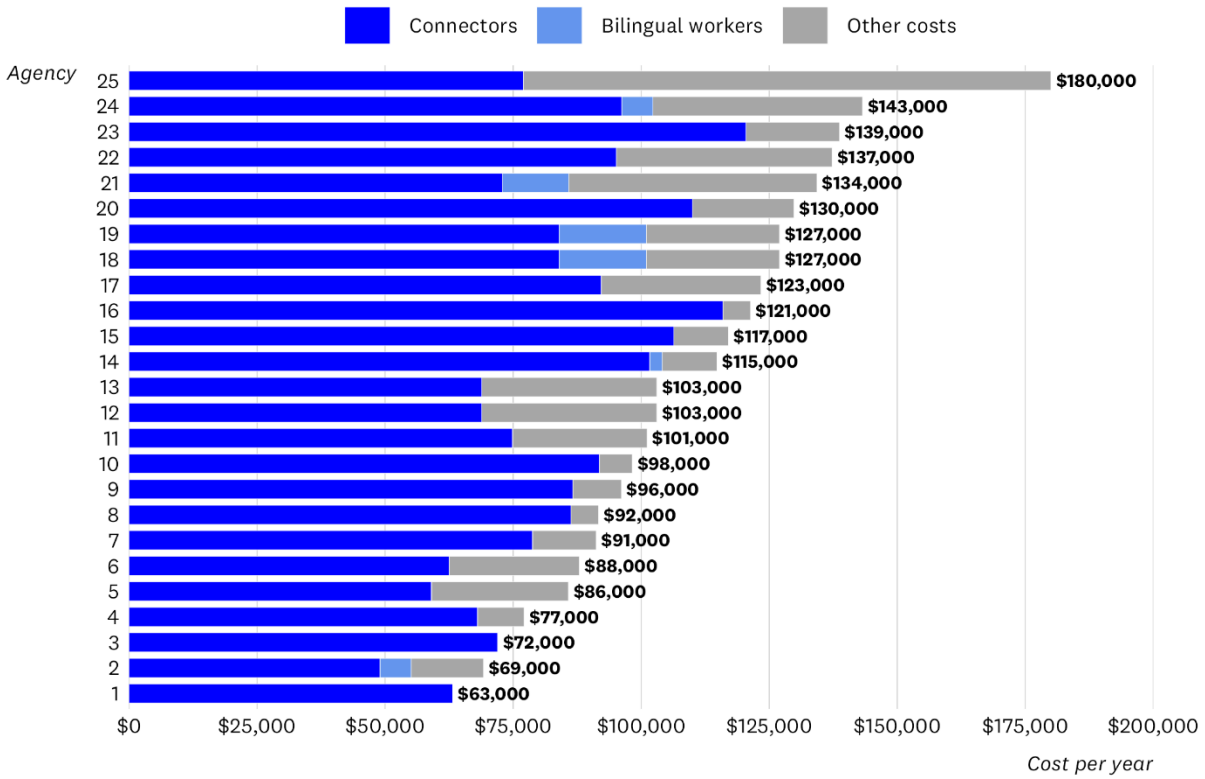
[25] This comprised 93 clients recorded in one of the two snapshots and six clients recorded in both snapshots. For clients that appeared in both snapshots, support time was averaged across the two snapshots to calculate weekly support time per client.

[26] Complexity scores range from zero to seven (see **Error! Reference source not found.** above), but only scores between three and six are shown in Figure 26 as there are only three clients in the task and time snapshots with complexity scores less than three.

5.8.14.3 Agency costs

Figure 29 summarises the staffing and other cost information that was provided by 25 of the sites.[27] Each site was asked to provide its costs and the number of FTE for Connectors and other staff over a 12-month period. All 25 of these sites reported Connector staff costs, and six reported costs for bilingual support workers. All but three sites also reported costs for other staff or overheads, typically managers, project support workers, or other administrative staff.

Figure 29 Annual costs reported by sites.



As shown in Figure 29, staffing costs reported by sites vary from $63,000 to $180,000.[28] All sites were allocated the same total amount of funds (just under $190,000) to provide services over periods that varied between 12 and 18 months. This translates to an equivalent of between $127,000 and $190,000 over a 12-month period, depending on how long the site provided services for. On this basis, it appears that some sites have reported costs over 12 months that are substantially less than the funding that was provided, but the reasons for this are not clear. It is possible that sites did not fully understand what cost information they were asked to provide, have reported actual costs incurred over a period of less than 12 months, or that non-staffing costs accounted for a significant proportion of costs and were not reported in the cost information provided.

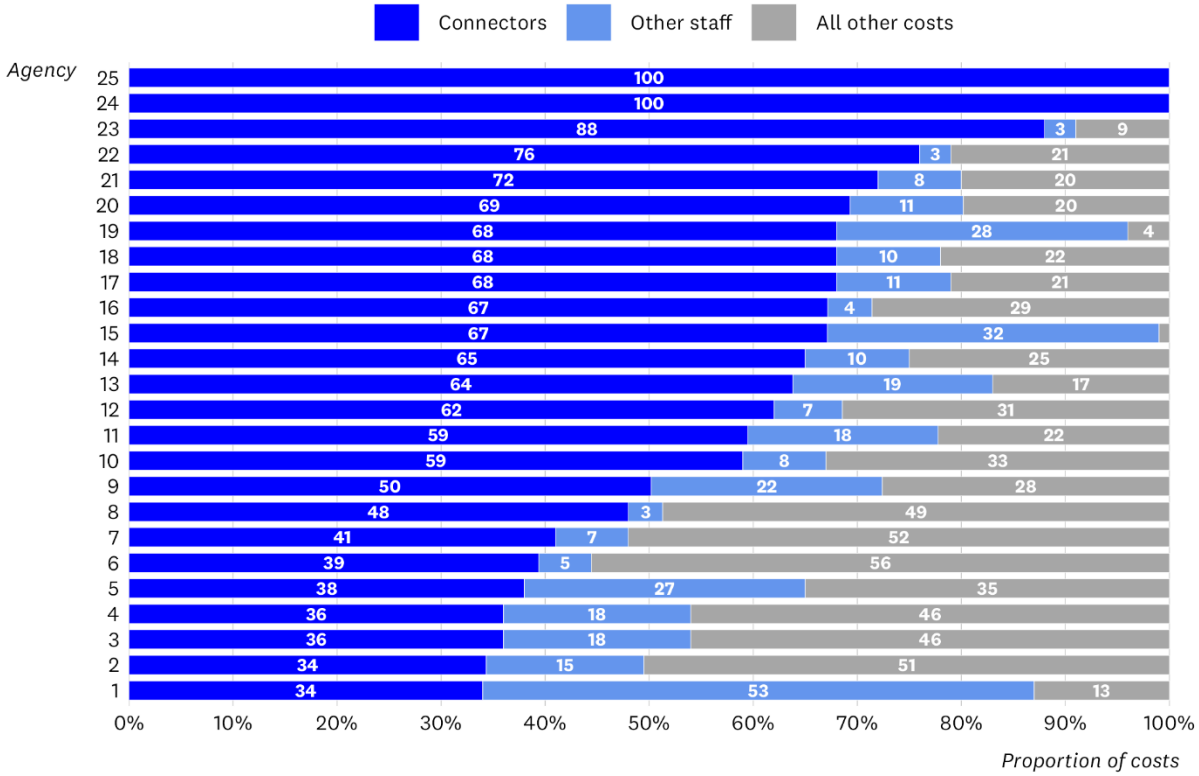
Sites were also asked to provide information about the overall allocation of their costs to paying for Connectors, other staff, and all other costs such as overheads (Figure 30). This shows considerable

[27] As noted above, agency numbers on this chart are not the same as on other charts, to preserve the anonymity of agencies. Agencies were asked to provide cost information together with both task and time snapshots, but the cost data provided with the first snapshot had significant quality issues, so the analysis in this section is based on the cost data from the second snapshot only.

[28] Costs have been rounded to the nearest $1,000 to help preserve the anonymity of the agencies.

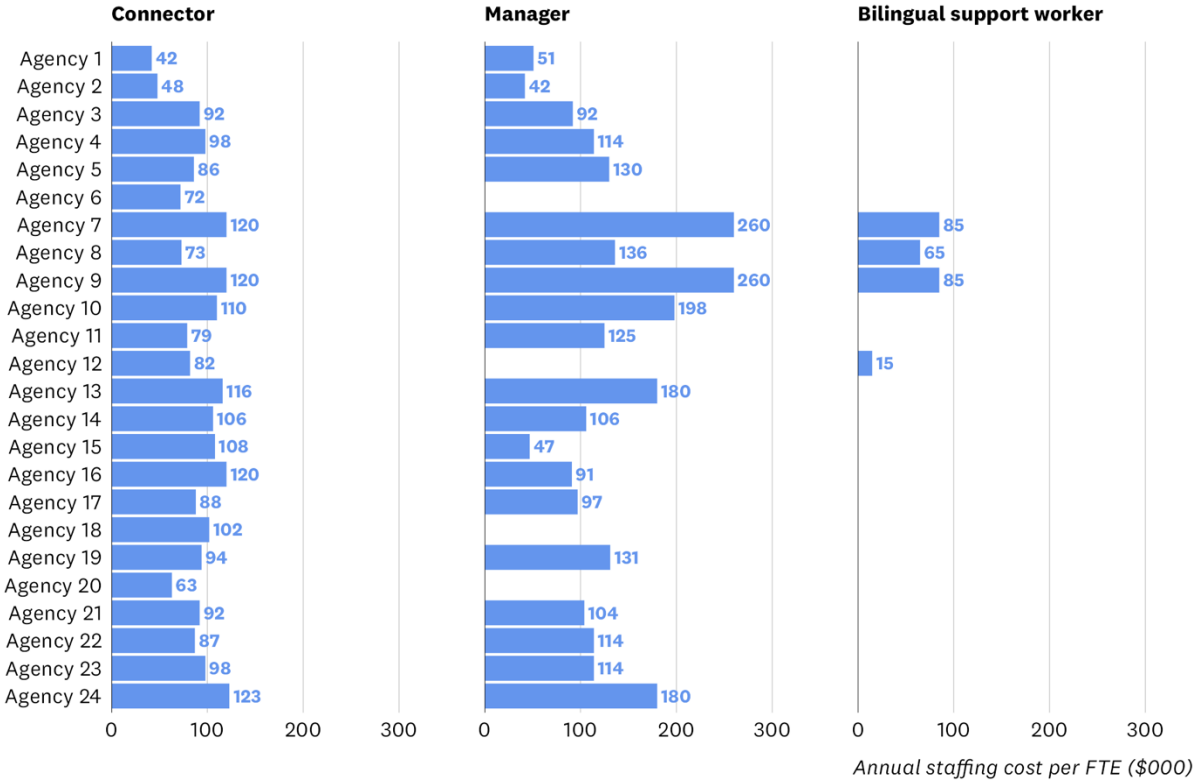
variation in the ways that sites have chosen to use their funding, with payments to Connectors ranging from around one-third to 100% of total costs. All but two sites reported allocating some funding to other costs aside from staffing, with this proportion ranging from 2% to 56% of funding.

Figure 30 Cost allocations reported by sites.



Sites also provided the number of full-time equivalent (FTE) workers for connectors and other roles. Figure 31 shows the implied cost per FTE calculated by dividing the reported staffing costs by the number of FTE for each site. Across all sites that provided this information, the median cost per FTE is around $93,000 for Connectors, $114,000 for managers, and $75,000 for bilingual support workers, although there is a relatively wide range of reported costs per FTE for each of these roles, and particularly for managers.

Figure 31 Annual staffing cost per FTE by role ($000).



6 References

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