



Evaluation of the Aged Care System Navigator Measure **Final Report**

for the Australian Government Department of Health
April 2021



Australian Healthcare Associates
Australia's largest health & human services consulting firm

© Commonwealth of Australia as represented by the Australian Government Department of Health 2021

Apart from uses permitted by the Copyright Act 1968 and this copyright notice, all other rights (including all commercial rights) are expressly reserved.

Permitted Uses

You may download, display, print, and reproduce the whole or part of this publication in unaltered form for:

- your own personal use;
- use within your organisation; or
- distribution and sharing with third parties,

but only if:

- you or your organisation do not use or reproduce the publication for any commercial purpose; and
- if reproduced, this copyright notice and all disclaimer notices are included as part of any reproduction.

This licence does not cover, and there is no permission given for, use of the Commonwealth Coat of Arms or any logos and trademarks (including the logo of the Department of Health).

Disclaimer

This publication has been produced independently by Australian Healthcare Associates on the request of the Department of Health.

The Australian Government accepts no responsibility for material contained in the publication. The views or recommendations expressed in this publication may include the views or recommendations of third parties and do not necessarily reflect those of the Australian Government or indicate a commitment to a particular course of action.

Providing access to the publication does not constitute an endorsement, approval or recommendation by the Australian Government of any organisation, association, entity, service, program, products or research offered by virtue of any information, material or content within the publication.

The information in this publication is provided on the basis that all persons accessing it undertake responsibility for assessing the relevance and accuracy of its content.

Suggested Citation

Australian Healthcare Associates, 2020, *Evaluation of the Aged Care System Navigator Measure Final Report*, Australian Government Department of Health.

AHA Australian Healthcare Associates

Level 6, 140 Bourke St, Melbourne VIC 3000

Locked Bag 32005, Collins Street East, VIC 8006

1300 242 111

aha@ahaconsulting.com.au

www.ahaconsulting.com.au

Acknowledgement of Country

In the spirit of reconciliation, the authors acknowledge and pay respect to the traditional custodians of Country, the Aboriginal or Torres Strait Islander peoples, and their continuing connection to land, waters, and community.

Australian Healthcare Associates is located on the lands of the Kulin Nation. We pay respect to Elders past and present.

Abbreviations

Term	Definition
A&S	Access and Support
ACAT	Aged Care Assessment Team
ACPR	Aged Care Planning Regions
ACSN	Aged Care System Navigator
ADAA	Aged and Disability Advocacy Australia
AHA	Australian Healthcare Associates
APS	Australian public service
CAC	Community and Aged Care
CALD	Culturally and Linguistically Diverse
CHSP	Commonwealth Home Support Programme
CoP	Communities of practice
CVS	Community Visitors Scheme
DEX	Data Exchange
DHS	Department of Human Services (now known as Services Australia)
DVA	Department of Veterans' Affairs
EPOA	Enduring Power of Attorney
FECCA	Federation of Ethnic Communities' Councils of Australia
FIS	Financial Information Service
FTE	Full-time equivalent
HAAG	Housing for the Aged Action Group
HACC	Home and Community Care
HCP	Home Care Package
IQR	Interquartile range
IUIH	Institute for Urban Indigenous Health
KPI	Key performance indicators
LGBTI	Lesbian Gay Bisexual Transgender Intersex
MCCI	Multicultural Communities Council of Illawarra Incorporated
MDS	Minimum data set
MRC	Migrant Resource Centre
NACAP	National Aged Care Advocacy Program
NDAP	National Disability Advocacy Program
NDIS	National Disability Insurance Scheme
NHW	Northeast Health Wangaratta
OPAN	Older Persons Advocacy Network
PCAN	Positive CALD Ageing Network
PHN	Primary Health Network

Term	Definition
PICAC	Partners in Culturally Appropriate Care
RACF	Residential Aged Care Facilities
RAS	Regional Assessment Service
RFT	Request for tender
ROI	Record of Interview
RSL	Returned and Services League
SMRC	Southern Migrant and Refugee Centre
SSW	Specialist Support Worker
the ACSN Measure	the Aged Care System Navigator Measure
the Department	the Australian Government Department of Health
TIS	Translating and Interpreting Service

Glossary

Aged care consumer: a person eligible (or potentially eligible for) aged care services. For the purposes of this report, this term includes people who are seeking information about aged care services and/or their eligibility for these, as well as those who have already engaged with the aged care system through My Aged Care (e.g. awaiting assessment, assessed, and/or awaiting provision of services).

Aged care service providers: includes Australian Government-funded and private providers of community-based and/or residential aged care services.

Service user: an actual or hypothetical user, or client, of an aged care navigation service.

Lay navigator: a navigator without directly relevant professional experience/qualifications (could be a paid worker or volunteer).

Peer navigator: a navigator with lived experience relevant to the setting or target population group.

Contents

1	Executive summary	1
1.1	Introduction.....	1
1.2	Key evaluation findings.....	2
2	Introduction	11
2.1	Background	11
2.2	Context.....	13
2.3	Evaluation objectives	13
2.4	Evaluation design.....	13
2.5	Reporting of evaluation findings	16
2.6	Caveats and limitations.....	17
3	Findings: COTA Australia-led trials	19
3.1	Key Messages	19
3.2	Introduction.....	24
3.3	Overview of trials.....	24
3.4	Findings: Implementation	39
3.5	Findings: Appropriateness	81
3.6	Findings: Effectiveness	114
3.7	Findings: Cost-effectiveness	128
3.8	Findings: Opportunities to enhance the trials	129
4	Findings: FIS Officer trials	130
4.1	Key messages	130
4.2	Introduction.....	131
4.3	Trial overview.....	131
4.4	Findings: Implementation	134
4.5	Findings: Appropriateness.....	143
4.6	Findings: Effectiveness	157
4.7	Findings: Cost-effectiveness	168
4.8	Findings: Opportunities to enhance the trials	172
5	Opportunities for the future of aged care navigation.....	173
5.1	Key messages	173
5.2	Introduction.....	174
5.3	Models of system navigation	174
5.4	Promising models	200
5.5	Addressing implementation challenges.....	202
5.6	Summary.....	211
6	Conclusions, options and policy considerations	212
6.1	Principles	212
6.2	Service elements.....	214
6.3	Implementation considerations.....	216
	Cited references	218

Tables

Table 1-1: Important design principles for aged care navigation	7
Table 3-1: COTA Australia-led trial types	25
Table 3-2: Distribution of trial activity types delivered between February 2019 and August 2020	43
Table 3-3: Groups and organisations connected with partner organisations	49
Table 3-4: Number of target populations planned during the original trial delivery period and trial extension period, by partner organisation	61
Table 3-5: Survey module relevance	84
Table 3-6: Navigator service users' long-form survey responses, reported between February 2019 and August 2020	88
Table 3-7: Distribution of positive, neutral and negative long-form survey responses, reported between February 2019 and August 2020, by trial activity type	91
Table 3-8: Diverse groups and vulnerable populations reported short-form survey respondents	96
Table 3-9: Language/s spoken at home, reported short-form survey respondents	97
Table 3-10: Distribution of short-form survey responses to the question 'Do you feel that it is easier for you to access aged care services and supports?', by population group	101
Table 3-11: Distribution of the most common vulnerabilities reported for navigator service users, between February 2019 and November 2020	104
Table 3-12: Distribution of the most common diverse groups reported for navigator service users, between February 2019 and November 2020	107
Table 3-13: Status of aged care services received by all navigator service users, presenting at the trials between February 2019 and November 2020	109
Table 3-14: Most common referral sources for the COTA Australia-led trials	119
Table 3-15: Most common onward referrals made by the COTA Australia-led trials	120
Table 4-1: Main DHS service centres used in FIS Officer trials	137
Table 4-2: Distribution of navigator service user types presenting at the FIS Officer trials	147
Table 4-3: Distribution of individuals accompanying aged care consumers in the FIS Officer trials	149
Table 4-4: Distribution of aged care consumers' payment types, by FIS Officer trial	150
Table 4-5: Distribution of aged care consumers' marital status, by FIS Officer trial	150
Table 4-6: Distribution of home ownership status, by FIS Officer trial	151
Table 4-7: Distribution of total assets, by FIS Officer trial	151
Table 4-8: Distribution of complex situations, by FIS Officer trial	153
Table 4-9: Number of interactions reported, by FIS Officer trial	158
Table 4-10: 'Survey 1', 'Survey 2' and 'Survey 3' scores reported by navigator service users	161
Table 4-11: Change in mean score (Q1-5) between 'Survey 1' and 'Survey 3', by FIS Officer trial	162
Table 4-12: Planned distribution of funding for the FIS Officer trials: service delivery	168
Table 4-13: Planned distribution of funding for the FIS Officer trials: project administration	168
Table 4-14: Calculated unit costs of FIS Officer trial interactions and costs per navigator service user, based on direct service delivery funding	169
Table 4-15: Adjusted unit costs of FIS Officer trial interactions and costs per navigator service user, based on direct service delivery funding, using March to September 2019 data	170

Table 5-1:	Identified models of system navigation	175
Table 5-2:	Key strengths and weaknesses of system navigator models.....	176
Table 5-3:	Rated importance of suggested design principles for aged care system navigator services, categorised by stakeholder group	185
Table 5-4:	Rated importance of provider type for aged care system navigator services, by stakeholder group (mean/100).....	189
Table 5-5:	Rated importance of various elements of aged care system navigator services, by stakeholder group (mean/100).....	191
Table 5-6:	Rated importance of system navigator services' modes of delivery, by stakeholder group (mean/100).....	194
Table 6-1:	Important design principles for aged care navigation models.....	213

Figures

Figure 1-2: Suggested range of navigator services across the aged care journey.....	8
Figure 2-1: Implementation timelines for the COTA Australia-led trials, the FIS Officer trials and the evaluation.....	12
Figure 2-2: Evaluation methodology	14
Figure 2-3: High-level data sources	15
Figure 3-1: Distribution of Individual and Group trial activities delivered over time, from February 2019 to November 2020	40
Figure 3-2: Distribution of trial activities (Group and Individual combined) delivered between February 2019 and August 2020, by trial type.....	44
Figure 3-3: Number of trials reporting Group and/or Individual trial activity delivery over time, February to December 2019.....	62
Figure 3-4: Distribution of positive, neutral and negative long-form survey responses, reported between February 2019 and August 2020, by trial type	90
Figure 3-5: Distribution of positive, neutral and negative short-form survey responses – CALD respondents	98
Figure 3-6: Distribution of positive, neutral and negative short-form survey responses – Aboriginal or Torres Strait Islander respondents	99
Figure 3-7: Proportions of vulnerable populations reported by trial type, between February 2019 and November 2020	106
Figure 3-8: Proportions of diverse group populations reported by trial type, between February 2019 and November 2020	110
Figure 3-9: Distribution of onward 'internal trial' referrals between February 2019 and November 2020, by trial type.....	122
Figure 4-1: Frequency of navigator service users presenting at each FIS Officer trial.....	146
Figure 4-2: Distribution of the most commonly reported complex situations	152
Figure 4-3: Number of navigator service users receiving support over time.....	158
Figure 4-4: Changes in understanding and confidence levels of navigator service users from pre-interaction ('Survey 1') to 2-3 months post-interaction ('Survey 3')	162
Figure 4-5: Calculated unit costs of FIS Officer trial interactions overall, and by FIS Officer trial, based on direct service delivery funding (including adjusted costs).....	171
Figure 5-1: Rated importance of design principles for aged care navigator services.....	184
Figure 5-2: Relative importance of the highest rated design principles for aged care system navigator services	186
Figure 6-2: Suggested range of navigator services across the aged care journey.....	215

1 Executive summary

1.1 Introduction

Australia's aged care system is difficult for older people and their families to understand and navigate. Some population groups – including those that are 'hard to reach' or who have complex needs – face particular challenges in accessing the services they need using My Aged Care, the gateway to Australian Government-subsidised aged care services (Department of Health 2017).

In the 2018–19 budget, the Australian Government announced the Aged Care System Navigator Measure ('the ACSN Measure'). The ACSN Measure is a program of 4 trials that aim to support people to:

- Understand the aged care system, including what services are available to meet their needs and how to access them
- Engage with and access the aged care system. This includes supporting older people to connect with My Aged Care and to use it to choose and access services.

Of the 4 trial programs, 3 programs – the Information hub, Community hub and Specialist Support Worker (SSW) trials – are being delivered by a consortium of 30 partner organisations led by COTA Australia. Originally intended to finish on 30 June 2020, these trials have been extended to 30 June 2021. The fourth trial program – the Financial Information Service (FIS) Officer trials – was delivered by the Department of Human Services (DHS)¹ and concluded in October 2019.

The Australian Government Department of Health (the Department) engaged Australian Healthcare Associates (AHA) to evaluate the 4 trial programs, and to review other system navigator models, to inform future decision-making about aged care system navigation. AHA has used a mix-methods approach to the evaluation, supplementing quantitative and qualitative data collected through the trials with extensive stakeholder consultation and a literature review.

This Final Report for the evaluation is based on analyses of trial data collected from 28 February 2019 to 5 February 2021, and includes updates to the comprehensive findings that were provided in the Interim Report (drafted April 2020).

Note: areas of this Final Report which contained potentially commercially sensitive information have been removed prior to publication.

The remainder of this chapter summarises:

- The key findings of our evaluations of the trial programs and the review of other system navigator models
- Opportunities for the future of aged care navigation, as drawn from our review of other system navigator models
- Important principles, service delivery elements and implementation considerations for future aged care navigation services for diverse and vulnerable population groups.

¹ On 29 May 2019, the Prime Minister announced that DHS was to be renamed Services Australia.

1.2 Key evaluation findings

The ACSN Measure provides an important means of supporting older people to better understand and engage with the aged care system. The COTA Australia-led trials and FIS Officer trials have been delivered by a committed, passionate workforce and have delivered a range of achievements, including strong levels of engagement with local communities and positive feedback from navigator service users (where reported). Importantly, the ACSN Measure has provided opportunities to test and refine approaches to navigation and contribute to a growing evidence base for aged care system navigation in the Australian context.

A summary of key findings from the evaluation of the COTA Australia-led trials and the FIS Officer trials, along with opportunities for the future of aged care system navigation, is provided below.

1.2.1 COTA Australia-led trials

Implementation

The COTA Australia-led trials have largely been implemented as intended. The compressed timeframe between contract finalisation and commencement of the trials resulted in challenges for partner organisations in terms of scoping, recruitment and promotion, but these challenges have resolved over time.

Flexible, hybrid approaches to navigation may be preferable to prescribed models in addressing the needs of diverse and vulnerable population groups. As noted in the Interim Report, the boundaries between the 3 trial types (Information hubs, Community hubs and SSWs) have been blurred. While this makes it difficult to determine which trial type might work best, this lack of distinction does not appear to have caused significant issues in terms of the day-to-day delivery of the trials, nor the experience of navigator service users.

Opportunities for improving the governance and coordination of the trials were identified, including a need to streamline contractual processes. The trials' extension was an opportunity for refinements to be made to processes, including data collection and reporting (at the level of individual trial sites and within COTA Australia), which had been problematic and have limited the extent to which some evaluation questions could be addressed.

Partner organisations have remained highly committed to the trials, despite these challenges. They demonstrated an impressive level of resilience and pragmatism in adapting their implementation approach following the onset of the COVID-19 pandemic in March 2020. The pandemic saw a shift towards telephone and online modes of engagement, and the introduction of 'welfare checks' for navigator service users, which were seen as an important additional service.

Appropriateness

Navigator service users were very satisfied with the services. Broadly speaking, they considered partner organisations to be trusted supports, and navigator service users' responses to the trial survey tools indicated that they valued the services they received. This positive feedback was generally consistent across trial types, trial activity types, and vulnerable populations and diverse groups.

Limitations in the trial activity data collected and reported by the partner organisations, and the recent redefinition of trial activity types, have prevented a detailed assessment of

appropriateness. It has not been possible to determine whether certain trial activities are more appropriate for some population groups than others.

Existing aged care service users need ongoing support. While the original intent of the ACSN Measure was to support people who had not yet engaged with the aged care system, a relatively high proportion of navigator service users were already receiving aged care services. This indicates that support is often required even once individuals are 'in the system'. This finding was supported by case study examples of navigator staff supporting individuals to arrange reassessments, follow up on referrals, address concerns with quality of care, and provide linkages to other services.

Effectiveness

The vast majority of navigator service users reported that participating in trial activities improved their knowledge of the aged care system, and increased their confidence in accessing services. This finding, as derived from responses to the short-form and long-form surveys, was supported by (limited) qualitative data from consultations with navigator service users. Due to data limitations, it was not possible to determine differences in effectiveness between trial types, activities, or target populations.

Face-to-face interactions (often over multiple occasions) and outreach are important for addressing the needs of those who are particularly hard to reach. This finding was consistent with findings in the Interim Report. In addition, group activities continued to be seen by trial staff and navigator service users as a positive way of engaging individuals in a discussion about aged care, and were considered particularly effective if followed up with a session of individual support to address specific needs or questions.

Cost-effectiveness

Program and data limitations prevented robust evaluation of cost-effectiveness. The Interim Report outlined a range of program and data limitations that have hampered the ability to establish the cost-effectiveness of the trials. As these limitations have persisted, and have been compounded by the impact of COVID-19 on both service delivery volumes and data reporting, the evaluation has been unable to establish whether certain trial types or activities represent better value for money than others.

Opportunities to enhance the trials

The opportunities for improvement presented in the Interim Report remain relevant. While some of these opportunities have been explored (particularly in relation to data collection and reporting), there are ongoing avenues for continuous quality improvement, outlined in the areas below.

Trial design, including:

- removing the distinction between Information hubs, Community hubs and SSWs, where multiple trial types are delivered by a single partner organisation in a specific location
- maintaining focus on face-to-face engagement (with repeat interactions where necessary), outreach, and targeted efforts to engage particularly hard-to-reach populations
- continuing to support navigator service users to the point of aged care service commencement.

Data collection and management, including:

- strengthening internal processes for data management within the organisation responsible for over-arching trial management

- supporting partner organisations to improve the accuracy and completeness of reported data
- considering opportunities to further reduce the number of data variables to be collected through the trial data set, to improve levels of reporting of those variables that are collected.

Governance and project coordination. The organisation responsible for over-arching trial management should:

- continue to raise awareness of the trials with My Aged Care, assessors and other related aged care services and programs
- support consistency of information provided through the trials. Given mixed views on the usefulness of the Communities of Practice and state/territory forums as well as the apparent limited uptake of the BoostHQ resource platform, the organisation should seek input from partner organisations on the types of support that may best meet their needs.

1.2.2 FIS Officer trials

Implementation

Implementation of the FIS Officer trials ran largely to plan. The FIS, with its long history of providing independent financial information in relation to aged care, proved to be well-placed to deliver the trials. Local promotion and outreach to local communities (including vulnerable populations) were seen as important in increasing uptake of the trials, given that awareness of the FIS among the broader population was relatively low.

The lack of alignment of implementation timeframes and geographical locations between the FIS Officer trials and the COTA Australia-led trials meant that the intended level of integration between the trials did not eventuate.

Appropriateness

Most navigator service users were satisfied with the services, but the appropriateness of FIS for vulnerable or diverse population groups could not be established. The profile of navigator service users seeking support through the FIS Officer trials was somewhat different from those whom the COTA Australia-led trials sought to engage: most had complex financial circumstances in relation to aged care due to their moderate (or higher) levels of wealth, rather than due to particular cultural or personal vulnerabilities. Moreover, vulnerability information was under-reported in the trial data set ('DHS data set'), largely because FIS Officers were reluctant to collect this information from navigator service users.

Effectiveness

Interacting with a FIS Officer improved navigator service user knowledge and confidence.

Navigator service users reported that, following their interaction with a FIS Officer, they had a greater understanding of financial arrangements and options, and greater confidence in making financial decisions when planning for and accessing aged care. Importantly, these improvements were *sustained* over time. Navigator service users identified the longer duration of trial services (compared with standard FIS offerings) and being provided with a written 'Record of Interview' to take home as important in maximising their understanding. Unsurprisingly, given the complexity of the system, a number of navigator service users required additional follow-up contact.

Cost-effectiveness

The cost-effectiveness of the FIS Officer trials could not be established due to limitations in the available financial data.

Opportunities to enhance the trials

Increased promotion of the FIS Officer trials – and the FIS more broadly – was seen by trial staff and navigator service users as important to improve uptake. This should include networking and relationship-building to engage with diverse and vulnerable population groups.

A more consistent approach to scheduling follow-up sessions would improve the experience for those with complex needs who require additional support from FIS Officers.

1.2.3 Opportunities for the future of aged care navigation

A number of system navigator models have been developed in aged care and other sectors in Australia and internationally. Though it is difficult to evaluate the relevance of these models to the Australian aged care setting, a range of opportunities were identified, with the following themes emphasised:

- **Overall, stakeholders participating in the evaluation favoured professional navigation models delivered by a quality workforce**, noting that peer models could be used alongside professional models to perform complementary functions.
- **Face-to-face service delivery and outreach were seen as critical elements within holistic, multi-modal approaches** to ensure engagement with and appropriate service delivery to diverse or vulnerable population groups.
- **Aged care system navigation models should seamlessly integrate with other elements of the aged care system**, and interface with other sectors (e.g. health, disability, social welfare) in order to support those with complex needs.

1.3 Conclusions, options and policy considerations

A wide range of approaches to aged care system navigation have been described through this evaluation, including those delivered through the trials funded through the ACSN Measure and those uncovered in the review of other system models. However, there is no clear evidence of which model will work best for different population groups or in different settings. Rather, the evaluation has found that navigator services should be locally tailored, holistic, and flexible to meet the needs of diverse population groups and individuals.

Yet, despite the recognised need for a tailored response, there is benefit in some aspects of broader consistency, coordination and support. The following principles, service delivery elements and implementation considerations have been identified as important for future aged care navigation services for diverse and vulnerable population groups.

1.3.1 Principles

The review of system navigator models identified a range of principles that should underpin the design of system navigator services (Table 1-1). While these principles have largely been incorporated into the trials tested through the ACSN Measure, the evaluation has highlighted the importance of the following:

- **Aged care navigation services should be underpinned by a professional workforce** (supported, where appropriate, by trained volunteers).
- **Navigation services should, where possible, be independent of aged care service providers** in order to provide impartial advice (exceptions may apply in 'thin' markets such as Aboriginal or Torres Strait Islander services).
- **Aged care navigation services should be designed with the end user in mind**, taking into account the:
 - need for flexible approaches to engage with individuals, while adhering to a clear scope of practice
 - holistic needs of individuals (not limited to aged care services), including linkages and partnerships, if not integration, with other services and organisations
 - importance of trusted relationships in engaging and supporting people from vulnerable and/or hard-to-reach populations.

Table 1-1: Important design principles for aged care navigation

Design principle	Details
Quality workforce	Navigators should be appropriately experienced, with relevant qualifications* where required, trained and supported (e.g. with ongoing training and professional development)
Implementation resources	Navigator programs should include implementation resources/toolkits/guides to support consistent, high-quality delivery of navigation services
Flexibility and adaptability	Navigator models should be flexible, adaptable and responsive to meet the needs of the service user and the required level of service intensity
Linkages and partnerships	Navigators should dedicate time to developing their knowledge of local services, building partnerships with other organisations and sectors, and performing promotional/integration activities
Clear scope of role and practice	Navigators should have a defined scope of practice with roles and responsibilities that are transparent and commensurate with the skills and experience of the navigator delivering the service, including guidance on management of risk
Integration	Navigator models should aim to integrate fragmented and disconnected systems of care, and draw on existing local efforts/supports/infrastructure
Relationship-centred services	Navigator models should identify the context, needs and priorities of the service user, in order to provide a personalised navigation service. They should recognise the importance and influence of the relationships that exist between the service user and others, including service providers
Independence	Navigators should be independent from service providers, to foster the necessary trust and rapport required to reach people facing challenges when accessing and navigating aged care services**
Active participation	Navigation should enhance the capacity of service users (including individuals/carers/families) to be actively involved in navigating the aged care system
Evaluation outcomes	Implementation of aged care navigator programs should include an evaluation framework to monitor outcomes for service users and inform future policy decisions
Defined target population	Navigator models should focus on defined target populations and prioritise those who are vulnerable or are experiencing barriers to accessing information and care
Other	Accessibility, inclusive design, innovation, sustainability, responsiveness, simplicity.

Note: *professional aged care system navigators should hold qualifications in aged care and/or relevant health, behavioural and/or social sciences. **Exceptions to these design principles may apply in thin markets such as Aboriginal or Torres Strait Islander services, to ensure access to culturally appropriate navigation support and aged care services.

1.3.2 Service elements

Aged care navigation services should:




- **Be informed by detailed, localised needs assessment** that considers population demographics, aged care service availability and mapping of other relevant services to support the development of referral networks and avoid duplication.
- **Provide a flexible mix of services**, recognising that levels of need (and, therefore, intensity of required support) will vary between individuals, and may fluctuate over time.
- **Support people where necessary up to the point at which aged care service delivery is commenced**, including the process of registering with My Aged Care, and assessment.
- **Use a range of modes of delivery, bearing in mind that face-to-face interaction is generally preferable for marginalised populations.** However, partner organisations have indicated the value of telephone and online modalities during the COVID-19 pandemic. While

these cannot fully replace face-to-face delivery, they are valuable supports and warrant further exploration.

- **Use targeted approaches**, including assertive outreach, to engage with people who are particularly marginalised, socially isolated, or otherwise unlikely to engage with the aged care system.
- **Refer clients where necessary to independent financial navigation services**, such as the FIS. While financial navigation is an important service, it requires specialist expertise that may be outside the skill set of many navigators. The FIS should continue to be promoted as a high-quality, independent source of aged care financial information.

Figure 1-2 provides an example of the range of services that should be considered as part of a flexible, multi-modal system navigator model that accommodates the different support needs of navigator service users across the aged care journey.²

Figure 1-1: Suggested range of navigator services across the aged care journey

Complex  Moderate  Low  Intensity of need	Targeted approaches <ul style="list-style-type: none"> • May or may not be from diverse populations 	Individual support to register with My Aged Care and address other needs ----- Assertive outreach	Regular follow-up (face-to-face, if feasible): <ul style="list-style-type: none"> • Assistance with assessment process • Support to address other needs 	Regular follow-up (face-to-face, if feasible): <ul style="list-style-type: none"> • Assistance to select provider/s • Support to address other needs 	Ongoing case management if required (out of scope for navigators)
	<ul style="list-style-type: none"> • Diverse populations • Distrust of government • Social/financial disadvantage 	Individual support to register with My Aged Care ----- Information and education	Periodic follow-up: <ul style="list-style-type: none"> • Assistance with assessment process 	Periodic follow-up: <ul style="list-style-type: none"> • Assistance to select provider/s • Support to address other needs 	
	Universal approaches	Information and education: <ul style="list-style-type: none"> • Healthy ageing • Aged care system • How to register with My Aged Care 			
Aged care journey					
	Learning about aged care	Registration with My Aged Care	Assessment	Service commencement	

² While individuals may need ongoing support and case management beyond the point of aged care service commencement, this is outside the scope of aged care system navigators as conceptualised in the ACSN trials and this evaluation.

1.3.3 Implementation considerations

Service provider organisations

Navigation services can be delivered effectively by a range of organisations, including local governments, Primary Health Networks (PHNs), advocacy organisations and community organisations that support special needs groups.

Where feasible, navigation services should have a physical presence, with an accessible space to facilitate face-to-face engagement – for example, by operating as a ‘hub’. Services may also be co-located with other services.

It is essential for organisations delivering navigation services to have established trust with the groups they are working with. Further, given that distrust of government has been found to be a barrier to people from diverse and vulnerable populations engaging with the aged care system, **navigation services should be delivered separately from the government.**³

While navigation services may specialise in serving a particular population group, they should be accessible to all, and where required facilitate referrals to other population-specific navigation services.

Staffing

Services should be staffed by experienced personnel, including qualified professionals where required, with expertise in the aged care system, and the specific populations with which they work.

Training in cultural awareness and trauma-informed practice should be provided to all staff.

Volunteers can play a role in several areas, including:

- connecting with local/diverse communities and providing basic information
- providing emotional or peer support, serving as an example of successful engagement with the aged care system
- undertaking administrative tasks to support professional navigators.

Funding

The funding model should ensure that sufficient funds are allocated to the resource-intensive work of serving those with complex needs.

Sustainability of funding is important in order to grow services over time and build recognition and trust within local communities.

Funding should be sufficient to support innovation and service improvement.

³ Distrust of government appears to be more focused at the Commonwealth and state/territory level. Stakeholders participating in this review (including, but not limited to, partner organisations and navigator service users, and representatives from external organisations such as peak bodies, service providers, PHNs and academia) report that local government is viewed more favourably.

Building national consistency

A nationally networked, branded program of aged care navigation services would:

- increase awareness and visibility among the Australian public
- enhance consistency in processes, including scope of practice, service delivery guidelines, data collection/reporting and processes for interacting with other services
- facilitate communication, training, information sharing and referrals between organisations.

While national consistency in the objectives and scope of aged care navigation is important, services should be encouraged to tailor activities to best meet local needs. This may include considering different approaches to local promotion, networking and delivery of navigation support.

A central coordination function could support national consistency and promotion of good practice. This role could be provided by a navigation service provider or an independent third party. The option of keeping the central coordination function separate from contract management – which may be more efficiently managed by the Department – could be considered. This may enable organisations that lack the *infrastructure* or *capacity* to provide contract management, but who are well-qualified to support coordination and quality improvement, to undertake that role.

Monitoring and evaluation

Navigation services should be responsible for monitoring local population demographics and need, and modifying their approaches accordingly.

Nationally consistent data collection will support ongoing monitoring and evaluation. Data collection requirements should aim to minimise the burden on service providers and navigator service users, and reporting should be streamlined to maximise the quality and quantity of collected data (e.g. through an online portal).

This evaluation has highlighted the benefits of qualitative reporting in addition to collection of quantitative data because many of the successes of aged care system navigation cannot easily be measured through quantitative means.

2 Introduction

2.1 Background

In January 2019, the Department of Health (the Department) engaged Australian Healthcare Associates (AHA) to undertake an evaluation of the Aged Care System Navigator Measure ('the ACSN Measure'). Commencing in October 2018, the ACSN Measure was initially planned to run until June 2020 but was subsequently extended to June 2021 (with the evaluation extended to February 2021).

The ACSN Measure comprises 4 programs of trials – which are testing different system navigator models in different circumstances – in order to inform future decision-making about aged care navigation services.

Three of the 4 programs of trials are being delivered by a consortium of 30 organisations ('partner organisations') led by COTA Australia and comprise:

- 32 aged care **Information hubs** to provide locally targeted information and build people's capacity to engage with the aged care system.
- 21 **Community hubs** where older Australians support each other in navigating aged care and healthy ageing.
- 9 (6.2 full-time equivalent [FTE]) **Specialist Support Workers** (SSWs) in consumer-focused organisations to offer one-on-one support for vulnerable people.

A further 2 hybrid trials – integrated aged care **mobile Information hub** and **SSW** (1.6 FTE) ('Integrated Information hub/SSW') – have also been established to provide both information and more intensive one-on-one support to improve engagement with the aged care system.

The fourth trial program making up the ACSN Measure was delivered by the Department of Human Services (DHS)⁴ and concluded in October 2019:

- 6 FTE aged care **Financial Information Service (FIS) Officers** to support people making complex financial decisions about entering aged care.

The implementation timelines for the COTA Australia-led trials, the FIS Officer trials and the evaluation are shown in Figure 2-1.

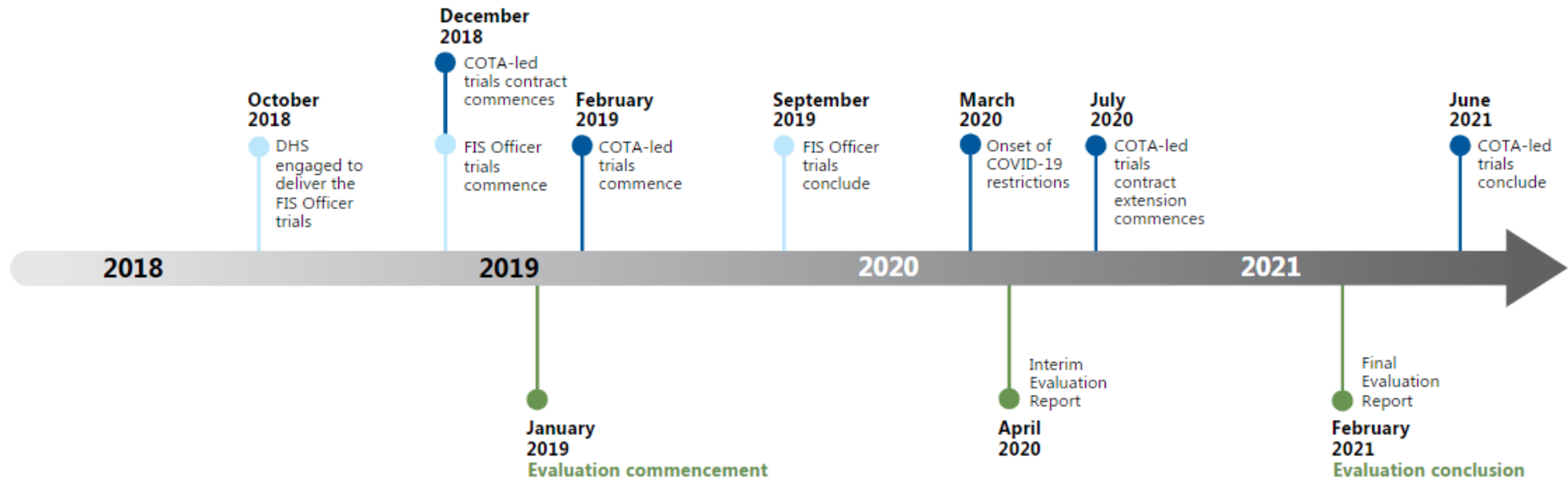
The program logics for the 4 programs of trials are shown in Appendix A.

The 4 programs aim to improve older people's (and their families') understanding of what services are available and how to access them, and to improve their confidence to engage with the aged care system.

As shown in Appendix A, the extent to which the trial programs improve access to aged care services was not within the scope of this evaluation. This was, in part, due to the timeframes of the evaluation but also due to the range of systems factors – such as unavailability of aged care services or long waiting lists – which may hinder this outcome (and, importantly, are largely outside of the trials' control).

⁴ On 29 May 2019, the Prime Minister announced that DHS was to be renamed Services Australia.

Figure 2-1: Implementation timelines for the COTA Australia-led trials, the FIS Officer trials and the evaluation



2.2 Context

The ACSN Measure was launched in response to the 2017 Legislated Review of Aged Care (Department of Health 2017). The review found that, despite ongoing reforms to My Aged Care – the centralised entry point for Australian Government-funded aged care in Australia – there remained unmet need in the support for certain population groups when accessing and navigating aged care services.

It is intended that findings from this evaluation of the ACSN Measure, as presented in the Interim Report and this Final report, will be used to inform future decisions about how best to support people accessing and navigating aged care.

2.3 Evaluation objectives

The objectives of the evaluation were to:

- Assess the implementation, appropriateness, effectiveness and cost-effectiveness of the trials implemented under the ACSN Measure.
- Identify and review existing and historical system navigator services, including aged care system navigator services and system navigator services in other sectors, in Australia and internationally.
- Identify stakeholder views on existing and historical aged care system navigator models and opportunities for the future.
- Identify potential aged care system navigator models to inform future policy considerations, including barriers and enablers to achieving intended outcomes.

2.4 Evaluation design

2.4.1 Project methodology

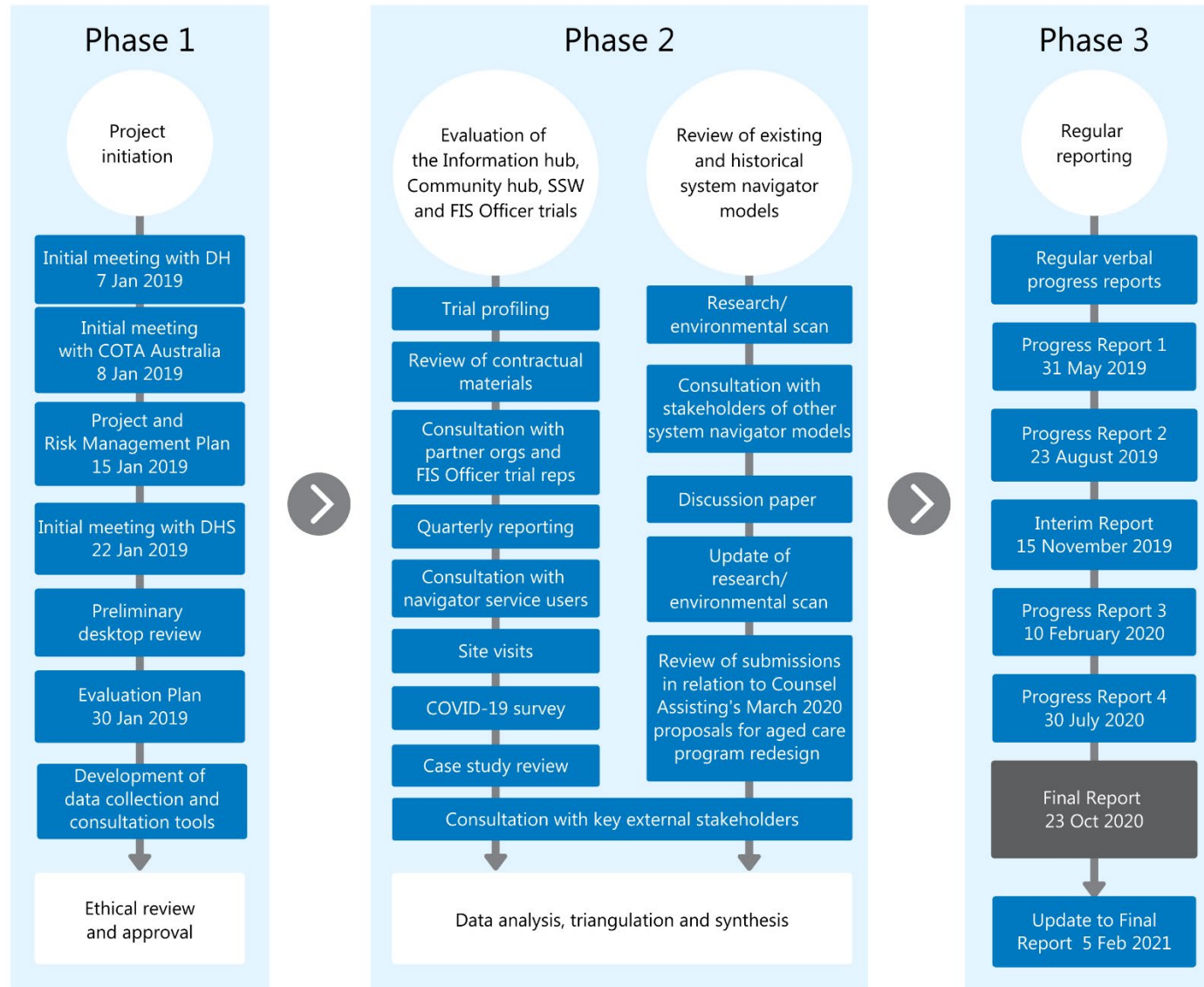
The evaluation comprised a three-phase methodology – including 2 central streams – as shown below and in Figure 2-2.

- **Evaluation of the Information hub, Community hub, SSW and FIS Officer trials** (left stream of Phase 2 below).
- **Review of existing and historical system navigator models** (right stream of Phase 2 below).

Detailed information about each component of the evaluation is described in AHA's Evaluation Plan.

2. Introduction

Figure 2-2: Evaluation methodology



Note: some of the *planned* evaluation reporting deliverables, including timelines, shown in Phase 3 were subject to change throughout the evaluation, including in relation to the extension to the evaluation.

2.4.2 Data sources

Two main types of information were used to inform the evaluation:

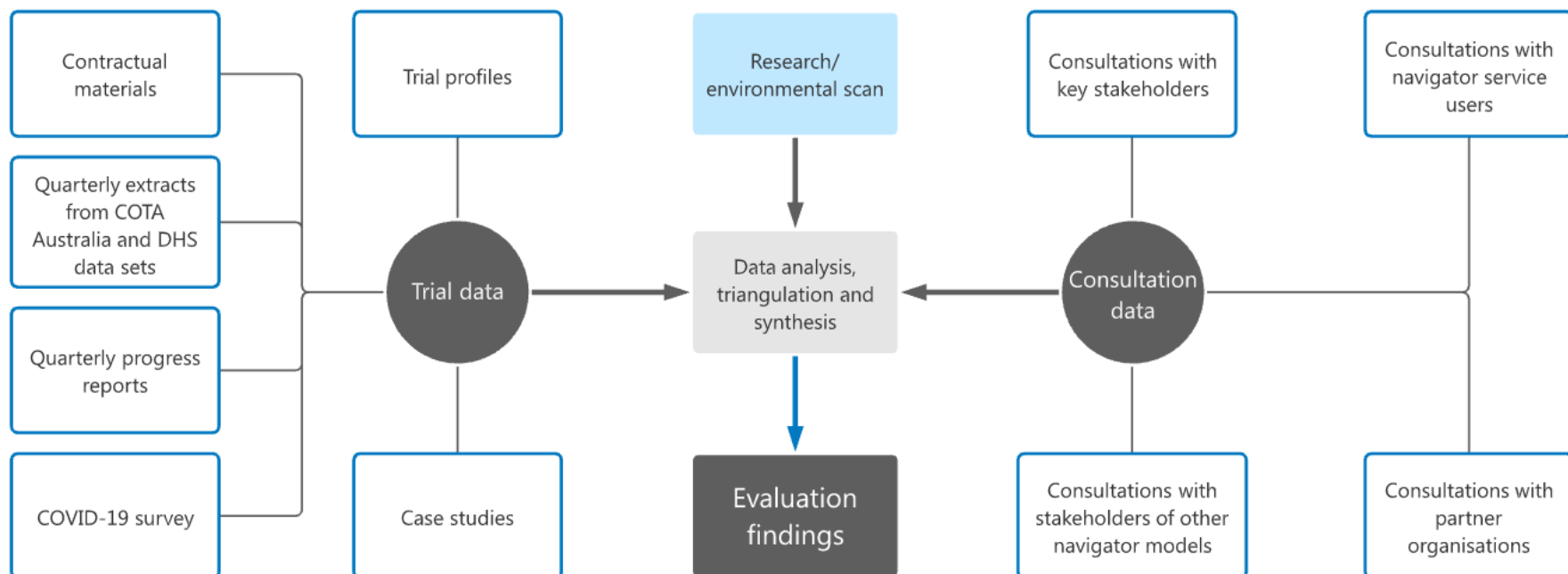
- **Trial data**, collected and reported by partner organisations, COTA Australia and DHS (now Services Australia) during the delivery of the trials.
- **Consultation data**, based on findings from consultations with stakeholders, including both those internal and external to the trials.

The *high-level* data sources that underpin the above types of information are shown in Figure 2-3.

Details of the *specific* data sources used to inform this Final Report are shown in Appendix B.

More information about each type of data source – including how the sources have been used to inform evaluation findings – is presented in the Interim Report (April 2020) and AHA’s Evaluation Plan.

Figure 2-3: High-level data sources



2.5 Reporting of evaluation findings

The Interim Report – which was submitted in April 2020 (delayed from November 2019) – contained comprehensive findings in relation to the (concluded) FIS Officer trials and the (concluded at that time) review of other system navigator models (see Phase 2 of Figure 2-2 above). While the COTA Australia-led trials were still ongoing at the time of drafting the Interim Report, they had been in operation for well over 12 months – and were, arguably, well-established at that point. As such, AHA considers the findings presented in the Interim Report in relation to the Information hub, Community hub and SSW trials to be similarly comprehensive.

This Final Report presents an update to the findings presented in the Interim Report, and incorporates the latest trial data and consultation findings *primarily* in relation to the Information hub, Community hub and SSW trials, and the review of other system navigator models.

2.5.1 Report structure

Subsequent chapters of this report present:

- Updated findings from the COTA Australia-led trials (Chapter 3)
- Findings from the FIS Officer trials (Chapter 4)
- Opportunities for the future of aged care navigation (Chapter 5)
- Conclusions, options and policy considerations (Chapter 6).

The appendices (provided in a separate document) present:

- Program logics for the 4 programs of trials (Appendix A)
- Data sources for the COTA Australia-led trials and FIS Officer trials (Appendix B)
- COVID-19 survey results (COTA Australia-led trials) (Appendix C)
- Supplementary information from the COTA Australia data set (Appendix D)
- Review of other system navigator models (Appendix E)
- Findings from the modified short-form survey (COTA Australia-led trials) (Appendix F).

2.5.2 Data sources used to inform this report

The data sources used to inform the evaluation of the COTA Australia-led trials and the FIS Officer trials are presented in Appendix B. The data sources used to inform the review of other system navigator models are described in Appendix E.

The cut-off date for available data sources used to support the findings presented in this Final Report was 5 February 2021.

Based on these data sources (e.g. where supporting information was available), an updated synthesis of findings from the COTA Australia-led trials is presented in Chapter 3.

2.6 Caveats and limitations

The caveats and limitations described here centre on the evaluation of the COTA Australia-led trials.

Data collected and reported by partner organisations in the COTA Australia data set have been used to support the findings presented throughout Chapter 3 (with supplementary trial data presented in Appendix D).

However, the collection, reporting and management of trial data have consistently been key challenges for the COTA Australia-led trials, as detailed in the Interim Report. At the time of drafting this Final Report, there were still a number of important data issues which contributed to the primary limitations highlighted below.

The ability to describe, compare and draw robust conclusions about different trial types and different trial activity types has been limited by:

- The observed variability between (and within) the Information hub, Community hub and SSW programs of trials, in terms of their scope of service offerings.
- The blurring of boundaries between trial types, particularly when they are co-located and being delivered by a single partner organisation.
- Inconsistencies in the interpretation and partner organisation reporting of some trial activity types, for example, 'Outreach'.

The ability to draw robust conclusions in relation to the appropriateness and effectiveness of the trials has also been hampered by the quality and completeness of the overall COTA Australia data set, particularly in relation to the reporting of:

- Vulnerable population and diverse group information
- Trial referral information
- Long-form (and to a degree, original short-form) survey responses (see below).

The COVID-19 pandemic has had a substantial impact on partner organisations' trial delivery approaches, including:

- The requirement for partner organisations to quickly adapt to COVID-19 restrictions, including adoption of alternative modes of trial activity delivery.
- Temporary reductions in the quantum of (particularly Group) trial activities delivered to navigator service users.
- Some increases in the level of under-reporting in the COTA Australia data set, with higher proportions of records reported with missing data in quarters 6 and 7 (e.g. compared to data reported in the Interim Report).

Other unplanned events also impacted some trials' ability to operate at full capacity, including bushfires (south-eastern Australia) and cyclones (Northern Territory) in early 2020.

Along with the above COVID-19 and non-COVID-19 data reporting issues, the following points further hampered the *trial-wide* evaluation and comparison of cost-effectiveness between trial types and trial activity types, including in different 'target populations':

- Under-reporting or reporting of sub-optimal data in trial summary records (particularly earlier in trial implementation), affecting the completion and quality of:
 - Individual and Group trial activity ('actual' and 'in-kind') costs
 - Trial resourcing information.

- The quantum of trial activities reported are likely to be an underestimation, due to brief, informal or unplanned interactions with navigator service users less likely to being captured in the COTA Australia data set.
- Limitations with reported long-form survey responses (above) make it difficult to link navigator service outcomes with trial costs (where possible to estimate).

Evaluation of navigator service user outcomes has been constrained by:

- The limited ability of navigator service users to adequately recall their trial experience during follow-up consultations with AHA.
- The accuracy of long-form survey responses, when they have been reported without associated trial activity information, requiring COTA Australia to 'link' them (or AHA to make assumptions) post-hoc using available identifying information.
- The substantial skewing of 'long-form' survey data caused by the uneven distribution of responses from across the 64 trials.
- The limited sample of 'short-form' survey responses reported during the piloting of the tool.
- The inability to evaluate whether short-term positive outcomes reported by navigator service users eventuate in longer-term positive outcomes (noting that this was outside of the scope of the trials and the evaluation).
- The roll-out of the refined COTA Australia data set (including redefined trial activity types) from September 2020 limited the ability to assess changes in trial effectiveness and appropriateness over the overall trial implementation period (e.g. from February 2019). Measures which could not be reliably assessed included planned versus actual comparisons of:
 - Trial activity types delivered
 - Target populations presenting at the trials.

3 Findings: COTA Australia-led trials

3.1 Key Messages

Implementation

By the end of November 2020, a total of 388,462 people had received aged care navigation support from the 64 COTA Australia-led trials, although a significant portion of this number comes from information provided (passively) via mass communications.⁵

All partner organisation representatives were supportive of the ACSN Measure and saw value in the trial activities they were providing, and the linkages they were establishing within communities. However, they noted substantial in-kind support from their organisation was required in order to deliver the trials.

While the COTA Australia-led trials have largely been implemented as intended, a range of challenges have arisen. However, it is unsurprising for implementation challenges to occur when trialling innovative new programs – and particularly those involving many participating organisations.

The compressed timeframe between contract finalisation and commencement resulted in a number of challenges, including:

- Lack of clear expectation setting in relation to trial design, including definitions of trial types and trial activity types, the extent of support to be provided to navigator service users and reporting arrangements
- Lack of opportunity for partner organisations to undertake the necessary scoping activities to identify local organisations with which to engage, and to avoid duplication of existing services
- Delayed commencement for many trials, and a slow ramp up in navigator service user numbers.

Partner organisations reported that a lack of centrally-developed resources (such as information sheets, presentations, and promotional materials) hampered their ability to get up and running quickly, and diverted time from navigation service provision. This was a particular challenge for partner organisations that did not have a background in aged care.

While the Information hub, Community hub and SSW trials were originally conceptualised as 3 distinct trial types, in reality there continues to be considerable blurring of the boundaries between the trial types.

While a number of governance groups, forums and communities of practice were set up to support implementation of the trials, these groups have met less frequently than planned, which has arguably resulted in less consistent trial oversight, and a less collaborative approach to implementation than intended.

⁵ The total number of recipients includes 315,442 people from quarter 8, of which 201,547 'received' Group trial activities delivered by mass communications (via email and/or websites).

The onset of the COVID-19 pandemic and associated restrictions created a range of challenges, which partner organisations responded to with resilience and pragmatism.

COVID-19 resulted in a shift in the types and modes of trial activities delivered by the trials, with more Individual activities occurring via telephone, (rather than face-to-face) and an overall reduction in the number of Group trial activities. COTA Australia encouraged partner organisations to conduct 'welfare checks', which were found to be useful in identifying unresolved issues. Partner organisations reported providing advice and support to people who wished to move family members out of residential aged care settings during the height of the pandemic, and then back in once the risk had subsided.

The modes of delivery of the redefined trial activity types (reported from the eighth quarter of trial delivery [September 2020]) followed a similar pattern to above, although overall increases in the quantum of trial activities – and particularly Individual trial activities – were observed towards the end of 2020.

Partner organisations found the data collection and reporting requirements to be onerous. The extension to the trials created an opportunity to streamline these processes, by removing some data variables in the COTA Australia data set, and the development of a modified short-form survey for navigator service users.

Early indications show that the general improvements in quality and completeness observed in the data set over time were replicated in the refined data set. Further, much of the modified short-form survey data was of higher quality, more complete and more representative than data collected via previous survey tools.

However, overall, the quality and completeness of data submitted by partner organisations remains sub-optimal. That said, the observed challenges with COTA Australia's data management processes do appear to have been addressed.

Partner organisations felt well supported by COTA Australia's National Coordinator, but questioned if the role was adequately resourced to support 64 trials. In late 2020, COTA Australia recruited an additional staff member to assist with data collection and reporting, along with other project management functions. This additional support should help COTA Australia to take a more streamlined and proactive approach to communication with partner organisations.

A number of partner organisations reported delays in the process of negotiating contracts for the extension of the trials, and in receiving contract variations. This was reported to have led to interruptions in service delivery in some instances. Improved communication between the Department, COTA Australia and partner organisations, as well as longer timeframes, may have improved the re-contracting process.

Recruitment, retention and ongoing training of paid staff and volunteers was a challenge during early implementation but has stabilised over time. While some partner organisations expressed concerns about the use of volunteers, many (notably those focused on 'CALD' populations) have developed effective approaches to working with volunteers, such as the use of 'community champions'.

Broadly speaking, the partner organisations that were able to implement the trials most effectively were larger, had experience of working in the aged care sector, and had pre-existing linkages with the target populations.

The Advocates as Agents pilot has been welcomed as a positive initiative by participating partner organisations.

Appropriateness

Given the limitations of the trial activity data collected and reported by partner organisations, including the quality of long-form and original short-form survey response information, previous findings in relation to trial appropriateness – and particularly in relation to the trials' target populations – should be interpreted with caution.

However, the trial-wide adoption of the modified short-form survey provided an opportunity to build on – and strengthen – the quality, completeness and representativeness of navigator service user feedback on the trials' appropriateness, including in relation to different target populations.

Overall, survey responses and consultations with navigator service users indicated they were highly satisfied with the service they received. This feedback was consistent across Information hubs, Community hubs and SSW trials and across trial activity types.

Navigator service users considered partner organisations to be trusted supports, with the majority indicating that they would recommend the trials' services to others.

Modified short-form survey feedback suggested that in-person and individualised trial activities – such as those typically delivered by the SSW trials – may be preferable for some navigator service users. This may reflect the higher-intensity support associated with this type of trial activity, and/or the fact that this type of support doesn't require the navigator service user to have access to technology and/or technical know-how.

Few, if any, meaningful differences were observed between different 'target populations', with any observed differences likely to be an artefact of low numbers. Where positive response rates were observed to be lower, this tended to be driven by higher levels of neutral, rather than negative, feedback reporting.

The one potential exception to this was responses from 'CALD' individuals – one of the most highly represented groups in the modified short-form survey pool of respondents. This group reported proportionately more negative responses compared to other similarly sized groups, albeit still at a very low rate of <1%.

More broadly, across the trials, 'Social isolation or at risk of social isolation' was the most commonly reported vulnerability. CALD was the most commonly reported diverse group.

A relatively high proportion of navigator service users were already receiving aged care services, which indicates that ongoing support is required even once individuals are 'in the system'. This finding was supported by case study examples of navigator staff supporting individuals to arrange reassessments, follow up on referrals, address concerns with quality of care, and provide linkages to other services.

According to trial profile documentation reported by partner organisations and vulnerability and diverse group information reported in the COTA Australia data set, some target populations may be underrepresented in the trials. This may point to need for more focused and proactive efforts by partner organisations to engage with particular groups.

Effectiveness

The vast majority of navigator service users who responded to the trial surveys reported that their participation in trial activities had improved their knowledge of the aged care system and how to access it, and they felt more confident in accessing services. This finding was supported by (limited) qualitative data from consultations with navigator service users.

It is not possible to establish, based on quantitative data, if the reported changes in knowledge and confidence have improved ease of access to aged care services, due to the short timeline of the trials and the evaluation. However, case study examples demonstrate several instances where trial staff were able help put aged care services in place more quickly than would otherwise be possible, by following up with My Aged Care and contacting service providers directly to enquire about waiting lists.

Based on available quantitative data, it is not possible to establish meaningful differences in the effectiveness of trials between original or redefined trial activity types, modes of delivery or target populations. According to partner organisations, face-to-face engagement (often over multiple occasions) and outreach are important to addressing the needs of individuals who are particularly vulnerable. Group sessions were seen as a positive way to engage individuals in a discussion about aged care and were considered particularly effective if followed up with a session of individual support to address specific needs or questions.

Referral data shows that navigator service users are often referred *back* to the same trial, suggesting that additional sessions or visits may be needed to address unresolved issues. Referrals were rarely made to trial types (ostensibly) offering lower-level supports.

As noted previously, the relationship between the COTA Australia-led trials and other existing supports does not appear to be well-defined. While there are examples of positive working relationships between the trials and other existing navigator services, more work is required to ensure that the trials complement and do not duplicate other services or supports. This could include efforts to ensure that the partner organisations, the RAS and ACAT assessment workforce, and My Aged Care have a shared understanding of the scope and role of the COTA Australia-led trials.

Despite the best efforts of trial staff, the ongoing issues with availability of aged care services remained a significant barrier to the effectiveness of the trials – several partner organisations expressed frustration that they were ‘navigating to nowhere’. The main unintended consequence was that the trials raised navigator service users’ expectations of receiving services more quickly than may be possible.

Despite these challenges, a range of positive outcomes were demonstrated, including preventative benefits (e.g. by identifying and addressing issues earlier, thereby avoiding further deterioration of health), and improved wellbeing.

Cost-effectiveness

The Interim Report noted that a range of program and data limitations have hampered the ability to reliably establish the cost-effectiveness of the trials. However, a subsequent sub-analysis – based on a subsample of higher quality trial data – provided an opportunity to more reliably assess trial costings and, to a limited degree, their cost-effectiveness.

Commonwealth funding for the COTA Australia-led trials to June 2021 was \$11 million.

Using an adjusted time period of October/November 2019 – when the trials were arguably operating at, or near, full capacity – the overall estimated budget per navigator service user presenting at the trials was \$61, ranging from \$47 for Community hubs, to \$153 for Integrated Information hub/SSWs (based on original analyses of the full COTA Australia data set).

As expected, Group trial activities appeared to be associated with higher throughput, a lower estimated budget per navigator service user, and less intensity of support, compared with Individual trial activities (based on original analyses of the full COTA Australia data set).

From the sub-analysis, the actual estimated cost of delivering a Group trial activity was \$168, which increased to \$180 when in-kind costs were factored in. The equivalent estimated costs for delivering an Individual trial activity were \$139 (actual) and \$238 (total).

'Seminars' were the costliest Group trial activity to deliver (\$609 [total]) with 'Distribution of tailored information' the least costly (\$50).

When factoring in attendance at Group trial activities – and depending on calculation method – the estimated total cost per navigator service user was \$13 or \$24. Where the quantum/quality of supporting data permitted more robust analyses, the per navigator service user costs were \$22 for 'Group support by a staff member', \$17 for 'Seminars', \$15 for 'Outreach', and \$7 for 'Distribution of tailored information'.

The actual costs associated with delivering Group trial activities reported by Community hubs were generally higher compared to those of Information hubs (and SSW trials [where information available]) and were compounded by the addition of large in-kind costs.

In-person delivery of Group trial activities was the least costly option (\$148) compared to telephone (\$161) or online (\$2,500) modes, and when attendance was factored in, cost \$24 per navigator service user.

The actual estimated cost of delivering an Individual trial activity was \$139 which increased to \$238 when in-kind costs were factored in.

The total costs for Individual trial activities ranged from \$2,301 for 'Outreach' down to \$228 for 'Assistance with form filling/Distribution of tailored information'.

The actual costs associated with delivering Individual trial activities reported by Community hubs were much lower compared to other trial activity types, and, again, were compounded by the addition of large in-kind costs.

The actual and total costs of Individual trial activity delivery reported by the SSW trials were observed to be considerably higher compared to the Information hubs and Community hubs.

Unlike Group trial activities, in-person delivery of Group trial activities was the most costly option (\$204 per navigator service user) compared to telephone (\$141) or online (\$49).

3.2 Introduction

This chapter addresses the following evaluation questions in relation to the COTA Australia-led trials:

- Has each trial been implemented as planned?
- What lessons can be learned from the implementation of each trial?
- How appropriate was each trial in meeting the needs of navigator service users (i.e. aged care consumers, carers and their families [particularly those who need additional support to understand, choose and access aged care services])?
- Who are the trials reaching (and who may not be reached)?
- To what extent are the trials achieving their intended outcomes? What are the:
 - Enablers and barriers to success?
 - Unintended outcomes (positive/negative)?
- How cost-effective is each trial?
- What are the opportunities to enhance each trial?

This chapter is based on analysis of the following types of data sources:

- Contractual materials
- Trial profile information
- Quarterly progress reports, including data extracts from the COTA Australia data set⁶
- COTA Australia governance materials
- Consultation data
- Other data sources.

3.3 Overview of trials

COTA Australia – a well-recognised national aged care consumer peak body whose purpose is to promote the rights, interests and positive futures of Australians as they age – was selected as the successful tenderer to lead trial delivery, by the Department in December 2019.

With established links to a range of organisations across the country, including advocacy and/or special needs-specific groups, COTA Australia is leading a consortium of 30 partner organisations⁷ to deliver the Information hub, Community hub and SSW trial programs, as shown in Table 3-1. Sixty-four trials commenced on 28 February 2019⁸ and are due to conclude on 30 June 2021.

⁶ Eight quarterly extracts of data from the COTA Australia data set were available to inform this report (spanning trial delivery from February 2019 to November 2020, inclusive). A full list of data sources is presented in Appendix B.

⁷ 29 partner organisations are responsible for delivering the trials, with the remaining partner organisation (FECCA) supporting the CALD Community of Practice (CoP).

⁸ The 2 Integrated Information hub/SSW trials were established later in 2019.

Partner organisations are providing free and independent information to individuals/groups who present at the trials ('navigator service users') about aged care, through a range of trial activities and delivery modes, including:

- Seminars
- Distribution of tailored information
- Assistance with form filling and application processes
- Outreach services
- Individual or Group support by a (paid) staff member
- Individual or Group peer support by a volunteer.

The 3 primary types of trial types – Information hub, Community hub and SSW – were identified by the Department in the original request for tender (RFT) documentation and subsequently further developed by COTA Australia. However, as highlighted in the Interim Report, there has been considerable variation in how partner organisations have interpreted and delivered each trial type, and, for organisations delivering multiple trials, there has sometimes been substantial blurring of boundaries between trial types.

For these reasons, the evaluation also focused on the impact of *different trial activity types* (e.g. 'Seminar' delivery, 'Individual support by a staff member', etc.) rather than the trial types per se. However, in some cases, partner organisations *also* had differing interpretations of the trial activities they delivered, notably that of 'Outreach', which created additional challenges for drawing robust conclusions, particularly around the trials' effectiveness.

Table 3-1: COTA Australia-led trial types

Trial type	Description of planned support offerings
Information hubs (n=32)	<ul style="list-style-type: none"> • Led by paid staff with aged care expertise, where required • Locally targeted information to build capacity to engage with the aged care system • Moderate intensity of support, including a mix of one-on-one and group support/educational activities
Community hubs (n=21)	<ul style="list-style-type: none"> • Primarily volunteer-led • A broader focus on healthy ageing as well as navigating aged care • Least intensive level of support
SSWs (n=9 [6 FTE])	<ul style="list-style-type: none"> • Paid staff with aged care expertise • One-on-one support • Most intensive level of support • A specific focus on people who are vulnerable, including outreach services that actively seek out the target population
Integrated Information hub/SSW trials (n=2)	<ul style="list-style-type: none"> • Combination of Information hub and SSW trial offerings

3.3.1 Partner organisations and trial types

The 29 partner organisations subcontracted by COTA Australia to directly deliver the 64 trials are described below, along with additional delivery partners used to support trial delivery (where applicable).

The selection of partner organisations by COTA Australia aimed to achieve representation across every state and territory, with a mix of urban and regional/rural settings, a focus on different 'target populations' and a variety of trial approaches. The organisations range from small, community-based organisations to larger, more established organisations with variable *baseline* levels of experience in the aged care sector. (Note: information presented below is based on partner organisations' updated trial profile documentation, submitted for the trial extension period (1 July 2020 to 30 June 2021)).

Virtually all of the 64 COTA Australia-led trials planned to continue trial delivery in *broadly similar* ways in the extension period compared to original trial delivery (albeit with some top-level modifications [shown in italic text]). The one exception was the Information hub being run by National LGBTI Health Alliance, which moved locations from the Northern Territory to the ACT and engaged a suite of new delivery partners.

Note: information in italic text denotes new or updated trial delivery partner and/or trial location information reported by partner organisations, in updated trial profile documentation for the trial extension period.

ACT Disability, Aged and Carer Advocacy Service (ADACAS)

ADACAS is a non-government human rights organisation that provides free advocacy and information to people with disabilities, those experiencing mental ill-health, older people and carers.

ADACAS is the ACT provider for both the NACAP and the NDAP.

1 Community hub:

- ACT state-wide (and Queanbeyan NSW)

Advocare Incorporated

Advocare is an independent, community-based not-for-profit organisation that supports and protects the rights of older people in Western Australia through information, advocacy and education.

It has a 20-year history of supporting vulnerable older people across WA by delivering the NACAP program, the former Home and Community Care (HACC) advocacy & education program and the WA Elder Abuse Helpline. Advocare chairs the WA Alliance for the Prevention of Elder Abuse.

1 Information hub:

- Metro WA – Greater Perth

1 SSW

- Metro WA – Greater Perth

2 Integrated Information hub/SSW trials

- Rural WA – Mid-West region
- Rural WA – North West region

Aged and Disability Advocacy Australia (ADAA)

ADAA is a not-for-profit, independent, community-based advocacy and education service. ADAA is headquartered in Brisbane but provides services to communities across Queensland. ADAA is the Queensland service delivery organisation for Older Persons Advocacy Network (OPAN), delivering the National Aged Care Advocacy Program (NACAP) and Elder Abuse Advocacy. ADAA also receives funding for the National Disability Advocacy Program (NDAP).

1 Information hub

- Regional Qld – Wide Bay

Aged Rights Advocacy Service Inc. (ARAS)

As South Australia's NACAP provider, ARAS helps people to understand aged care services and supports older people or their representatives with information, education and advocacy support in relation to their rights and aged care entitlements.

1 Information hub

- Regional SA and Adelaide (Metro North)

1 SSW

- Regional SA and Adelaide (Metro North)

Agelink Consulting

Agelink Consulting, based in South East Queensland, offers fee-for-service support to individuals in choosing and organising aged care (both residential and home-based) in order to achieve the best outcomes possible.

*Note: Agelink Consulting has engaged COTA Queensland as a partner to support delivery of their trial.

1 Community hub*

- Rural Qld

Brisbane South PHN Ltd

Brisbane South PHN covers 4 local government areas and is Queensland's largest PHN (by population). It works with a range of primary health care services, health professionals, service providers and the community to enhance the efficiency and effectiveness of services for patients, particularly those at risk of poor health outcomes.

Brisbane South PHN provides support services and workforce development initiatives, works with primary care practices to use eHealth systems, identifies and addresses health service gaps and purchases or commissions health services for local groups in need.

*Note: Brisbane South PHN has engaged the following partners to support delivery of their trials:

- Ethnic Communities' Council of Qld (all trials except the SSW trial)
- The Donald Simpson Community Centre (Information hub and Community hub trials in Cleveland)

- Logan Central Community Centre/Local Area Committee on the Ageing (Information hub and Community hub trials in Logan)
- Aged and Disability Advocacy Australia (mobile Information hub trial).
- *Inala Community House (Information hub and Community hub trials in both Cleveland and Logan)
- *Institute for Urban Indigenous Health (Community hub trial in Cleveland)

2 Information hubs*

- Metro Qld – Logan region
- Metro Qld – Cleveland region

2 Community hubs*

- Metro Qld – Logan region
- Metro Qld – Cleveland region

1 mobile Information hub*

- Metro Qld

1 SSW*

- Metro Qld

Chung Wah Association

The Chung Wah Association is the largest and most established Chinese organisation in Western Australia.

Chung Wah has been delivering community care programs for seniors, their family members and ethnic communities since 1909. The Chung Wah Community and Aged Care (CAC) group currently provides around 800 clients with support and services delivered by professional bilingual staff, support workers and volunteers. CAC is funded by the CHSP, the Home Care Packages (HCP) program, the National Disability Insurance Scheme (NDIS) and the Community Visitors Scheme (CVS).

1 Community hub

- Metro WA – Greater Perth

Co.As.It. Italian Assistance Association

Co.As.It. is a major provider of services to the Culturally and Linguistically Diverse (CALD) community. Co.As.It. currently provides language classes, an independent bilingual primary school and a range of community services, including aged care (private home help services and social support groups as well as government-funded HCP and CVS services).

Co.As.It. is an active member of the Positive CALD Ageing Network (PCAN).

1 Information hub

- Metro NSW – Greater Sydney

COTA ACT Inc.

COTA ACT is the peak organisation for all issues relating to older Canberra citizens, seniors, those of mature age and their families.

COTA ACT provides advice and referrals to individuals on a wide range of issues through their Seniors Information Service, which includes a telephone information and referral service and a resource library (housed in a community centre).

1 Information hub

- ACT Metro (and Queanbeyan NSW)

COTA NSW Inc.

COTA NSW, an independent, consumer-based non-government organisation, is the peak organisation for people aged over 50 in NSW.

COTA NSW develops and delivers a range of programs that aim to make a practical contribution to the lives of older people.

COTA NSW is a leading member of the NSW Ageing Alliance, which comprises over 25 organisations and was established to promote the needs, rights and interests of all people in NSW aged 50 years and over.

1 Information hub

- Metro NSW – Greater Sydney

1 Community hub

- Metro NSW – Wollongong/Illawarra

COTA NT Inc.

COTA NT is the peak body for older Australians living in the Northern Territory. It works to achieve wellbeing and social justice for older people through its events calendar, coordination of the NT seniors card, the Multicultural Affairs Sponsorship Program, and PICAC program.

1 Information hub

- NT state-wide

1 Community hub

- NT state-wide

COTA Qld Inc.

COTA Qld is a state-wide not-for-profit organisation advancing the rights, interests and futures of people as they age.

COTA Qld has run a peer education program for over 20 years, delivered by specially trained older people to other older people in their communities.

COTA Qld is funded by the Australian Government to deliver Sector Support and Development services and by the Queensland State Government to deliver Information, Education and Training Activities.

1 Community hub

- Regional Qld – Wide Bay

COTA SA Inc.

COTA SA is the peak body for older people in South Australia.

COTA SA offers many services and programs for older people, including an exercise initiative, peer education centre, active program of workshops in Adelaide and regional areas, individual consultations for older people requiring assistance in a range of activities, a member rewards program and an annual arts and community festival.

COTA SA provides a My Aged Care Support Program, with support from the Country SA PHN and the Australian Government Department of Health (see Appendix E), and Maximising My Independence (CHSP and My Aged Care information sessions funded by the Department of Health).

COTA SA also provides CVS services, and specialises in matching Lesbian Gay Bisexual Transgender Intersex (LGBTI) visitors and elders. It is also the SA partner for the (government-funded) Silver Rainbow LGBTI Aged Care Awareness Training Project.

1 Information hub

- Rural SA – Country SA

1 Community hub

- Metro SA – Adelaide

1 SSW

- Metro SA – Adelaide

COTA Tasmania Inc.

COTA Tasmania developed and delivered the Aged Care Know How Program through its CHSP Sector Support and Development funding. The program consists of a suite of information and support from a consumer perspective for people accessing aged care services at home (CHSP and HCP program).

*Note: COTA Tasmania has engaged Working It Out as a partner to support delivery of their Community hub trial.

2 Information hubs

- Metro Tas – Hobart
- Metro Tas – Launceston

1 Community hub*

- Tas state-wide

1 SSW

- Tas state-wide

COTA Victoria Inc.

COTA Victoria is the leading not-for-profit community organisation representing the interests and rights of people aged 50 and over in Victoria. COTA Victoria engages with older people through a range of activities including community information and education sessions, e-news and social media. COTA Victoria delivers the Seniors Rights Victoria service, which provides legal aid and support, advice, and education to prevent elder abuse and protect the rights of older Victorians.

- Outlook Community Centre (Community hub trial)
- Older Men: New Ideas Groups (Community hub trial)
- City of Greater Dandenong including their Positive Ageing Advisory Committee (Information hub trial)
- Ethnic Communities Council of Victoria (Information hub trial)
- Southern Migrant Refugee Centre (Information hub trial)
- Enliven Primary Care Partnership (Information hub trial)

1 Information hub*

- Metro Vic – Dandenong

1 Community hub*

- Metro Vic – Casey Cardinia

1 telephone Information hub

- Vic state-wide

*Note: COTA Victoria has engaged the following partners to support delivery of their trials:

COTA WA Inc.

Since 2004, COTA WA has had extensive experience with working with volunteers to provide community education through information sessions (via interactive seminars), and delivering community-based seminars to older Western Australians.

Current COTA WA programs include areas of computer classes and online safety, seniors week awards and grants, and active ageing initiatives.

1 Information hub

- Metro WA – Greater Perth

1 Community hub

- Metro WA – Greater Perth

Dementia Australia Limited

Dementia Australia is the peak, non-profit organisation for people living with dementia, their families and carers, representing 459,000 Australians living with dementia and the estimated 1.6 million people involved in their care. Programs and services include a library service, counselling, education and support (in-person, telephone and online), carer support and public awareness activities.

2 Information hubs

- Regional NSW – Newcastle and Hunter regions
- Metro WA – Greater Perth

2 SSWs

- Regional NSW – Newcastle and Hunter regions
- Metro WA – Greater Perth

Elder Rights Advocacy

As Victoria's NACAP provider, Elder Rights Advocacy provides aged care information and individual advocacy services for older people, their families and representatives. Other services include an elder abuse prevention and response service, and community education about aged care topics.

Elder Rights Advocacy is funded to provide the CVS across Victoria.

1 SSW

- Vic state-wide

Institute for Urban Indigenous Health Ltd (IUIH)

IUIH leads the planning, development and delivery of comprehensive primary health care services to the Indigenous population of South East Queensland and integrates 4 community-controlled health services in South East Queensland.

IUIH Home Support provides household and social support services to help Aboriginal or Torres Strait Islander people aged 50 or over maintain their independence and improve their quality of life.

IUIH Connect provides support with a focus on transitions, e.g. at hospital entry and discharge, and in transit from primary care (in and out of outpatient specialist and allied health services); rehabilitation; mental health; and other specialised services.

IUIH also provides support in understanding and accessing services through the NDIS.

4 Information hubs*

- Qld – Cabool region
- Vic – Bendigo region
- Vic – Mildura/Swan Hill region
- Qld – Brisbane South

3 Community hubs*

- Qld – Cabool region
- Vic – Bendigo region
- Vic – Mildura/Swan Hill region

1 SSW

- Qld – South East

*Note: IUIH has engaged the Bendigo District Aboriginal Cooperative and the Mallee District Aboriginal Service as partners to support delivery of their Information hub and Community hub trials in Bendigo and Mildura/Swan Hill, respectively.

Migrant Resource Centre (MRC) (Southern Tasmania) Inc

MRC is a not-for-profit organisation that provides targeted services to meet the needs of migrants, humanitarian entrants and refugees living in Tasmania. Its services include support for older people and specialised settlement services, including youth work, health and wellbeing services, community development, migration support, and assistance with employment.

MRC provides HCP services, social support groups, day centre programs and 'client workers' to help individuals access assistance with housework, personal care, meals, outside activities, transport, medical, legal and welfare issues and advocacy.

Tasmania's PICAC officer is based at MRC, and the organisation also provides the Australian Government's Humanitarian Settlement Program across the state.

1 Information hub

- Tas state-wide

1 Community hub

- Tas state-wide

Multicultural Communities Council of Illawarra Incorporated (MCCI)

MCCI is a peak body and niche community organisation focused on advocating and representing the interests of CALD communities, and delivering services to meet community needs. MCCI – also the PICAC organisation in NSW – is funded by the Commonwealth to provide CHSP and HCP, and provides a range of other aged care services including in-home respite, social support, meals on wheels, carers and dementia support programs.

*Note: MCCI has engaged the following partners to support delivery of their Information hub trial:

- Aged Care Assessment Team – Illawarra Shoalhaven Local Health District
- Carers Program – Illawarra Shoalhaven Local Health District
- Dementia Advisory Services
- Financial Services – Services Australia
- Greek Community Services
- Italian Social Welfare
- Kiama City Council
- Macedonian Social Welfare
- Multicultural Health Services
- Spanish And Latin American Community Organisation
- Shellharbour City Council

1 Information hub*

- Regional NSW – Illawarra region

1 Community hub

- Regional NSW – Illawarra region

National LGBTI Health Alliance

The National LGBTI Health Alliance is the national peak health organisation in Australia for organisations and individuals that provide health-related programs, services and research focused on LGBTI people and other sexuality, gender, and bodily diverse people and communities.

Its Silver Rainbow program, funded by the Department of Health, provides national coordination and support activities promoting the wellbeing of LGBTI elders and the ongoing delivery of LGBTI awareness training to the aged care sector.

*Note: The National LGBTI Health Alliance has engaged the following partners to support delivery of their Information hub trial:

- Westlund Counselling
- Northside Community Service
- Community Options
- A Gender Agenda
- Health Care Consumers Association of the ACT
- St Andrews Village Residential Aged Care Facility
- Sexual Health & Family Planning ACT

1 Information hub*

- ACT state-wide (and Queanbeyan NSW)

1 Community hub

- Metro WA – Greater Perth

Northeast Health Wangaratta (NHW)

NHW is a Victorian health service providing health care to people across North East Victoria. NHW's hospital has a 24/7 emergency department and offers an extensive range of emergency health care services, and the organisation also has its own residential aged care facility.

*Note: NHW has engaged the following partners to support delivery of their trials:

- Gateway Health
- The Rural City of Wangaratta
- COTA Victoria
- Urban Indigenous Health Ltd in regional Victoria
- Housing for the Aged Action Group
- Sunraysia Mallee Ethnic Communities Council Inc.

1 Information hub*

- Rural Vic – Wangaratta

1 Community hub*

- Rural Vic – Wangaratta

Older Persons Advocacy Network (OPAN)

OPAN is a national network of the 9 funded NACAP providers. OPAN aims to provide a national voice for aged care advocacy, and promote excellence and national consistency in the delivery of advocacy services under that program.

1 online Information hub*

- National

*Note: OPAN has engaged the following partners to support delivery of their trial:

- State specific based advocacy agencies such as ADAA within the OPAN network
- One Contact

Seniors Rights Service Limited (SRS)

SRS is a community organisation dedicated to protecting and advancing the rights of older people, particularly vulnerable and disadvantaged groups.

It provides free and confidential telephone advice, aged care advocacy and support, legal advice and rights-based education forums to seniors across New South Wales.

SRS receives funding through the NACAP program.

2 Information hubs

- Metro NSW – Inner Sydney and Wollongong
- Regional NSW – Dubbo

1 Community hub

- Regional NSW – Dubbo

Sunraysia Mallee Ethnic Communities Council Inc. (SMECC)

SMECC is the CALD peak body within North West Victoria. SMECC provides advocacy and support to CALD communities in its area.

It runs a number of community programs and supports including resettlement support, employment support and adult education.

*Note: SMECC has engaged the following partners to support delivery of their trial:

- Swan Hill community issues group
- Robinvale District Health Services

1 Information hub*

- Regional Vic – Mildura and Swan Hill region

The Housing for the Aged Action Group Inc. (HAAG)

HAAG is the only Australian organisation specialised in the housing needs of older people. It is involved in a range of projects, including those targeting homelessness in the aged care context.

HAAG's service delivery arm – Home at Last – provides information, referral and outreach services to older people at risk of homelessness, and assists them with accessing long-term affordable housing. Home at Last receives CHSP funding through the Assistance with Care and Housing sub-program. HAAG also provides retirement housing information, advocacy and advice.

1 Information hub

- Metro Vic – Melbourne

Umbrella Multicultural Community Services Inc.

Umbrella Community Care provides aged care services for the Perth metro area and regional WA, offering more than 20 culturally diverse aged care services to help individuals stay connected and maintain independence. Umbrella's focus is supporting people from CALD backgrounds and the LGBTI community. It delivers support through HCP, CHSP and the CVS.

1 Community hub

- Metro WA – Greater Perth

UnitingSA Ltd

UnitingSA is a not-for-profit organisation that provides housing, aged care, employment and training support, disability support and other community services to support people across regional and metro South Australia.

It is a major provider of residential aged care services in Adelaide and also provides home care, respite care and retirement living communities.

Its Ethnic Link Services program provides support (in 20 languages) to help people from non-English speaking backgrounds remain living independently in the community.

1 Information hub

- Metro SA – Adelaide

3.3.2 Target populations

As outlined in the contract between the Department and COTA Australia, the trials are broadly aimed at supporting individuals who:

- Need additional support to understand, choose and access aged care services
- Have difficulty engaging through existing channels
- Have not yet accessed aged care services.

However, it is important to note that individuals who do not meet the above criteria are also able to receive support from the trials.

Further, the COTA Australia-led trials also target certain *sub-populations*.

Population groups facing challenges when accessing and navigating aged care services:

- Aboriginal or Torres Strait Islander people
- People from CALD communities
- People who identify as LGBTI
- People who live in rural or remote areas
- People with limited access to technology or people with limited computer literacy
- People who have special website accessibility requirements, such as people with a vision impairment.

Target populations who are considered vulnerable:

- People who are financially or socially disadvantaged
- People who are socially isolated or at risk of social isolation
- People who are homeless or at risk of becoming homeless
- Care leavers
- People separated from children by forced adoption or removal
- People with a disability
- People with cognitive impairment, including dementia
- People with mental health challenges
- Veterans.

3.4 Findings: Implementation

This section presents evaluation findings in relation to the implementation of the COTA Australia-led trials.

It is important to acknowledge that when trialling innovative new programs – such as those delivered under the ACSN Measure – implementation challenges are expected, which have occurred during delivery of the COTA Australia-led trials.

As previously described in detail, the short lead time for establishing the trials had many knock-on impacts to longer-term implementation of the trials throughout 2019. Further, the onset of the COVID-19 pandemic in early 2020 had a substantial impact on delivery of trial services throughout 2020, particularly in those states/territories that experienced more lengthy periods of restrictions. (Note: further information about the impact of the pandemic on trial delivery, is shown in Appendix C, as well as throughout this section, where relevant).

The overarching implementation challenges outlined above are evidenced by fluctuations in the quantum of trial activities delivered by partner organisations over time, as shown in Figure 3-1. The trials got off to a relatively slow start in the first half of 2019, although started to pick up in mid-year with generally steady increases in the number of trial activities delivered until the end of the year. Following the Christmas/New Year holiday period,⁹ trial activity delivery again picked up in early 2020, followed by a downturn – particularly in Group trial activities – attributable to the COVID-19 pandemic (Figure 3-1).

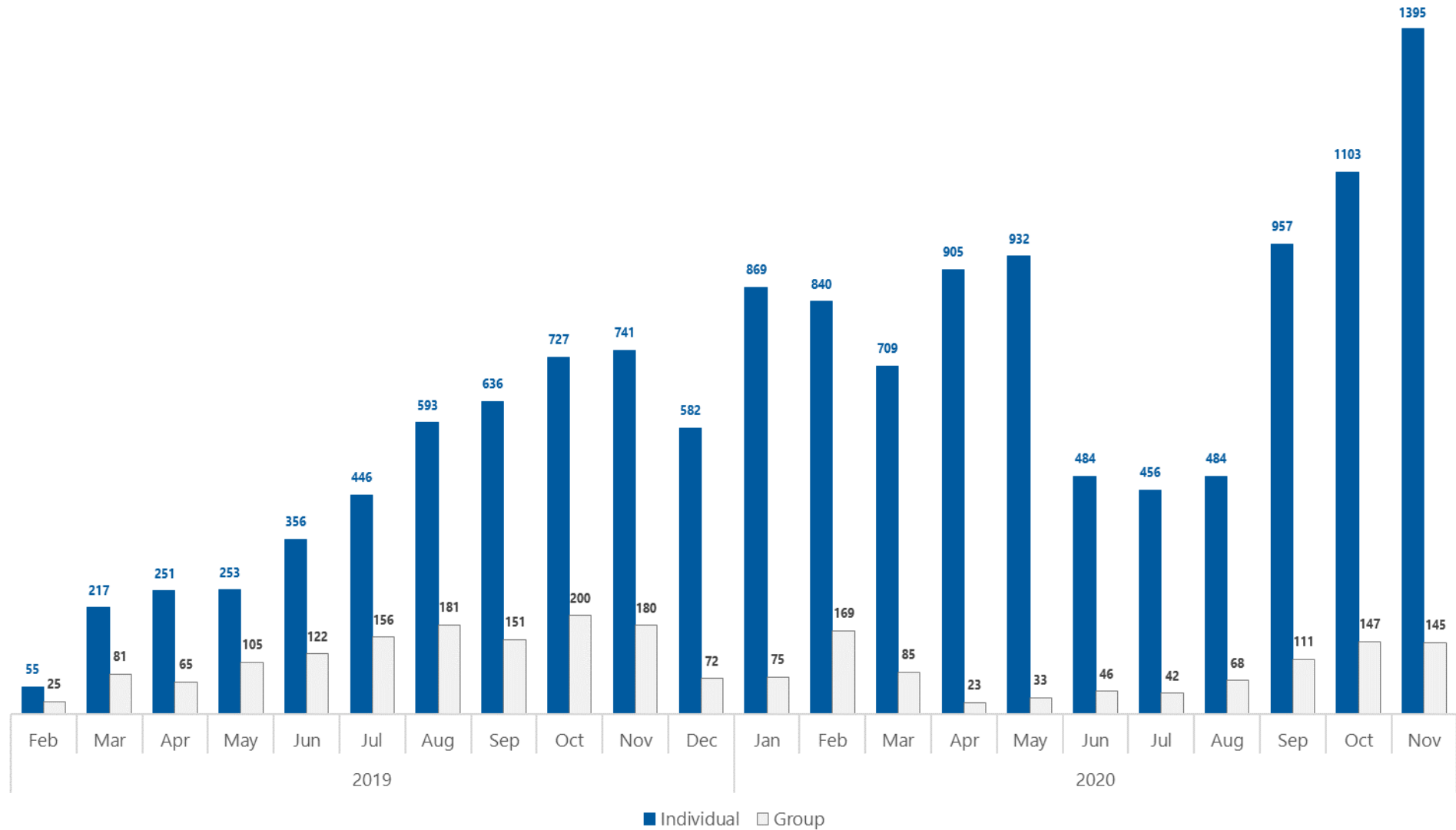
Interestingly, a subsequent bounce-back in delivery of Individual trial activities observed in April and May 2020 was followed by a substantial decrease in trial activities delivered between June and August 2020 (the seventh reporting quarter) (Figure 3-1). The reasons for these marked reductions are unclear, but may, in part, be attributable to:

- The ongoing impact of COVID-19 restrictions reducing trial capacity.
For example, Victoria (home to 12 of 64 trials) was placed back into a lengthy lockdown in July 2020, following an initial easing of restrictions.
- This period coinciding with contract renegotiations for the extension of the trials. A few partner organisations reported a lack of capacity to continue seamless trial delivery during this time (see Section 3.4.1, 'Was each trial delivered within required/planned timeframes? If not, why not?').

However, in September 2020, the quantum of Individual trial activities delivered by partner organisations returned to April/May 2020 levels and continued to increase (Figure 3-1). Indeed, in the final quarter where information was available (quarter 8), a total of 3,478 Individual trial activities – along with 409 Group trial activities – were delivered by partner organisations (see Figure 3-1).

⁹ Note: some trials were further adversely affected by bush fire season around this time.

Figure 3-1: Distribution of Individual and Group trial activities delivered over time, from February 2019 to November 2020



Note: one Group trial activity record reported date of delivery as January 2019 (e.g. before the required contractual start date), which has been omitted.

By November 2020, the 64 trials had delivered 18,132 separate trial activities (reported in a total of 17,842 records of navigation support), to 388,462¹⁰ navigator service users:

- 14,245 *original* trial activities delivered between February 2019 and August 2020 (as presented in the section below [where applicable])
 - 1,921 Group trial activities delivered to 57,508 navigator service users
 - 12,324 Individual trial activities delivered to 12,034 navigator service users
- 3,887 *redefined* (see below) trial activities delivered between September and November 2020 (presented below [where applicable] and as supplementary data in Appendix D)
 - 409 Group trial activities delivered to 315,442 navigator service users
 - 3,478 Individual trial activities delivered to 3,478 navigator service users.

(Note: See Table D-1, Appendix D for more information about the redefined trial activity types introduced in the COTA Australia data set from September 2020 [quarter 8]).

As highlighted in Section 3.4.1, the COTA Australia data set was streamlined in mid-2020, with the modified version adopted for use from September 2020 (the eighth reporting quarter). One of the modifications was revision of the trial activity type categories to more accurately reflect the types of activities the trials are delivering. This change was also aimed at increasing the consistency of reporting across different components of the COTA Australia data set over time.

As indicated above, information presented in this section is generally based on *original trial activity types* reported in the first 7 quarters of trial implementation (e.g. February 2019 to August 2020), unless otherwise stated. Where applicable, additional information related to the *redefined trial activity types* reported in quarter 8 (September to November 2020) is presented in Appendix D.

Table 3-3 shows the number of trial activities delivered to individuals and groups between February 2019 and August 2020, by original trial activity type (see Table D-1 in Appendix D for quarter 8 data in relation to redefined trial activity types; see Figure D-2 and accompanying commentary for the distribution of navigator service users who attended Group trial activities to August 2020 (n=57,508) and to November 2020 (n=372,950).

In line with previous reports, 'Support by a staff member' was again the most common trial activity delivered to individuals (58.8%, n=7,076), while 'Seminar' delivery (35.9%, n=689) and 'Distribution of tailored information' (27.0%, n=518) were the most common trial activities delivered to groups (Table 3-3). Interestingly, the proportions of trial activities reported in the 'Other activity' category had increased substantially compared to the Interim Report, from 4.3% (n=241) overall to 13.9% (n=1,981).

The number of each original trial activity type (Group and Individual combined) delivered by each trial type is shown in Figure 3-2. (Note: see Table D-1 in Appendix D for the equivalent information for redefined trial activity types delivered in quarter 8). Though all trial types reported delivering every kind of trial activity (apart from the 2 Integrated Information hub/SSW trials, which reported no 'Peer support by a volunteer'), the frequency/scale of some activities differed substantially across trial types. Unsurprisingly, the Information hub and SSW trials again delivered by far the highest number of 'Support by a staff member' activities, with the Information hubs also reporting disproportionately more 'Distribution of tailored information' activities (Figure 3-2).

The large increase in the number of 'Other activities' reported by partner organisation (see above) appeared to have been driven by the Community hubs, which reported n=1,562 'Other' trial activities (Figure 3-2), with the vast majority (n=1,498) associated with individual support (data not shown). Previously, the Community hubs had reported just n=86 'Other activities' (from both Individual and

¹⁰ Note: The attendee number was *skewed* by n=315,442 Group trial activity attendees from quarter 8, of which 201,547 'received' Group trial activities delivered by mass communications (via email and/or websites) (see Appendix D).

Group support). The reason for this substantial increase is unclear, but may, in part, reflect the Community hubs' switch toward conducting individual 'welfare checks' (not defined as a separate trial activity in the COTA Australia data set) in response to COVID-19. However, it is important to note that similar differences were not observed in the other trial types, which had similarly planned to conduct 'welfare checks' (see Appendix C).

Table D-2 in Appendix D shows the median durations of Individual and Group trial activities reported in the COTA Australia data set, by trial type (including data from quarter 8). The median durations of individual trial activities were 0.5 hours for the Information hubs, SSWs and Integrated Information hub/SSW trials, and 0.3 hours for the Community hubs. The equivalent durations for Group trial activities were 5.5 hours for the SSW trials, 3.0 hours for Community hubs, and 2.0 hours for the Information hub and Integrated Information hub/SSW trials (Table D-2). (Note: duration information was only recorded for 44.4% [n=1,035/2,330] of Group trial activity records, compared to 96.8% [n=15,016/15,512] of Individual trial activity records).

In line with previous reports – and including data from quarter 8¹¹ – the majority of Group trial activities had been delivered in person: 83.5% (n=1,945), with 10.5% (n=244) delivered online (including via a website or email), 2.7% (n=62) via video call, and 1.1% (n=30) via telephone. The remaining modes of delivery (n=49) were not reported.

For the redefined Group trial activity types delivered in quarter 8, the largest number of attendees – by far – was reported for 'Other' activities: n=310,978 (98.6%). By comparison, the number of attendees reported for other redefined Group trial activities types included n=3,955 (1.3%) for 'Attended a group' and n=378 (0.1%) for 'Received information materials'.

However, on review, just under two-thirds (n=201,547) of all attendees (actual plus estimated) receiving group support in quarter 8 were reported to have received it via the mass media communication mode of 'Information on a website or in an email' (and virtually all for 'Other' trial activity types). It is important to note that this passive trial delivery mode – which navigator service users may or may not choose to engage with – had not been specifically captured in the COTA Australia data set prior to quarter 8, instead falling under the generic category of 'online' if/where it was reported.

As the inclusion of this specific mass media communication mode at quarter 8 has substantially inflated overall reported attendee numbers, it is important to note this point when considering the number of navigator service users supported via Group trial activities, overall, and when making any comparisons of the numbers receiving support pre- versus post-reporting quarter 8.

(Note: see Section D.1.1 in Appendix D for additional commentary around the modes of delivery reported for redefined Group trial activity types, and associated navigator service user attendee numbers [quarter 8 data]).

As reported previously, for Individual trial activities, telephone support had *overtaken* in-person support as the most common mode of delivery: 59.3% (n=9,192) and 24.1% (n=3,732), respectively. The proportion of individual support delivered online, including via a website or email, remained largely unchanged at 15.6% (n=2,422). Very few Individual trial activities were delivered via video call (n=8, [0.1%]).

These findings appear to continue to reflect the *relative ease* of partner organisations making trial activity adaptations in response to the COVID-19 pandemic, and, therefore, their ability to continue delivering trial activities during that time. For example, for Individual trial activities, switching away

¹¹ Note: The options of 'face-to-face' and 'online' trial activity delivery were replaced by 'in-person', 'information on a website or in an email' and 'video call' in the modified COTA Australia data set from eighth round of reporting (September 2020 onwards).

3. Findings: COTA Australia-led trials

from in-person support (to telephone support) was likely to have been fairly straightforward, meaning that trial activity delivery continued *relatively* unaffected, as shown in Figure 3-1. Conversely, the ability to switch Group trial activities away from in-person delivery – to telephone, video calls or other online modes – was likely to have posed a far greater challenge to partner organisations, and led to falls in the delivery of these activities (Figure 3-1).

Table 3-2: Distribution of trial activity types delivered between February 2019 and August 2020

Trial activity	Individual n (%)	Group n (%)	Overall n (%)
Assistance with filling in a form/application process	618 (5.1%)	No data	618 (4.3%)
Distribution of tailored Information	1,258 (10.5%)	518 (27.0%)	1,776 (12.5%)
Outreach	989 (8.2%)	272 (14.2%)	1,261 (8.9%)
Support by a staff member	7,076 (58.8%)	150 (7.8%)	7,226 (50.7%)
Peer support by a volunteer	534 (4.4%)	46 (2.4%)	580 (4.1%)
Seminar	No data	689 (35.9%)	689 (4.8%)
Other activity	1,750 (14.5%)	231 (12.0%)	1,981 (13.9%)
Not reported	99 (0.8%)	15 (0.8%)	114 (0.8%)
Total	12,324	1,921	14,245

Note: some trial activity records reported in the COTA Australia data set contained > 1 trial activity per record, and these have been reported as *separate* activities above. In this table, > 1 trial activity was reported for 2.2% (n=260/12,034 records) of Individual trial activities and 0.0% (n=0/1,921 records) of Group trial activities. See Figure D-2 in Appendices (and accompanying commentary) for the distribution of navigator service users who attended Group trial activities to August 2020 (n=57,508) (and to November 2020 [n=372,950]).

3. Findings: COTA Australia-led trials

Figure 3-2: Distribution of trial activities (Group and Individual combined) delivered between February 2019 and August 2020, by trial type



Note: some trial activity records reported in the COTA Australia data set contained more than one trial activity per record, and these have been reported as *separate* activities above. In this figure, >1 trial activity was reported for 2.2% (n=260/12,034 records) of Individual trial activities and 0% (n=0/1,921 records) of Group trial activities. See Figure D-2 (and accompanying commentary) for the distribution of navigator service users who attended Group trial activities to August 2020 (n=57,508) (and to November 2020 [n=372,950]).

3.4.1 Have the trials been implemented as planned?

The COTA Australia-led trials officially launched on 28 February 2019, just over 2 months after the contract for delivery of the trials was signed. COTA Australia and the Department have acknowledged that the lead time for establishing the trials was short, especially given the number of partner organisations involved and the timing (around the Christmas and New Year holiday period).

That said, COTA Australia's well-established relationships with partner organisations meant they were appropriately placed to support these organisations in the trials' early establishment phase.

Trial implementation was guided by COTA Australia's original *Implementation Approach* (January 2019) and contracts with the Department. COTA Australia's Implementation Plan (September 2020) for the trials' extension period indicated that minimal changes would occur to the broad implementation approach over the final year of trial operations (e.g. 1 July 2020 to 30 June 2021).

Have all components of each trial been implemented?

Governance arrangements

COTA Australia is responsible for the governance of the trials (as detailed in their original *Implementation Approach*), updated Implementation Plan for the extension phase, and contracts with the Department. The main elements of the trials' governance comprise:

- Defined roles and responsibilities
- Oversight, including by governance groups
- Established processes for collaboration and communication between trials.

These are outlined below.

In addition, COTA Australia is responsible for supporting integration within and between partner organisations, as well as with the FIS Officer trials and with existing services. Integration is discussed in more detail in Section 3.6.1, 'What level of integration occurred between the different trials and with existing supports?'

Roles and responsibilities

The Interim Report noted inconsistencies in partner organisations' understanding of their roles and responsibilities, which included:

- Whether the trials were intended to support navigator service users only to the point of registration with My Aged Care, or beyond
- Expectations around the availability of centralised promotional materials – many partner organisations expected more centrally available resources
- Extent of data collection and reporting requirements
- Differences in the interpretation of trial types and trial activity types to be delivered.

It is important to note that these issues have diminished as the trials have progressed. This is perhaps unsurprising as partner organisations have become more confident and assured about the trial offerings they provide, regardless of whether they are truly aligned to the roles and responsibilities as originally conceived.

Oversight

Mechanisms for oversight of the trials include a National Coordinator, as well as a Steering Committee and a Communications and Education Working group. (Although there were also early plans for an Advisory Group for the trials, this did not eventuate due to a lack of nominations.) AHA understands that these groups met less frequently than planned during the first half of 2020, but met more regularly in the latter part of the year.

Collaboration and communication between trials

COTA Australia established 2 main mechanisms for collaboration and communication between trials.

Trial collaboration forums (state/territory-based meetings)

- These have occurred on a relatively informal – and irregular – basis in 2020, with some states and territories participating in combined meetings (for example ACT, Northern Territory and Tasmanian trials in October 2020).
- Some forums have reportedly functioned more effectively than others. For example, trials in Tasmania, South Australia, Western Australia and Queensland reported that their individual state forums have helped with information sharing, making referrals between different trial locations, and avoiding duplication of service delivery.

Communities of practice (CoP)

- Four CoPs were established for the trials, focusing on 3 'target populations' (Aboriginal or Torres Strait Islander, LGBTI and CALD), and one trial type (SSWs).
- Participating partner organisations reported mixed views about the usefulness of the CoP meetings. For example, some organisations with more extensive experience of working with particular 'target populations' reported that they gained little from the meetings.
- Feedback on the CALD CoP was positive, with participating partner organisations appreciative of the involvement of the Federation of Ethnic Communities' Councils of Australia (FECCA) in supporting discussion of implementation challenges. These included access to translators, technology support for navigators (such as mobile phones) and the impacts of COVID-19. It was noted that FECCA was then able to raise these important issues with COTA Australia management in a unified manner.
- During the first half of 2020, the number of CoP meetings dropped off for a range of reasons, including COVID-19 and uncertainty around the continuation of the trials.

As a result of the irregularity of these trial collaboration and CoP meetings in 2020, some partner organisations reported feeling like they were 'on their own', rather than operating as part of a coordinated set of trials. AHA understands that COTA Australia's National Coordinator worked to re-establish more regular meetings for both sets of groups in the latter part of 2020, and led a number of recent meetings.

Currently, it feels like there is less cohesiveness and togetherness than there was at the start of the trials, which I think may be due to [trial personnel] struggling with COVID issues.

– Partner organisation representative

Coordination activities

Central coordination of the 64 trials has been provided primarily through the work of COTA Australia's National Coordinator. Partner organisations have consistently commented on the *helpfulness* and *responsiveness* of the National Coordinator, particularly in relation to support with ongoing data collection and reporting issues, and drafting and finalisation of the documentation associated with the trials' extension.

At the onset of COVID-19 in Australia, the National Coordinator had a central role in disseminating information to partner organisations about how the restrictions may impact trial delivery, and helped guide partner organisations to develop alternative, innovative approaches in response to the pandemic. As mentioned above, AHA understands that the National Coordinator has also been working to *reinvigorate* the trial collaboration forums and CoPs in late 2020, following a slowdown in their meeting schedules earlier in the year (attributable, in part, to COVID-19).

It is important to acknowledge the *extensive scope* of the National Coordinator role in providing day-to-day support to the 64 trials. Indeed, AHA understands that COTA Australia has recently recruited an additional team member to support the National Coordinator. This was, in part, in response to feedback in the Interim Report that the workload could be considered *unmanageable* for a one FTE role, particularly given the need to support ongoing improvements in the quality and completeness of qualitative and quantitative data reporting.

Aside from the National Coordinator role, other mechanisms for supporting coordination, consistency and information sharing between the trials have not been fully realised. For example, *BoostHQ* – an online document sharing platform for partner organisations – was established by COTA Australia in August 2019; however, the utility of this resource has been somewhat limited in 2020.

The platform *was* utilised to good effect at the onset of COVID-19, with the sharing of resources on the use of digital technology/videoconferencing in health and aged care (March 2020), and slides from a COTA Australia webinar about potential trial adaptations that could be considered in response to the pandemic (April 2020). However, at the time of drafting this Final Report (February 2021), these resources still appear to represent the *most recent* additions to the *BoostHQ* platform.

Integration activities

Trial Integration activities can be classified into 4 components:

- Within trials run by a single partner organisation
- Between different partner organisations
- Between partner organisations and other services/organisations
- Between COTA Australia-led trials and FIS Officer trials.

More information about these trial integration components are shown below.

Integration within partner organisations

Movement of navigator service users between co-located trials – for example, an Information hub and a Community hub run by the same partner organisation has been a common feature of the trials. In this way the distinction between trial types is often blurred, and, therefore, can be considered somewhat artificial.

Anecdotal reports also suggest that immediately following a Group trial activity (typically, but not always run by an Information hub trial), navigator service users may go on to access individual support, for example, from a co-attending SSW. (Note: although inward/onward referral information reported in

the COTA Australia data set did not support these anecdotal reports, the rate of reporting referral information was relatively low [see Section 3.6.1, 'What level of integration occurred between the different trials and with existing supports?']).

Integration between different partner organisations

Partner organisations in some states (including South Australia and Queensland) reported having clear processes in place for referring navigator service users between partner organisations. These referrals occurred when navigator service users:

- Lived outside the catchment area of the original partner organisation
- Were from a 'target population' that another partner organisation could better cater for
- Required specific support that was not offered by the partner organisation – such as individual support from an SSW trial.

Conversely, in other states (such as ACT) some partner organisations reported operating in *relative isolation*. However, this was not necessarily seen as a negative point, because these partner organisations felt that they were already providing a comprehensive service to their navigator service users.

We did have a few telephone link-ups at first but I can't remember one since Christmas. It's not really an issue. There didn't seem to be much point in sharing information once we all figured out what we were doing.

– *Partner organisation representative*

Integration with other services

Partner organisations also worked hard to connect with other relevant groups and organisations in the community (as listed in Table 3-4). These connections served to promote the trials, and expand the potential sources for inward referrals of navigator service users to the trials, and destinations for the trials' onward referrals.

Interestingly, during the COVID-19 pandemic, partner organisations reported that they had more direct contact than previously with aged care service providers, including residential aged care services. This was in response to requests from individuals who wished to take their relatives out of aged care homes, due to fears they were at high risk of infection. Trial staff also worked closely with aged care assessment teams to facilitate access to CHSP services to support the residents in the community. This was described by partner organisations as 'reverse navigation'.

Integration with the FIS Officer trials

As described in the Interim Report, integration between the COTA Australia-led trials and the FIS Officer trials had been difficult to realise due to the lack of alignment between the trial programs' respective timelines and locations. Despite this, a number of partner organisations reported that they continued to refer to the FIS even after the conclusion of the FIS Officer trials, noting that many navigator services users required tailored, independent financial information, which they recognised the FIS was ideally placed to deliver.

Table 3-3: Groups and organisations connected with partner organisations

Type	Examples
Aged care assessment workforce	<ul style="list-style-type: none"> • RAS assessors • ACAT assessors
Aged care services and settings	<ul style="list-style-type: none"> • Residential aged care facilities • Retirement villages • CHSP Sector Support and Development Officers* • Community Visitors Scheme*
Peak organisations	<ul style="list-style-type: none"> • Dementia Australia • Queensland AIDS Council*
Community	<ul style="list-style-type: none"> • Aboriginal Elders • CALD community/social groups including Arabic, Chinese, Hungarian, Italian, Indian, Polish, Serbian, Thai, Vietnamese • Drop-in centres/cafes • Libraries • Legal services • Lions groups* • Neighbourhood centres • Probus groups • Returned and Services League (RSL) clubs • Rotary clubs* • Shopping centres • Cemetery trusts • Tai Chi providers • Weight Watchers
Health care	<ul style="list-style-type: none"> • Ambulance services* • Primary Health Networks (PHNs) • Aboriginal Liaison Officers • Community liaison officers • GP clinics • Hospitals (e.g. emergency departments, discharge teams) • Mental health services • Pharmacies
Government departments and services	<ul style="list-style-type: none"> • Centrelink/FIS • DVA • Carer Gateway*
Other	<ul style="list-style-type: none"> • A&S program (Victoria) • Multicultural services • Financial Counsellors* • Local member of parliament offices • Alliance for Forgotten Australians • Bilingual workforce/interpreters • Aboriginal Corporations • Lifeline • Lotus Place (for Forgotten Australians) • Helping Hand (services for Care Leavers)* • Police Services* • Red Cross • Unity Housing

* Denotes additional examples of groups and organisations reported since the Interim Report.

Communication and engagement activities

It has not been possible to establish the community-level awareness of the COTA Australia-led trials, and consultation with stakeholders external to the trials has suggested that general awareness of the trials is limited. Information about trial communication and engagement activities are described below.

National level

Promotion of the trials at a national level has been relatively limited, primarily driven by an understandable reluctance by COTA Australia and the Department to undertake widespread promotion for a program of trials that are not nationally available.

Although COTA Australia developed some fact sheets around the time of trial launch (early 2019), several additional planned resources – including translated information resources and education and training templates – have not eventuated. In the early stage of trial implementation, COTA Australia noted that it would be preferable for partner organisations to use their local knowledge to generate more appropriate resources for use in their communities, rather than rely on centrally-developed materials.

Further, many partner organisations reported that they were not aware of this shift to a decentralised approach, and a number found it particularly resource intensive – and costly – to develop their own local resources (including translations [where applicable]). In addition, some partner organisations reported a reluctance to continue investment in developing resources (or promoting the trials) while there was uncertainty about whether funding would be extended beyond the original trial conclusion date (30 June 2020).

Other components of national-level communications included:

- The development of a postcode look-up function on the ACSN webpages of the COTA Australia website. Originally intended to be made available in 2019, this facility was launched in early 2021.
- The advertisement of the trials by COTA Australia in the DPS¹² Guide to Aged Care publication.
- The engagement of a communications consultant by COTA Australia to develop graphics for social media, factsheet templates and media release templates. These were expected from mid-April but are now expected to be available in early 2021.
- Repeated attempts by COTA Australia to build awareness of the trials with My Aged Care. However, partner organisations have continued to report that many of the contact centre staff at My Aged Care remain unaware of the trials, meaning trial staff are not recognised as legitimate representatives when calling in on behalf of navigator service users. This will need to be addressed when planning the delivery of any future aged care navigation services.

(Note: see Section 3.4.2, 'What worked well when implementing each trial, and what was the positive impact?' for information about the My Aged Care Advocates as Agents pilot.)

Local level

Partner organisations reported conducting a wide range of communication and awareness-raising activities at a local level. In addition to networking with the organisations and services shown in Table 3-4 above, partner organisations developed information leaflets, postcards and flyers, participated in local (ethnic) radio broadcasts, advertised in newspapers and e-newsletters, and participated in seniors' expos. The onset of the COVID-19 pandemic saw a number of partner

¹² Formally David's Publishing Services, the name was subsequently changed to the acronym 'DPS'.

organisations shift to different modes of promotion, including Facebook advertising, and Zoom and YouTube information videos (see Appendix C for more information).

Data collection and reporting arrangements (including technology solutions)

The collection and reporting of data in the COTA Australia data set have been an ongoing – and well characterised – challenge for partner organisations throughout the trials. Indeed, they have consistently reported that the *volume* of data collection and reporting is unreasonably high, given the nature of the trials and the quantum of funding they receive to deliver them. It is also important to note that the bulk of partner organisation data collection and reporting is underpinned by *manual processing* (e.g. via the administration of excel spreadsheets), with the potential risks associated with user error.

We hope the data is getting through – that the right data is being gathered – but it feels to us like we spend many more hours, days and weeks than we might do for other programs, reporting on this trial, asking for clarification, feeling like we’re duplicating information. It feels very messy [and] complicated.

– Partner organisation representative

Although COTA Australia is contractually required to ‘ensure the rigor, accuracy and completeness’ of reported quantitative trial data and qualitative progress information, the quality and completeness of the former has continued to limit the extent to which robust conclusions can be drawn about the trials’ effectiveness (see Section 2.6).

In the first half of 2020, COTA Australia undertook *substantial remediation* work on the COTA Australia data set to rectify data quality issues identified by AHA in earlier rounds of reporting (e.g. quarters 1 to 5). As part of this process, COTA Australia also implemented a suite of strategies to improve the ongoing accuracy, validity and completeness of submitted data, including:

- Automated data checking functions (which were developed in conjunction with an IT programmer, and reflected in updates to the ‘business rules’ for the COTA Australia data set)
- Provision of ongoing support to partner organisations – and orientation for new trial personnel – in relation to data collection, reporting and cleaning
- Automatic reminders to partner organisations to submit their data in required time frames.

Reassuringly, far fewer issues were identified in the COTA Australia data set from the sixth round of reporting (March 2020 onwards), indicating that the above refinements to COTA Australia’s data management strategies had resulted in *sustained improvements* in data quality.

The extension to the trials also provided an opportunity for *streamlining* the COTA Australia data set, with the removal of some data variables that had since been deemed less important to collect for evaluation purposes. Further, the trial activity types were redefined to more accurately reflect the types of activities the trials are delivering:

- ‘Attended a group’
- ‘One-on-one/individual assistance’
- ‘Individual outreach’
- ‘Help with filling out application forms’
- ‘Received information materials’
- ‘Other’.

Redefinition of trial activity types was also aimed at increasing the consistency of reporting across different components of the COTA Australia data set over time. However, it is important to note that the redefinition of trial activity types created some *misalignment* with previous data reported in the COTA Australia data set (see below).

A further refinement to the COTA Australia data set involved the reconfiguration of the 'trial summary' data tab, in order to improve its utility for the reporting of aggregated trial costs and associated resources (see Section D.1.4 in Appendix D).

As part of the extension to the trials – and in response to observed limitations with the original long-form survey tool – a modified short-form survey for collecting navigator service user feedback was also rolled out to all trials from the eighth round of reporting (see Section 3.4.1, 'Have all components of each trial been implemented?' for more information). This followed the successful piloting of an earlier version of the short-form survey with a subsample of partner organisations. During follow-up consultations, partner organisations reported that this simplified tool is less intrusive, more culturally appropriate, and easier to administer, compared to the original long-form survey tool.

The first tranche of data from the modified data set, including short-form survey responses, was collected from quarter 8 (e.g. September 2020) and submitted for evaluation purposes in December 2020. Where appropriate, quarter 8 data have been integrated into the previous analyses and presented as updated findings in the main body of this Final Report.

All remaining findings/information – including stand-alone findings/information from quarter 8 – are presented separately in appendices, as shown below:

- Supplementary information: Appendix D
- Findings from the modified short-form survey: Appendix F.

The trial-wide roll-out of the modified short-form survey also provided an opportunity for COTA Australia to introduce *additional technological solutions* for data collection and reporting. For example, navigator service user responses may now be collected via a printed survey (as before) or an online version, accessed via a link emailed by partner organisations. Responses collected via printed surveys can now be reported directly by partner organisations into a dedicated ACSN survey webpage on the COTA Australia website, while those collected via the online version are automatically uploaded following completion. It is anticipated that these approaches will reduce the risk of errors associated with the manual processing of survey data, and hopefully increase the quality, completeness and, importantly, the *representativeness* of navigator service user feedback from the 64 trials.

Further, COTA Australia's eighth progress report highlighted that hosting the online survey tool on its website (in a non-public area) enhanced data privacy and safety, and allowed partner organisations to administer the tool to navigator service users more effectively.

More broadly, the acknowledged limitations associated with *quantitative* data reporting in the COTA Australia data set has led to a greater focus being placed on the collection of *qualitative* information. In July 2020, all partner organisations were required to submit up to 3 case studies, which was an additional opportunity for them to clearly articulate some specific examples of how their trial delivery approaches had impacted navigator service user outcomes. These case studies, along with those submitted as part of standard quarterly progress reporting, have proven an invaluable resource for the evaluation, highlighting the many successes (and certain challenges) of supporting navigator service users that would otherwise not be captured through quantitative reporting.

(The Department) listened about the (quantitative) reporting and that has improved; the narrative reports have improved significantly.

– *Partner organisation representative*

All types/modes of trial activity

As shown in Table 3-3, a number of different Individual and Group trial activities were delivered by the 64 trials. Through consultations with partner organisations, it became evident that some had differing interpretations of trial activity types. In particular, the definition of 'Outreach' varied across organisations. Some partner organisations considered 'Outreach' to be making connections with community organisations (such as local libraries) to increase local awareness of the trials; some defined it as the direct support of individuals who were socially isolated, while others considered 'Outreach' as conducting activities at a location external to their standard location. As outlined in Section 2.6, these observed inconsistencies have made it difficult to compare the relative effectiveness – and cost-effectiveness – of trial activity types delivered by the trials.

Unsurprisingly, following the onset of the COVID-19 pandemic in Australia in March 2020, many planned trial activities could no longer occur (as evidenced by their impact on delivery in Figure 3-1 above). COTA Australia advised all partner organisations to cease in-person/face-to-face service provision except where urgent and necessary, and to switch to telephone and online modes of delivery, where feasible. Unsurprisingly – and as touched upon above – this led to *reductions* in the delivery of Group trial activities, 'Outreach' (as part of group or individual support), and community engagement activities.

As outlined in Appendix C, many partner organisations used the additional time to conduct *welfare checks* on navigator service users they had engaged with previously.¹³ This new activity was seen by many as an *unexpected positive outcome* of the COVID-19 pandemic, as not all partner organisations routinely followed up with navigator service users following a trial interaction. For example, by conducting welfare checks, new or (previously unknown) unresolved issues could be identified, including instances where individuals had been registered with My Aged Care, but had been left waiting for an assessment.

These welfare checks have been the silver lining of COVID. We have [reviewed] all clients for follow-up and to see how they're going. We would definitely continue the ongoing welfare check approach post-COVID.

– *Partner organisation representative.*

As part of the extension period, partner organisations were required to submit updated trial profile information, which included the number of each type of *original* Individual and Group trial activity they planned to deliver between 1 July 2020 and 30 June 2021. At the time of drafting this Final Report (February 2021), trial activity information was available to November 2020 (e.g. the eighth reporting period). However, the *redefinition* of trial activity types from this latest reporting quarter hampered the ability to quantify planned versus actual trial activity delivery over the trial implementation period to date.

However, it is important to note the substantial ramping up of (particularly Individual) trial activity delivery reported in the eighth quarter, along with partner organisation progress reports, indicating

¹³ Welfare checks were not defined as a separate trial activity type in the COTA data set. Where partner organisations reported these checks, they are expected to have been reported under the category of 'Other (trial) activity'.

3. Findings: COTA Australia-led trials

that most trials were operating at or near full capacity during this period (ongoing COVID-19 associated challenges aside).

John's story

John was an 85-year-old man living in an isolated caravan park. He had no transport and no family for support. The SSW first visited John after referral by his GP in June 2019. John, being a fiercely independent person, declined all services he may have been eligible for.

The SSW reconnected with John during the COVID-19 pandemic as part of welfare checking, and was able to organise for groceries to be delivered to him via a service provider. This served to build trust, and when John was very distressed and in severe pain following a fall in June 2020, the SSW was the first person he called. Due to the rapport that had been built with John, the SSW was able to convince him to call for an ambulance and he was transported to hospital. Subsequently, John agreed to receive domestic assistance, laundry and transport services with social support, and to participate in a My Aged Care assessment for short-term restorative care.

Has each trial been staffed and resourced as intended? If not, why not?

As outlined in Section 3.4.2, 'What were the challenges to implementing each trial and how were they addressed?' below, following some early delays in the recruitment of paid staff, staffing levels generally stabilised throughout 2020. However, recruitment and retention of volunteers has proved more challenging for partner organisations. Indeed, the number of volunteers used in the trials has been lower than originally anticipated, due to difficulties in recruitment and retention, and a realisation that some volunteers may not be equipped to present complex information or handle difficult enquiries.

Table D-3 in Appendix D shows the paid staff and volunteer FTE levels reported by partner organisations in the COTA Australia data set between February and November 2019 (as presented in the Interim Report). (Note: this period was chosen because it excludes the observed trial 'slowdown' periods – and potential temporary reductions in reported FTE – associated with the Christmas/New Year holiday season, and the onset of the COVID-19 pandemic in early 2020 [as indicated in Figure 3-1]).

Table D-3 also shows the *planned* paid staff and volunteer FTE levels reported by partner organisations (in updated trial profile documentation) for the extension period (1 July 2020 to 30 June 2021), as well as the *reported* levels (quarter 8 only). The median planned FTE for paid staff was 0.8 FTE per partner organisation, which was the same level as previously planned *and* reported (e.g. in the COTA Australia data set between February and November 2019). The planned FTE levels for volunteers during the extension were considerably lower, with only 13 partner organisations reporting any planned volunteer FTE (range: 0.2–6.0 FTE). However, this was similar to the actual FTE levels reported for volunteers between February and November 2019.

It is anticipated that the planned paid staff and volunteer FTE levels reported for the trial extension period were, in part, informed by partner organisations' experiences of COVID-19 earlier in the year. For example, in the COVID-19 survey (completed in April 2020), it was anticipated that 86% of trials would still retain their paid staff at the same FTE level compared to pre-COVID-19 (based on November 2019 reports) (see Appendix C).

Anecdotal reports also indicated that the COVID-19 pandemic led to further reductions in volunteer staffing compared to pre-COVID levels – due to associated reductions in trial delivery activities, and many volunteers having to self-isolate (e.g. due to their age making them at higher risk). Interestingly, COTA ACT noted that several volunteers remained anxious and were reluctant to recommence their roles even after COVID-related local restrictions had eased. For example, one volunteer who had not driven a car for some time due to the restrictions was nervous to start driving again.

Was each trial delivered in the planned location?

As described originally in the Interim Report, very few trials were delivered outside of their planned jurisdictions (as indicated in partner organisations' original trial profile documentation). Where this did occur, it tended to involve the delivery of Individual trial activities via telephone (e.g. to navigator service users living interstate), or delivery of (Group) trial activities just over state borders.

During consultations, some partner organisations reported making *some* modifications to their planned locations for trial delivery. For example, Seniors Rights Service Limited reported *expanding* their trial boundaries (as listed in their original trial profile) in an effort to reach more navigator service users. Conversely, some partner organisations reported 'contracting' their trial reach over time, in order to focus more closely on particular regions, rather being 'state-wide'.

Some partner organisations switched away from planned venues, for example, COTA SA who originally planned to deliver their Information hub trials in a GP waiting room and the local library/visitors information centre. COTA SA noted that while their host venues were *appropriate*, they were *under-utilised* by navigator service users, with visits to their hub trials low or non-existent.

Information hubs are limited in access and availability, and overall there is no way for a customer to connect with the hub unless it is at the time the hub is running and provided the volunteer is in attendance.

– Partner organisation representative (COTA SA)

As an alternative, some trial personnel agreed to be available *directly* to the community via mobile phone and email, with COTA SA updating their promotional messaging in local papers and community magazines to "*We are still here for you*" along with providing these contact details.

Advocare reported delivering Information hub sessions in *novel locations*, including op shops and the local foodbank, demonstrating adaptability in response to their local community's needs.

In terms of the impact of COVID-19, early on in the pandemic most trial activities that were still able to occur had to be delivered by phone or online, rather than in physical locations as planned. The duration of this forced shift in delivery modes varied between jurisdictions, with the trials in Victoria subject to the lengthiest state restrictions. Several partner organisations reported ongoing constraints in the delivery of face-to-face group activities in late 2020, due to venues being closed or meeting rooms not being of adequate size to meet social distancing requirements.

The planned delivery locations for the 64 COTA Australia-led trials during the extension period (1 July 2020 to 30 June 2021) is presented in Section 3.3.1, with new or updated trial location information indicated in italic text.

Was each trial delivered to the planned target populations?

As highlighted in Section 3.3.2, the COTA Australia-led trials are primarily aimed at targeting people who:

- Need additional support to understand, choose and access aged care services, and have difficulty engaging through existing channels
- Have not yet accessed aged care services.

Further, the original intent of the trials was to support individuals up to the point of receipt of aged care services. However, many partner organisations have found themselves having to provide support well beyond the point of service commencement. Indeed, the COTA Australia data set indicated that one-third of navigator service users receiving trial support were already in receipt of aged care services (see Table 3-13).

In terms of the specific sub-populations intended to be targeted during trial delivery (see Section 3.3.2), the Interim Report presented findings in relation to the number of vulnerable populations and diverse groups *planned* to be targeted during the original trial delivery period versus the number *actually* 'targeted' (by the fourth reporting quarter [November 2019]). However, as detailed in the report, the extent to which partner organisations had been *actively targeting* these populations – as opposed to providing navigation support to them *should they present at the trials* – was unclear.

Further, the *under-reporting* of vulnerability and diverse group information in the COTA Australia data set was another key limitation, meaning that the true numbers of population groups being targeted

and/or presenting at the trials was likely to be far higher than reported. As outlined in Section 2.6, the onset of the COVID-19 pandemic had a further negative impact on the completeness of data reported in the COTA Australia data set.

However, *anecdotal* reports from some partner organisations indicated that COVID-19 restrictions had a disproportionate effect on their ability to reach *certain* population groups during 2020:

- **People who were already socially isolated**

Due to potential reductions in their existing informal supports as a result of restrictions

- **People from CALD backgrounds**

Owing to a need for in-person bilingual support, and in many cases, an inability to communicate via other modes (such as telephone)

- **People with low digital literacy or limited access to technology**

Due to their inability to access online content (e.g. Individual and Group trial activities and trial promotional content)

- **People with vision impairment**

Due to difficulties with accessing trial support online or over the telephone

- **People experiencing homelessness, or at risk of homelessness**

As a result of their personal circumstances, they were more likely to physically 'drop in' to trials in person, rather than, say, call-up via telephone

- **People with mental health challenges**

Due to the pandemic creating additional layers of anxiety and complexity, meaning individuals may be less inclined to seek out support

- **People with cognitive impairment, including dementia**

Owing to COVID-19-related disruptions to their normal routine and activities, including those of their carers.

Leading up to the trials' extension, partner organisations were given the opportunity to review and revise the number of vulnerable populations and diverse groups they planned to target, based on their experiences of trial delivery to date, including the impact of COVID-19 during 2020. Information from updated trial profile documentation indicated that trials planned to target a median of 5 population groups, which was lower than the 7 planned during original trial delivery. Table 3-5 shows the number of populations each partner organisation plans to target during the extension period compared to those planned during the original trial delivery period.

Of the 29 partner organisations, 6 were planning to target the same number (and, generally same type) of 'target populations' during the extension period, 10 were planning to target fewer while 13 were planning to target a greater number (Table 3-5). These splits are likely to reflect the following trial delivery scenarios:

- Partner organisations that *accurately estimated* the original number of vulnerable populations and diverse groups they would be able to 'target', and, based on their planned trial delivery offerings would be able to continue targeting these populations.
- Partner organisations who originally *overestimated* the number of vulnerable populations and diverse groups they would be able to 'target', and so revised down their planned numbers based on their planned trial delivery offerings during the extension period.*
- Partner organisations that planned to *expand* the size and/or scope of their trial delivery offerings during the extension period, meaning they would be able to target additional populations compared to before.

*Note: While the revision down of planned 'target population' number could, in theory, be a direct result of a reduction in the size or scope of partner organisations' trial offerings – for example, in response to a reduced trial budget – this scenario was not identified during partner organisation consultations or from other available information.

The populations that partner organisations most frequently planned to 'target' during the extension period were: the 'Socially isolated or [those] at risk of social isolation', those with 'Limited access to technology or people with limited computer literacy' and the 'Financially or socially disadvantaged'. Notably, these 3 groups may have specific needs that have increased as a direct result of the COVID-19 pandemic, and associated restrictions.

Quarter 8 represented the first full reporting quarter of the trials' extension period. Table D-4 in Appendix D shows the number of different 'target populations' each partner organisation reported delivering Individual trial activities to in this period (September to November 2020). Where information was available, the number of different 'target populations' each partner organisation supported ranged from 1 to 12 (out of a maximum of 17) (Table D-4, Appendix D).

However, it is important to note that when comparing the 'planned for extension period' information in Table 3-5 (right column) and 'reported for quarter 8' information in Table D-4, the former (planned) estimates are based on the full 12 months of the extension period, while the latter (reported) are a snapshot from a 3-month period only.

Jimmy's story

Jimmy was a 72-year-old man who had moved around a lot and had no secure housing of his own. He was staying with a friend in an area with few services. Aside from his friend, he had no informal social supports.

Jimmy initially contacted the ACSN trial during the COVID-19 lockdown as he had heard that supermarkets were no longer accepting cash and he was worried that he wouldn't be able to buy food. Over several contacts, Jimmy expressed a need for help with shopping and banking, and possibly other services once the threat of COVID-19 had passed. Jimmy was confused by the CHSP approval code system and did not have access to the internet. The trial navigator contacted the service providers in his area to identify which ones were able to commence services immediately, and what their fees would be – as Jimmy was worried about costs.

The navigator's existing rapport with Jimmy, and ability to support him beyond the scope of My Aged Care registration, ensured that Jimmy was able to connect with a service quickly and have his concerns addressed.

Now familiar with both My Aged Care and the ACSN trial program, Jimmy will be able to re-access these services as his needs change over time. He knows that should he wish to change his housing situation in the future, the navigator will be able to link him with appropriate services.

Table 3-4: Number of target populations planned during the original trial delivery period and trial extension period, by partner organisation

Partner organisation	Original trial delivery period (Feb 2019–Jun 2020)	Trial extension period (Jul 2020–Jun 2021) (+/-difference)
Aged and Disability Advocacy Australia	8	5 (-)
ACT Disability, Aged and Carer Advocacy Service Inc.	6	9 (+)
Advocare Incorporated	14	15 (+)
Aged Rights Advocacy Service Inc.	12	13 (+)
Brisbane South PHN Ltd	4	15 (+)
Chung Wah Association	1	1 (/)
Co.As.It. Italian Assistance Association	2	3 (+)
COTA ACT Inc.	4	2 (-)
COTA NT Inc.	14	14 (/)
COTA NSW Inc.	11	12 (+)
COTA Qld Inc.	5	3 (-)
COTA SA Inc.	12	8 (-)
COTA Tasmania Inc.	15	15 (/)
COTA Victoria Inc.	9	6 (-)
COTA WA Inc.	11	1 (-)
Dementia Australia Limited	1	5 (+)
Elder Rights Advocacy	9	7 (-)
UnitingSA Ltd	8	7 (-)
Institute for Urban Indigenous Health Ltd	10	5 (-)
Migrant Resource Centre (Southern Tasmania) Inc.	1	5 (+)
Multicultural Communities Council of Illawarra Inc.	3	7 (+)
National LGBTI Health Alliance	6	10 (+)
Northeast Health Wangaratta	10	15 (+)
OPAN	2	2 (/)
Seniors Rights Service Limited	15	15 (/)
Sunraysia Mallee Ethnic Communities Council Inc.	12	12 (/)
Umbrella Multicultural Community Services Inc.	1	2 (+)
The Housing for the Aged Action Group Inc.	7	6 (-)
Agelink Consulting	2	5 (+)

Note: symbols shown in parentheses in the third column indicate positive (+), negative (-) or no differences (/) in the planned number of 'target populations' during the original trial delivery period and the trial extension period. Trial profile information recorded the diverse group of 'limited access to technology or people with limited computer literacy' as 2 separate groups. These have been combined for presentation in the table, meaning some planned numbers shown for the original trial delivery period will be lower compared to those presented in the Interim Report.

Was each trial delivered within required/planned timeframes? If not, why not?

As detailed in the Interim Report, implementation of the COTA Australia-led trials was constrained by tight timelines and a short establishment phase. This, in turn, had knock-on effects on the *timely* establishment of defined roles and responsibilities for partner organisations, data collection and reporting processes, promotional activities, and network-building between the trials, and with external services and organisations.

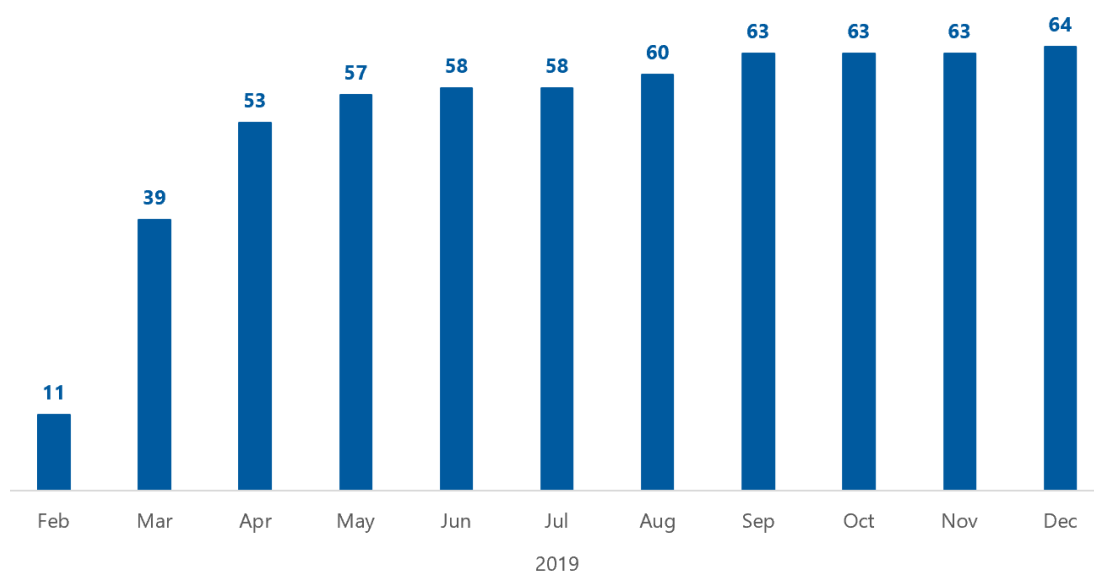
It was like flying the plane while they were still building it.

– Partner organisation representative

The short implementation timelines also meant that many partner organisations were unable to commence trial activity delivery by their contracted start date of 28 February 2019 (applicable to the original 62 trials only). Figure 3-3 shows the number of trials *reporting*¹⁴ Group and/or Individual trial activity delivery from February 2019, as reported in the COTA Australia data set.

A number of partner organisations reported delays or interruptions in trial activity delivery during the period of contract extension for the trials (which was in line with reductions reported between June and August 2020 [see Figure 3-1]). These were caused by delays in partner organisations receiving their Deeds of Variation for the trials' extension – due for commencement from 1 July 2020, but reportedly still not in place for a few partner organisations by September 2020. This prevented some partner organisations from being able to hire new staff (including to backfill vacancies created during the COVID-19 pandemic), secure venues for trial activity delivery or undertake promotional activities

Figure 3-3: Number of trials reporting Group and/or Individual trial activity delivery over time, February to December 2019



Note: one

trial reported the month of commencement of trial activity delivery as January 2019 (e.g. before their contractual start date of 28 February 2019); this trial has been included in the trial numbers shown from February 2019 onwards. Two of the 64 trials (the Integrated Information hub/SSW trials) were contracted to commence later than February 2019, and reported trial activity delivery from September/December 2019.

¹⁴ Note: due to *underreporting* in the COTA Australia data set (particularly in early trial implementation), it is expected that some trials commenced delivery of Group and/or Individual trial activities *earlier* than the first date reported.

Was Commonwealth funding appropriately dispersed to deliver the trials as planned?

Timeframes

The Department disperses funding for the trials to COTA Australia according to a payment schedule set out in the contract between the 2 parties. COTA Australia then disperses allocated funding to partner organisations. Following initial 'front-loaded' funding amounts (at the commencement of trial delivery and at extension) payments from COTA Australia to partner organisations have been linked to delivery of quarterly data and progress reports.

Partner organisations reported delays in receiving funding at 2 time points in the trials:

- While quality issues identified in the COTA Australia data set were being addressed (late 2019), which led to delays with payments linked to the submission of quarterly data reports.
- While the contract variations for the extension phase were being finalised. Due to these delays, some partner organisations reported operating without a contract in place between July and September 2020.

In both instances, partner organisations reported a lack of communication from COTA Australia to explain the delays. In relation to the trials' extension, COTA Australia noted that partner organisations were sent a 'letter of intent' in early June 2020, which outlined the potential funds available should trial extension go ahead. They further suggested that some delays may have arisen from a lack of communication between the partner organisations' contract team and trial personnel on the ground delivering trial activities. As described earlier (see 'Was each trial delivered within required/planned timeframes? If not, why not?' above), these delays in *secured* funding made it difficult to staff, plan and deliver trial activities, particularly for smaller partner organisations that did not have alternate sources of in-kind funds to 'dip into'.

Contract mechanisms

As outlined in the Interim Report, partner organisations reported a lack of up-front specifications in relation to their roles and responsibilities prior to original contract finalisation, which was largely attributable to the short lead time for the establishment of the trials. This meant that partner organisations initially lacked visibility about their obligations in relation to key components of trial delivery, including (but not limited to):

- The extent of trial data collection and reporting requirements in the COTA Australia data set
- The requirement to develop localised training and promotional resources.

Amounts of funding received by partner organisations

Many partner organisations reported – *anecdotally*, during consultations – that the funding provided for the trials was insufficient to deliver the trial activities they had planned. As reported previously, they noted having to rely considerably on *in-kind* supports from other parts of their organisations, which were often in excess of their initial expectations.

However, *quantitative reporting* of the 'actual' and 'in-kind' costs required to support trial delivery was limited in the COTA Australia data set and, therefore, was unable to support these anecdotal reports from partner organisations

During extension negotiations, partner organisations had the opportunity to propose new funding levels. Several partner organisations requested additional funding for specific purposes, for example,

for mobile phones in order to better engage with 'CALD' communities. However, this particular request was not granted.

Any measures to ensure that funding was not dispersed for activities already funded by the Commonwealth

As described in the Interim Report, the contract between the Department and COTA Australia provides a measure for ensuring that trial funding is not dispersed for activities already funded by the Commonwealth (either directly or indirectly).

Partner organisations were required to identify in their original and updated trial profile documentation if their planned trial activities were new, and if not, state how their planned trial activities would expand upon existing activities. During the extension period (and where information was available [n=54]), the planned trial activities of 34 trials represented an extension of existing partner organisation activities, including activities already funded by the Commonwealth. This was an increase of 5 trials compared to in the original trial delivery period (n=29, presented in the Interim Report).

While this action was required to identify how trial activities were *complementing* and *building on* existing aged care navigation services, it also provided an additional (albeit limited) measure for checking whether any funding was intended to be (inappropriately) dispersed for activities that were already funded by the Commonwealth.

Further, as outlined in the subsection above, partner organisations were able to request additional funding in order to support trial delivery during the trials' extension period. However, partner organisations working with 'CALD' communities had their requests for additional 'major' costs ($\geq \$10,000$ per trial) declined by the Department. The reason for this was to avoid duplication of Commonwealth funding across the existing ACSN trials and the planned 'CALD system navigator' trials (Australian Government Department of Health 2020), which these partner organisations would reasonably be expected to receive funding for. (Note: at the time of drafting this Final Report [February 2021], the date of commencement of the 'CALD system navigator' trials remains unknown).

Linkages to performance

The original contract between the Department and COTA Australia (also reflected in partner organisation subcontracts) did not stipulate any formal linkages between trial funding and 'performance', for example, delivery of a minimum number of trial activities. However, COTA Australia was (and remains) responsible for monitoring the performance of partner organisations and retains the ability to withhold funds if required.

During the extension negotiations, key performance indicators (KPIs) were introduced to the COTA Australia contract, and reflected in the partner organisation subcontracts. The KPIs introduced for the trials' extension period (1 July 2020 to 30 June 2021) comprise:

- Total number of navigator service users receiving Individual and Group trial activities: 40,000/extension period
- Proportion of navigator service users:
 - Provided with a (long-form or short-form) survey: $\geq 90\%$
 - Reporting ≥ 1 survey response: ($\geq 20\%$)
 - 'Agreeing' or 'Strongly agreeing' (via survey responses) that they know more about available aged care services and supports: $\geq 90\%$
 - 'Agreeing' or 'Strongly agreeing' (via survey responses) that they feel more confident to seek help from the aged care system if needed $\geq 90\%$.

3. Findings: COTA Australia-led trials

During consultations, both partner organisations and COTA Australia noted that the KPIs were reasonable and positive additions to trial delivery, because they gave partner organisations some tangible – and achievable – targets to aim for.

Quarter 8 represented the first full reporting quarter of the trials' extension period, and provided an early view of how the trials were tracking in relation to achieving the KPIs:

Navigator service user number: on track

The number of individuals receiving support via 3 of the main trial activity types alone ('One-on-one/individual assistance', 'Received information materials' and 'Attended a group' [as shown in Table D-1, Appendix D), was approaching 10,500 in the quarter.

Survey provision to navigator service users: on track for over half of trials

Around 60% of trials had achieved this KPI (as reported in partner organisations' progress reports).

Navigator service user survey response rate: on track

As indicated, for example, by the high response rates for the 5 trial feedback questions/statements in Table F-4, Appendix F, overall completion rates for the modified short-form survey response rates were high.

Navigator service user outcomes: on track

As indicated in Table F-4 in Appendix F, the overall positive response rates in relation to navigator service users' knowledge about available aged care services and supports, and their confidence to seek help from the aged care system if needed were 94.2% and 94.0%, respectively.

3.4.2 What lessons can be learned from trial implementation?

What were the challenges to implementing each trial and how were they addressed?

Challenges are to be expected when trialling innovative new programs. The main challenges identified to implementing the COTA Australia-trials were:

- Short timeframes for trial establishment
- Inadequate resourcing and funding uncertainties
- Staffing difficulties
- Burden of data collection and reporting
- Aged care systems issues
- COVID-19 and other events.

These issues are discussed in more detail below.

Short timeframes for trial establishment

The short timeframes for establishing the COTA Australia-led trials still represent the biggest single challenge to their implementation. The far reaching knock-on impacts meant that:

- COTA Australia had difficulty developing project governance arrangements. As a consequence:
 - Clear guidelines for trial activities and processes were not available in a timely manner
 - There were delays in establishing the planned governance groups and CoPs.

3. Findings: COTA Australia-led trials

- Partner organisations had difficulty recruiting staff and volunteers in time to commence delivering trial activities by the required contractual start date (28 February 2020 for the 62 original trials)
- Partner organisations could not conduct timely local scoping activities, which led to delays in building networks with existing organisations for promotional and referral purposes, and for avoiding duplications of effort
- COTA Australia was unable to develop clear data collection and reporting guidelines in a timely manner, and partner organisations were unable to test the data collection tools ahead of full implementation.

Over time, COTA Australia has attempted to address the above issues – where feasible – by providing targeted training and support to partner organisations, particularly in relation to data collection and reporting, and by establishing the *BoostHQ* platform for resource sharing. However, even without the additional pressures associated with the COVID-19 pandemic, it is still arguable that additional resources for trial administration and coordination would be beneficial.

We could have got more runs on the board more quickly if there'd been more collaborative promotion...rather than each trial site being...completely responsible for everything. Each one is basically a start-up and it takes a long time to cut through. We finally feel like we're getting somewhere but it's been a painful process.

– *Partner organisation representative*

Inadequate resourcing and funding uncertainties

As highlighted in Section 3.4.1, 'Was Commonwealth funding appropriately dispersed to deliver the trials as planned?', partner organisations have continued to report that the amount of trial funding received has been inadequate to deliver the quantum of trial activities planned. The unanticipated impact of having to develop their own local promotional resources, and the substantial data reporting requirements, placed additional strain on partner organisations – particularly those with >1 FTE of paid staff. Other partner organisations also reported having insufficient funding to travel to rural/remote areas during the original trial delivery period.

Adequacy of trial resourcing was addressed to some extent during the extension period, as partner organisations had the opportunity to review and revise their trial activity approaches, including planned number of trial activities, in line with agreed funding amounts.

As described in Section 3.4.1, 'Have all components of each trial been implemented?', in early 2020, uncertainty around whether the trials would continue past the original conclusion date of 30 June 2020 made it difficult for partner organisations to recruit staff and plan medium-term to longer-term trial activities.

Staffing difficulties

Although recruitment and retention of paid staff was an issue for a number of partner organisations in the early stages of implementation, this has largely stabilised over time.

As detailed in the Interim Report, trials that relied more heavily on volunteer workforces faced more substantial challenges, particularly if they had little or no prior experience of using volunteers, or if they did not have an established volunteer base to draw upon. The following issues were observed to be particularly challenging.

The requirement for ongoing training, supervision and supports is resource-intensive, and takes paid staff away from their other duties, or has meant that partner organisations have to rely more heavily on in-kind support.

It is quite difficult to find the right volunteers. They need the right language skills to explain the information, as well as their own IT skills for delivering the sessions. For every new person we pick up, we also need to train them to understand the aged care content, translate [it] and deliver it, but if there are any issues we still need to be around.

– Partner organisation representative

When the flow of navigator service users at Information hubs and Community hubs has not been consistent – for example, during early trial implementation, or as a result of the COVID-19 pandemic – **a shortage of work can lead to individuals seeking volunteering opportunities elsewhere.**

We need them [volunteers] to feel like they are providing worthwhile work as well. Sometimes the info hub would be quiet, and they would feel like: 'is this something we should pursue?'

– Partner organisation representative

Paid staff may be required to 'step-in' to address more complex questions from navigator service users, which volunteers may be unable, unqualified and/or lacking suitable experience to answer.

In line with the point above, **the consistency and accuracy of information provided by volunteers requires close monitoring** by paid staff.

When you want to provide a service with continuity and professionalism, it can be difficult with volunteers. You have to deal with volunteers saying 'Oh, I won't come in today' and 'Oh, I won't do this today', or offering medical advice and going way beyond their role.

– Partner organisation representative

Having to deal with navigator service users presenting at the trials with sensitive issues can **take an emotional toll on volunteers**, meaning that they require appropriate management (generally by paid staff), including opportunities for debriefing, when required.

Given that many volunteers are older, and therefore, at greater risk of COVID-19, **volunteer numbers at the trials understandably dropped following the onset of the pandemic in Australia.**

Over the long run, over-reliance on volunteers will impact the sustainability and consistency of service delivery.

– CALD CoP representative

Elsewhere, the case *for* volunteers continues to be made by some partner organisations. For example, those focused on 'CALD' communities have reported particular *successes* with using volunteers who are *bilingual* and *bicultural*, because these individuals are more likely to have strong links within their local communities, and, therefore, may be able to identify and establish trial connections with socially isolated community members. However, it also important to note that these functions are not necessarily limited to volunteers and could also be effectively fulfilled by bilingual and bicultural paid staff members.

The potential role of volunteers in future models of aged care navigation is discussed in Section 5.3.1.

Burden of data collection and reporting

As highlighted in Section 3.4.1, 'Data collection and reporting arrangements (including technology solutions)' above, the requirements of trial data collection and reporting – including administration of the original 'long-form' navigator service user survey – were viewed by most partner organisations as excessive, and required more resources than initially envisaged.

As detailed in Section 3.4.1 above, the COTA Australia data set was refined in mid-2020 and the new version rolled out from reporting quarter 8 (September 2020). On review, the general improvements in quality and completeness observed in the data set over time were reflected in the quarter 8 data. For example, the overall reporting rate for vulnerable population information was boosted by the addition of quarter 8 data, increasing from 33.8% (pre-quarter 8) to 37.8% (see Section 3.5.2). A similar but smaller increase was also observed for diverse group information reported in the overall COTA Australia data set: 51.1% increasing to 52.9% (see Section 3.5.2).

It is important to note that, on review, much of the modified short-form survey data was of higher quality, more complete and more representative than data collected via the previous long-form and original short-form survey tools. Indeed, the introduction of the new survey tool had been welcomed by partner organisations, as it was *generally* seen as more culturally appropriate and less time-consuming to complete and report on.¹⁵

More broadly, some partner organisations found the reporting processes to be inappropriate – especially the requirement to provide projections of trial numbers as part of the trial profiling. In particular, Aboriginal or Torres Strait Islander-focused organisations requested more flexibility, not just in reporting but also to adapt trial delivery over time.

¹⁵ Note: during follow-up consultations, one or 2 partner organisations did comment that the modified short-form survey tool was not culturally appropriate for all population groups.

Dionysia's story

Dionysia was 78 years old and suffered from emphysema, which had significantly impacted her ability to maintain her home. She also cared for her husband who had been diagnosed with dementia and could no longer drive.

Dionysia and her young family arrived in Australia from Greece in 1960. Her English was limited and she relied on her family for language assistance when attending medical and other appointments. Dionysia's family also assisted where they could with shopping and transportation.

Dionysia's son had obtained information about the Information hub trial at a community event and contacted them for assistance. Dionysia was able to communicate her needs and concerns in her own language to a Greek-speaking navigator, who assisted her to register with My Aged Care. As a result, Dionysia was able to access CHSP domestic assistance and individual support services, and was also assessed by ACAT for an HCP.

Having access to an ACSN navigator who spoke her language and shared her cultural background enabled Dionysia to relate her story in a more comprehensive manner, as well as communicate her fears and concerns about the future. The information she received in her own language also supported her to better understand her options and make informed choices about her care.

Dionysia's family were relieved that she was able to access the support she needed so that she could enjoy more quality time with her husband and be freed from the domestic tasks that she found physically taxing. A plan was also put in place for the future should Dionysia's health continue to deteriorate, which was strongly aligned with her wishes to remain living at home as opposed to being admitted to a residential care facility.

Aged care systems issues

As outlined in Section 2.2, the ACSN Measure was implemented, in part, in response to recognised deficiencies with the aged care system. Not surprisingly, some of these broader issues with the aged care system have created additional challenges for the implementation of the trials, as reported by partner organisations. These include:

Negative perceptions of aged care held by some in the general population, which means that some individuals may have been (at least initially) reluctant to engage with trial services.

A range of problems – whether actual or perceived – with My Aged Care, including:

- Contact centre staff being unaware of the trials and not allowing trial staff to speak on behalf of clients, even when verbal consent has been provided by the navigator service user (see 'What worked well when implementing each trial, and what was the positive impact?' below).
- Long wait times when put on hold by contact centre staff.
- Some contact centre staff not understanding that the eligibility criteria for aged care may differ for some populations. For example, people who are homeless or at risk of homelessness are eligible if they also meet more than one of the following criteria:
 - Aged 50 years or older and prematurely aged.
 - Aged 45 years or older if from an Aboriginal or Torres Strait Islander background.
 - On a low income.
- The inaccessibility of telephone-based services for people from certain populations, including 'CALD', those with 'Cognitive impairment including dementia' and those with hearing impairment (among others).
- Difficulties with accessing interpreters through the Translating and Interpreting Service (TIS National).
- Individuals not answering calls from My Aged Care because they display with 'no caller ID' and so are dismissed as spam calls.
- Difficulties with navigating the My Aged Care website, which may be a particular challenge for individuals with 'Limited computer literacy' (while noting that some improvements to the website have been made over time).
- Written correspondence from My Aged Care (e.g. in relation to HCP allocation) using bureaucratic language which is difficult to understand.
- The lack of easy-to-understand and/or easy-to-find translated materials on the My Aged Care website.
- Difficulties with accessing adequate numbers of printed resources from My Aged Care.

A general lack of awareness of the trials among RAS and ACAT services, and a lack of clarity in the respective roles of RAS, ACAT and trial services in terms of supporting individuals from the point of assessment to service provision.

A few **aged care service providers have reportedly chosen not to engage with the trials** because of concerns that they would lose their clients.

The limited availability of aged care services (including CHSP and HCP) has often resulted in long wait times, a lack of choice, and caused distress for some navigator service users.

The above challenges highlight the trials' collective need to provide ongoing, repeated interactions with navigator service users. Indeed, information from the COTA Australia data set indicates that nearly 10% of navigator service users returned to the trials for ≥ 1 visit with the same unresolved issue (see Table 3-14, Section 3.6.1). This proportion is likely to be an *underestimation* (due to data limitations) and provides further evidence that ongoing support to navigate the aged care system is a fundamental requirement of aged care navigation services.

We might be able to support the person on the spot, or they may come through and have more individualised support. Or it may be people receiving CHSP and want to know how they can receive more support. We have also had people who are on a wait list or been offered something. Or people who have had an ACAT and not sure what should happen next. We need to help people work their way through the system.

– Partner organisation representative

It's not just registering them with My Aged Care, people are having major issues in getting what they need in the aged care system. It's so much more than just registration, especially for the cohort we serve.

– Partner organisation representative

The big question is, where are we navigating people to? Are we just navigating them to waitlists?

– Partner organisation representative

COVID-19 and other events

The emergence of the COVID-19 pandemic required that partner organisations quickly adjust their trial delivery approaches, in order to ensure they could continue providing effective navigation support, while maintaining compliance with national and local guidelines (which have been subject to change over time). Specific challenges reported by partner organisations include:

- 'CALD' navigators reported that the reliance on telephone (rather than face-to-face) communication has been difficult for people with limited English. They also noted that the use of interpreters via a three-way phone call creates additional challenges compared to in a face-to-face setting.
- Low computer literacy meant online trial activities were inaccessible for some navigator service users.
- Some trials lacked the IT support needed for a smooth transition to working from home.
- Group trial activities were disproportionately affected, due to difficulties with switching to non-face-to-face modes of delivery. Where face-to-face delivery was permitted, some partner organisations struggled to source venues as local libraries, community centres, etc. were closed or had strict capacity limits to meet social distancing requirements.
- Trial promotion through some channels (e.g. local papers, flyers in libraries etc.) was no longer an effective way of connecting with the community.

It is important to note, however, that despite the challenges described above, partner organisations demonstrated *resilience* and *resourcefulness* in adapting to COVID-19. More information about the trial adaptations made in response to the pandemic is presented in Appendix C.

A little bit of facetime to some of the Elders, but majority telephone call or face-to-face. We even do face-to-face through COVID, because if we're dropping meals off, we'll put it at the back door and then go and stand at the back fence and talk to the clients. Because that is the most appropriate way for us to engage.

– Partner organisation representative

Finally, although the COVID-19 pandemic has been the dominant issue throughout 2020 other events also affected implementation of some trials, which required partner organisations to be *flexible* and *adaptable*. These included bushfires, which affected large areas of south-eastern Australia in early 2020, as well as cyclones in the Northern Territory.

What worked well when implementing each trial, and what was the positive impact?

As highlighted in the Interim Report, there were several observed factors that contributed to successful implementation of the 64 COTA Australia-led trials. These are outlined below.

Experience of the aged care sector

Partner organisations that had prior experience of delivering navigation services and/or a sound understanding of the aged care sector reported fewer implementation challenges and were able to commence delivery of trial activities sooner. These partner organisations had existing training and presentation resources about aged care, which could be readily adapted for trial purposes, *plus* established links with other community organisations. Indeed, *experience* and *long-established trust* were identified as particularly important for partner organisations working with 'CALD', 'Aboriginal or Torres Strait Islander' and 'LGBTI' communities.

Size of partner organisation and number of trials

Broadly, partner organisations that are larger and have more trials (and thus higher FTE allocations) have *generally* reported fewer implementation challenges over time. For example, one partner organisation that is running multiple trials has been able to take advantage of *economies of scale* to streamline their trial delivery approaches, allowing navigation staff to focus on delivering trial activities. Larger partner organisations have also been more readily able to tap into in-kind supports, where required. Further, larger partner organisations may have already had substantial existing pools of volunteers and established internal processes for recruitment, retention and support. (However, as noted previously, smaller organisations may also have had considerable prior experience of successfully managing volunteer workforces).

Larger organisations may also have been better placed to adjust to the challenges posed by COVID-19, for example, by having the necessary IT support to quickly transition to working from home. Further, their existing IT infrastructure may also have allowed them to more readily switch to alternative modes of delivery for trial activities, for example, online platforms.

Some partner organisations delivering multiple types of trials also reported that referrals *between* their own trial types have proved successful. For example, several reported navigator service users who presented at an Information hub with particularly complex issues were referred on to their SSW trial in order to receive more-in-depth support. However, the extent of these types of referrals could not

readily be established in the COTA Australia data set (see Section 3.6.1, 'What level of integration occurred between the different trials and with existing supports?').

Connections with community organisations and 'community champions'

According to partner organisations, many local community organisations, councils and libraries have been supportive of the COTA Australia-led trials, and feel they are providing a worthwhile and much-needed service. These organisations have supported the trials through promotion, offering physical facilities, and by making direct referrals of navigator service users into the trials.

Staff from Information and Community hubs have observed that word-of-mouth is a very powerful and cost-effective tool for raising trial awareness. Several trials, including those led by COTA Victoria, have reported high levels of success engaging 'community champions'. Community champions are leaders who have close and trusted links into the CALD communities these trials are aiming to engage, and a commitment to improving the wellbeing of their community. COTA Victoria reported that, rather than putting out *general calls* for volunteers to support the trials, they now actively identify and seek to work with community champions to build trust and educate the community.

The Institute for Urban Indigenous Health has reported similar successes with harnessing local experience and knowledge to extend their reach into communities and drive trial uptake.

We have leveraged a heap of people across the community now that are educated and knowledgeable. [These are] not formal volunteers – more of an informal 'Murray Grapevine' of people in appropriate positions who have enough information to point people the right way.

– *Partner organisation representative*

This approach demonstrated the success of tapping into an existing LGBTI network to engage with individuals in a friendly and comfortable environment. It also showed that utilising 'community champions' who already receive aged care services and can talk about their experiences can be reassuring for others who may be apprehensive about the subject.

Similarly, Working it Out in Tasmania¹⁶ has developed an effective model for raising awareness through community champions involved with existing community groups.

Elsewhere, the establishment of integrated pathways between partner organisations and other local community agencies had brought about better outcomes for some navigator service users with *particularly complex* aged care needs. For example, the Multicultural Communities Council of Illawarra reported finding value in conducting 'case conferences' (or multidisciplinary interventions) to discuss navigator service users with complex needs.

¹⁶ Working it Out is a service delivery partner of COTA Tasmania.

Don's story

Don was an older gay man who came out later in life, having never married. He lived in an independent living unit in a retirement village where he received some CHSP services. Don facilitated a social group for mostly (but not exclusively) older gay men and sent a regular newsletter to a contact list of over 200 people.

When Working it Out commenced delivery of an ACSN trial in Tasmania, the navigator contacted a range of LGBTI community groups in the state. Don responded, inviting the navigator to visit his social group. The navigator spoke at a morning tea, which was attended by 15 people. Don was pleased to be able to help others learn more about the aged care system and what services they could access, and he was happy to share his experiences of the services that he received.

A flexible approach to implementation

Some partner organisations reported that they have finessed the way they deliver certain trial activities – such as ‘Seminars’ – which has resulted in better outcomes, based on anecdotal navigator service user feedback. For example, Brisbane South PHN has reported success with moving towards more *semi-structured* group sessions, which has entailed switching from a *presentation* style of delivery (e.g. speaker at the front and presenting PowerPoint slides) to a more *conversational* style (e.g. speaker sitting with the group and facilitating open discussion).

This partner organisation also found that smaller group sessions (around 10 to 15 people) have been ideal as they allow for story sharing and open interaction within the group, and, importantly, a chance for all navigator service users to ask questions throughout the session.

Another example of a flexible delivery approach reported by partner organisations is the *co-delivery* of ‘Seminars’ by representatives from Information hub and SSW trials. In line with this finding, 3 partner organisations reported that the allocation of *dedicated extra time* after the delivery of a ‘Seminar’ for the provision of specialised supports – or an opportunity to book in for this – yielded positive results (see Section 3.4.1, ‘Have all components of each trial been implemented?’ above).

Indeed, Aged Rights Advocacy Service reported that providing practical support *immediately* after the delivery of a ‘Seminar’ was the best approach. The Multicultural Communities Council of Illawarra concurred with this, noting that the *combination of trials* to support the navigator service user as much as possible at the *first occasion* was most successful (e.g. rather than trying to arrange a follow-up contact after initial interaction).

Providing that integrated service, it’s quite logical. You go out to a community and speak to a group and tell them you can help them access something that will help to positively impact their life. Then they come up to you afterwards and ask if you can help them, which you do, one-on-one.

– Partner organisation representative

As detailed in Appendix C and outlined elsewhere in this chapter, the impact of the COVID-19 pandemic in 2020 was far-reaching and required partner organisations to introduce *additional flexibility* into their trial implementation approaches in order to continue meeting the needs of their local communities. It is important to note that, despite some inevitable reductions in the quantum of (particularly Group) trial activities delivered, partner organisations were successful at adapting their trial delivery approaches in response to the pandemic.

Advocates as Agents pilot

Led by OPAN (one of the partner organisations), the Advocates as Agents pilot commenced in March 2020 and seeks to reduce the barriers that advocates – namely ACSN trial representatives – face when assisting aged care consumers to engage with My Aged Care. The 10 partner organisations (not including OPAN) participating in the pilot are able (with navigator service users' consent) to access the My Aged Care Client Portal and My Aged Care Service Provider and Assessor Helpline, which provides key supporting information to assist with system registration.

The pilot seeks to determine what types of information and functionality would benefit advocates to assist their clients through My Aged Care, while system improvements are identified and developed. During consultations, participating partner organisations reported positive experiences of the pilot, noting that it had substantially improved their ability to effectively engage with My Aged Care. The pilot's success has resulted in 2 extensions – currently to 30 June 2021 – with plans for further expansion to include additional partner organisations/trials.

Were some trials (or combinations of trials) more successfully implemented than others? If so, how and why?

As described in the Interim Report, the observed lack of differentiation between trial types, most notably, the Information hubs and Community hubs, prevents any meaningful comparisons in relation to their respective implementation successes. Instead, successful implementation appears to have been primarily determined by the underlying *capabilities* and *capacity* of the partner organisations delivering the trials.

As highlighted in 'What worked well when implementing each trial, and what was the positive impact?' above, larger partner organisations running multiple trials have been better able to achieve economies of scale in their trial delivery approaches. They have also been more equipped to harness in-kind support, for example, for supporting trial administrative processes such as data reporting.

Organisations that were already well-established in the community – including with their 'target populations' – were better able to establish networks and local linkages quickly. Organisations that had pre-existing understanding of the aged care system and had provided similar types of navigator support before were also better able to implement the trials. For example, the NACAP organisations were well-placed in this regard.

I think our advocacy role fits really nicely into the navigator space. They complement each other.

– Partner organisation representative

Jan's story

Jan, a woman in her 60s, had multiple chronic and degenerative health challenges that impacted on her capacity to complete daily tasks. She had had a number of falls and was concerned about driving. Jan was socially isolated and lived alone in private rental accommodation. She had had a home support assessment nearly 12 months earlier, but despite a high priority referral for domestic assistance, and being accepted to the waiting lists of 2 organisations, Jan still had no services. She thought she had waited for long enough and asked herself 'what am I supposed to do?'

Jan attended an information session at one of the ACSN trials, where a navigator was able to directly follow up with the CHSP service providers to get domestic assistance in place, while continuing to stay in phone contact with Jan.

Jan's needs escalated over time, due to worsening respiratory problems, and the ACSN navigator recognised that she might benefit from the Advocates as Agents pilot. An initial three-way call was made to My Aged Care, where Jan's needs were noted and discussed, and a referral back to the assessment service was made. Jan also gave her consent to the navigator's appointment as her regular representative as part of the Advocates as Agents pilot.

The trial navigator attended the ACAT assessment as a support for Jan and to provide points of clarification. The navigator was able to view Jan's approval notification for a Level 3 HCP in the My Aged Care Client Portal and called her to confirm that she would soon receive a confirmation letter in the post. The navigator explained to Jan that she was in the queue for a Level 3 HCP and, although the waiting list time was over 12 months, she may get an offer at a lower level before this.

Jan was pleased with the new services that had been put in place, and commented that she was glad she had made the effort to attend an information session, otherwise where would she be?

The support that Jan received from the ACSN navigator was enhanced by participating in the Advocates as Agents pilot, which provided the navigator with timely access to information that previously would have likely required multiple calls to My Aged

Care. The pilot scheme also meant that Jan could be supported during the aged care assessment process, while retaining a sense of agency in her own affairs.

What opportunities exist for improving trial implementation?

Opportunities for improving *early* implementation of the COTA Australia-led trials are discussed below. Section 3.8 presents a more forward-looking discussion of opportunities to enhance the trials.

More extensive consultation with partner organisations prior to establishing the trials, including in-depth scoping of other local services and organisations operating in their trial regions, to maximise promotion and integration and avoid duplication of effort. However, we note that the timeframe for establishment were constrained by the underpinning budget measure for the trials and was outside of COTA Australia's control.

Stronger governance from COTA Australia in relation to:

- Ensuring partner organisations understand their roles and responsibilities – including clear definitions for trial activity types to be undertaken by the trials, and the scope of support to be provided
- Establishing more robust mechanisms for communication between partner organisations and COTA Australia, including holding more frequent state/territory forum and CoP meetings
- Ensuring partner organisations are able to meet the data collection requirements for the trials, including timely access to updated tools, and coordinated provision of support
- Promoting the trials to other key components of the aged care system, including the My Aged Care contact centre and assessment services
- Resolving *perceived* blockers reported by partner organisations, for example, confusion about the ability to access TIS National.

Timely development of a centralised, branded, suite of basic resources (including volunteer training information, presentations and promotional materials) that could have been adapted by partner organisations, thereby allowing them to commence trial delivery more quickly.

Earlier development of the dedicated ACSN webpages on COTA Australia's website, to promote and build awareness of the trials and increase trial uptake.

Are partner organisations satisfied with COTA Australia's overall management of the trials?

As highlighted in Section 3.4.1, 'Have all components of each trial been implemented?', COTA Australia's National Coordinator is regarded as *helpful*, *responsive* and *supportive* by the partner organisations. These qualities were even more highly regarded as the partner organisations had to meet the challenges posed by the COVID-19 pandemic.

More broadly speaking, partner organisations felt that a stronger degree of centralised coordination *at trial inception*, along with more available materials and agreed processes in place, would have streamlined early trial implementation. However, over time, these concerns *appear* to have lessened, as partner organisations have gained more confidence in their own trial delivery approaches, though this individualised approach has created divergence across the trial programs.

During consultations, several partner organisations reported a lack of communication from COTA Australia (at a management level) in relation to the contract extension, with delays in the subcontracting process causing stress and complicating resource planning for some. In some cases, the contract variation was not finalised until at least 3 months after the extension period commenced, making it difficult for partner organisations to 'lock in' trial delivery activities in the meantime.

Are partner organisations satisfied with the Department's overall management of the ACSN Measure?

During the original trial delivery period (February 2019 to June 2020), partner organisations reported having little direct contact with the Department, with COTA Australia acting as a conduit between the 2 parties. However, the trials' extension (commencing July 2020) has provided an opportunity for the Department to establish some more direct links with partner organisations, with COTA Australia's assistance. To this end, AHA understands that the Department has recently attended a number of state/territory forum meetings (occurring in October 2020).

Despite the recent establishment of these closer connections, partner-organisation feedback on the Department remains somewhat limited. As detailed in the Interim Report, previous feedback tended to focus on the Department's requirements for capturing 'trial profile' information, which partner organisations felt were overly *bureaucratic* and *rigid*. Perhaps partly in response to this feedback, the process for developing trial profiles for the extension period appeared to be more streamlined and was certainly quicker. Indeed, partner organisations reported having an increased flexibility in how they reported their updated trial profile information, including in relation to planned trial modifications.

However, as highlighted in 'What were the challenges to implementing each trial and how were they addressed?' above, at least one partner organisation has continued to raise concerns about a perceived lack of flexibility on the part of the Department, arguing that the Department requires partner organisations to 'fit' in with their stipulated processes. This organisation, delivering trials to 'Aboriginal or Torres Strait Islander' populations, noted that the Department's approach has not always been appropriate for their organisation, citing the issue of 'conflict of interest'. In this case, the Department has deemed it unacceptable for partner organisations to refer navigator service users into their own organisations for aged care services. However, this approach may represent the best, and possibly only, opportunity for navigator service users from 'Aboriginal or Torres Strait Islander' backgrounds to access culturally appropriate services in some areas.

Elsewhere, many partner organisations again noted that while they understand the Department's requirement for a comprehensive data set to support trial evaluation, the *extent* of data collection and reporting requirements remains *excessive*, and far from *customer centric*. In terms of the Department-approved refinements to the COTA Australia data set – planned for trial-wide roll-out from the eighth reporting period (e.g. from September 2020) – it was too early to assess their impact at the time of drafting this report (November 2020). However, the introduction of the approved 'short-form' survey (at the same time as above) had been broadly welcomed by partner organisations, as noted during consultations.

How useful were the state and territory forums and CoPs in sharing experiences of trial implementation?

This is discussed in Section 3.4.1 above.

3.5 Findings: Appropriateness

This section presents evaluation findings on the appropriateness of the COTA Australia-led trials.

3.5.1 How appropriate are the trials in meeting the needs of navigator service users?

The information presented in this section is *primarily* informed by feedback collected via surveys of navigator service users following a trial interaction, and reported by partner organisations in the COTA Australia data set. Where available, supporting information from navigator service user consultations and case studies submitted by partner organisations have also been used to support the findings presented in this section.

Given the limitations associated with the long-form and *original* short-form navigator surveys as well as the COTA Australia data set more broadly (as outlined in Section 2.6), the *survey response information* presented in this section should be viewed with caution. See Appendix F for findings based on (arguably) more robust information, collected via the modified short-form survey, which was rolled out for trial-wide use in September 2020.

Were the partner organisations trusted/considered accessible/considered supportive by the target populations?

Navigator service users generally trusted the partner organisations and considered them supportive. This is evidenced through feedback from consultations with navigator service users (where provided – see ‘Were navigator service users satisfied with the services?’ below), free-text responses in the long-form and original and modified short-form surveys, and case studies. This finding is also supported by the high proportion of navigator service users who would recommend the trials to others (see responses to question 11 in Table 3-6 and Table F-4 in Appendix F).

Although there were no specific issues raised in relation to accessibility by those that the trials reached, it is possible that accessibility may have been an issue for those who did *not* present at the trials. As outlined in Section 3.5.2, ‘Which populations may not be accessing each trial, and why? What are the gaps?’, certain population groups appear to be underrepresented in the COTA Australia data set. Though there may be a number of reasons for this – not least, under-reporting in the COTA Australia data set – a contributing factor could be that the trials were not considered accessible by these groups.

Rosa and Antonio's story

Rosa was a 75-year-old woman who emigrated to Australia from Portugal with her husband Antonio many years ago. She had dementia and found it difficult to communicate effectively in either English or Portuguese – although she understood Antonio somewhat. Rosa and Antonio had no children and no extended family in Victoria, and lived in a private rental property but were finding it increasingly difficult to manage their rent, bills and other debts. Although they were previously well connected in the Portuguese community, they had distanced themselves due to Rosa's dementia and Antonio's caring responsibilities.

Rosa had had a number of hospital admissions related to her dementia and had been allocated an HCP. During this time, Antonio was experiencing a high level of stress and had difficulty communicating with hospital staff and accepting Rosa's diagnosis. This unfortunately led to a number of verbal incidents and Antonio was restricted from contact with certain hospital staff. Antonio had also had a negative experience with their HCP provider, and felt that he and Rosa had been inappropriately pressured to sign service contracts they did not understand. They rejected the package and Rosa was without services for several months.

The trial navigator made a number of visits to Rosa and Antonio to build trust and understand both of their needs and preferences. They arranged discussions with several providers of their choice and presented a comparison of fees and features in a format that Antonio could understand and that he trusted was objective. The navigator then supported Rosa and Antonio through the service sign-up process. Antonio was referred to Carers Victoria for carer-focused support and financial counselling, and both were also referred to HAAG's Home at Last program to explore affordable housing options.

In this case, the trial's independence of all aged care providers and the navigator's ability to spend time building trust with the pair were essential to getting services in place. As a result, Antonio's carer stress was reduced, and Rosa was able to remain at home for longer.

Were navigator service users satisfied with the services?

As detailed in the Interim Report, and further outlined in Section 4.6.1, 'To what extent have navigator service users' understanding and confidence changed as a result of the trials?' below, obtaining feedback from navigator service users via consultations often generated mixed results, primarily due to issues of recall, which limited many individuals' ability to articulate their trial experience. However, where navigator service users were able to recount their experiences of navigation support, feedback was generally very positive, indicating good levels of navigator service user satisfaction with the support received.

As of November 2020, feedback from navigator service users had also been elicited via 3 survey tools, administered by partner organisations directly following a trial interaction:

- **Long-form survey**
 - This tool was rolled out in early trial implementation with the intention of being adopted for use by all partner organisations across all 64 trials, for the duration of the trials.
 - The Interim Report presented navigator service user outcomes collected via this tool, based on data collected to November 2019. Updated survey responses – collected to August 2020 – are shown below.
- **Original short-form survey**
 - This simplified tool, designed to be more *culturally appropriate* than the long-form survey (above), was piloted from late 2019 (quarter 5 onwards) in a *small sample* of partner organisations, for use in their trials.
 - Survey responses collected via this tool are shown below, based on data collected to August 2020.
- **Modified short-form survey**
 - Following the pilot of the original short-form survey (above), the tool was revised and a modified version was rolled out for use in all 64 trials from September 2020 (quarter 8).
 - Survey responses collected via this tool are shown in Appendix F.

More information about the use of the long-form and short-form survey tools is presented in Section 3.4.1, 'Have all components of each trial been implemented?'.

All 3 survey tools aim to assess *short-term* changes in navigator service users' *knowledge, understanding* and *confidence* when engaging with aged care services – along with asking specific questions about their trial experiences. As such, responses collected via these surveys can be used as a *proxy* for evaluating navigator service user satisfaction levels, as presented here and in 'To what extent, in what ways and why did reported satisfaction levels differ between populations?' below.

However, it has not been possible to evaluate whether these positive, short-term outcomes (e.g. reported directly following a trial interaction) actually eventuated in easier or quicker access to aged care services over the medium to longer term.

Long-form survey

As presented in the Interim Report, findings from the long-form survey were based on navigator survey user responses collected to November 2019 (n=1,736). By August 2020, a further 872 responses had been reported, bringing the total long-form responses to n=2,608. As before, survey response data were observed to be *skewed*, due to number of factors, including:

- Ongoing challenges of administering the long-form survey meant that only 21 of the 29 partner organisations submitted *any* survey responses – originating from 37 of the 64 trials (58.0%).
- The largest proportion of responses by far was reported by a *single partner organisation* (delivering 3 Information hubs, 2 Community hubs and one SSW trial):¹⁷ 41.3% of all responses (n=1,077).
- The bulk of reported survey responses originated from 2 trial types only:
 - Information hubs: 51.7% (n=1,349)
 - Community hubs: 45.2% [n=1,178]
 - SSW trials: 3.1% (n=81]
 - Integrated Information hub/SSW trials: 0.0% (n=0)
- The limited ability to *match* trial activity session codes in survey records with those reported in the Group and Individual trial activity tabs in the COTA Australia data set, meant that a proportion of trial activity types had to be estimated, or else remained unknown.

Note: since the Interim Report, a re-review of trial activity codes based on *partial* code matches led to the reallocation of some trial activity types, namely 'Seminars' (see below).

As a result, the following *updated* findings in relation to navigator service user outcomes should be interpreted with caution.

Survey format

As described previously, the long-form survey was comprised of 7 modules containing statements (or 'questions' for response), with the intention that navigator service users only provided responses in *relevant modules*, as shown in Table 3-5.

Table 3-5: Survey module relevance

Question	Relevance
1 to 8	Core questions, relevant to all navigator service users, following all trial activities
9 to 11*	Following Group trial activities
12*	Following volunteer-led Group trial activities
13 to 15*	Following Individual trial activities
16*	Following volunteer-led Individual trial activities
17*	Following outreach trial activities
18 to 20	Following trial activities delivered by telephone

* These modules contained additional free-text options to allow navigator service users to provide additional comments on their trial experience.

¹⁷ Note: as confirmed during consultations, this partner organisation had instated a dedicated staff member to manage the administrative side of trial delivery, including survey management.

As detailed in the Interim Report, some navigator service users provided responses across multiple, sometimes *seemingly* mutually exclusive modules of the long-form survey – for example, for both Group and Individual trial activities. Aside from observed challenges with the *matching* of trial activity information across the COTA Australia data set (see limitations above), this may also, in part, reflect navigator service users receiving *multiple types* of trial activity in a single session. An example of this could be an individual receiving one-on-one support directly following attendance at a seminar. Though it might be expected that these occasions of service would be recorded as *2 separate trial activities* elsewhere in the COTA Australia data set, this may partly explain the observed distribution of responses reported across seemingly mutually exclusive survey modules.

Given the general lack of visibility around these types of survey responses, *all* responses to survey questions have been used to inform the findings below (e.g. regardless of the seeming relevance of the questions).

Overall

Just under two-thirds of long-form survey respondents were aged care consumers (62.5% [n=1,631]). Over half of survey responses appeared to be associated with Group trial activities (56.4% [n=1,471]), 13.3% (n=370) with Individual trial activities, and the remainder unknown (30.3% [n=790]). The majority of survey responses were associated with trial activities that had been delivered in-person/face-to-face (76.9% [n=2,006]), with very low numbers originating from telephone (3.2% [n=83]) or online (0.1% [n=3]) modes of delivery, while the remainder (19.8% [n=516]) were unknown.

Table 3-6 shows navigator service users' responses to the 20 non-'free-text' questions making up the long-form survey, including the overall completion rate for each question. As before, completion rates for the core survey questions (1 to 8) were higher compared to those for the non-core survey questions (9 to 20) (Table 3-6). Overall, navigator service user responses – to both core and non-core questions – followed a very similar pattern compared to responses presented in the Interim Report, as outlined below.

Navigator service users reported *increased levels of understanding and awareness* of the aged care system, and felt more *confident* in seeking out required services, following their interaction at the trials (Table 3-6). In line with these findings, 89.5% (n=2,021) of navigator service users reported that they would tell others about their experience and encourage them to find out more about the trials (Table 3-6).

Doing this in a small group setting was great and explained in layman's terms. This has been a real eye-opener as to what is available to allow people to stay in their own home.

– Navigator service user

Responses to the other survey questions (including those in the non-core modules) were similarly *very positive* (although the completion rates for some questions were very low, which is likely reflective of their relative applicability to navigator service users' trial experiences [Table 3-6]).

As before, one core question generated a far more mixed set of responses from navigator service users: '[Is] the government...doing enough to help older people who need support navigating the aged care system? (question 8)'. Though it is important to note that this question was not aimed at capturing outcomes in relation to the trials, it is of note that only 43.5% (n=971) of navigator service users 'agreed', or 'strongly agreed' with the notion that the government is doing enough to support

older people navigate the aged care system. Conversely, almost a quarter (23.9% [n=532]) either 'disagreed' or 'strongly disagreed' with this notion, and a similar proportion (24.0% [n=535]) 'neither agreed nor disagreed'.

Feedback in relation to this survey question suggests that many navigator service users felt that *more resources* and/or *different approaches* are required from the government to appropriately support older people navigating the aged care system. However, it is also important to note that this feedback may be based on individuals' *actual* previous experiences of interacting with – or attempting to interact with – the aged care system, as well as those with *preconceived notions* about the system. Section 3.4.2, 'What were the challenges to implementing each trial and how were they addressed?' above presents further information about some of the negative perceptions associated with the aged care system.

Robbie's story

Robbie was a 66-year-old Aboriginal man who attended an Information hub session in South Australia. After the session he approached the Information hub worker for further support. Robbie was unclear if he was able to access CHSP home support because he was living in public housing and was unable to afford the cost of these services.

Utilising a private room on site, the Information hub worker spent time building rapport and trust with Robbie – which was key, given the cultural factors to consider. As a result, Robbie was reassured about his ability to access CHSP service.

Robbie was helped to register with My Aged Care and a RAS assessment was scheduled. Robbie was then advised that following confirmation of eligibility, he could expect services to commence. Although he initially only wanted an Aboriginal provider, the Information hub worker informed him of all the choices of providers available to him – including mainstream services. This opened the door to a discussion about the possibility of accessing mainstream support with a local provider.

Though Robbie remained concerned that he did not have the funds to pay for these services, the Information hub worker explained the fee waiver process and the potential for an SSW to support Robbie through the process while receiving interim domestic assistance. Robbie was agreeable to this and was referred to the SSW.

Following the scheduled RAS assessment, domestic assistance was approved on an ongoing basis. The SSW contacted Robbie to ensure his service had commenced and was to his satisfaction. Robbie expressed gratitude for the support he had received, stating that he felt *supported* and also *appreciated* the attention to detail which ensured that he received the services he was entitled to. The SSW was successful in having Robbie's fees waived via negotiation with the mainstream provider, and Robbie was overwhelmingly pleased by this positive outcome.

Table 3-6: Navigator service users' long-form survey responses, reported between February 2019 and August 2020

Long-form survey question	Response rate	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't wish to answer
1. Following today's visit/session, I have increased my knowledge of the aged care system.	2,246 (86.1%)	756 (33.7%)	1,285 (57.2%)	107 (4.8%)	16 (0.7%)	18 (0.8%)	36 (1.6%)
2. Following today's visit/session, I know more about what services are available.	2,368 (90.8%)	746 (31.5%)	1,386 (58.5%)	106 (4.5%)	20 (0.8%)	20 (0.8%)	47 (2.0%)
3. Following today's visit/session, I feel more confident to seek help from the aged care system if I need to.	2,326 (89.2%)	754 (32.4%)	1,296 (55.7%)	127 (5.5%)	25 (1.1%)	21 (0.9%)	60 (2.6%)
4. Following today's visit/session, I understand how and when I can get in touch with My Aged Care.	2,364 (90.6%)	761 (32.2%)	1,394 (59.0%)	86 (3.6%)	11 (0.5%)	13 (0.5%)	56 (2.4%)
5. Following today's visit/session, I understand that I have choices in the types of supports I can receive.	2,169 (83.2%)	680 (31.4%)	1,318 (60.8%)	79 (3.6%)	6 (0.3%)	16 (0.7%)	44 (2.0%)
6. Following today's visit/session, I am more likely to connect with an aged care service.	2,134 (81.8%)	604 (28.3%)	1,193 (55.9%)	180 (8.4%)	26 (1.2%)	17 (0.8%)	56 (2.6%)
7. Following today's visit/session, I will tell others about my experience and encourage them to find out more.	2,257 (86.5%)	838 (37.1%)	1,183 (52.4%)	107 (4.7%)	13 (0.6%)	13 (0.6%)	50 (2.2%)
8. The government is doing enough to help older people who need support navigating the aged care system.	2,230 (85.5%)	229 (10.3%)	742 (33.3%)	535 (24.0%)	368 (16.5%)	164 (7.4%)	75 (3.4%)
9. The information today was presented in a way I could understand.	1,868 (71.6%)	797 (42.7%)	924 (49.5%)	51 (2.7%)	12 (0.6%)	21 (1.1%)	41 (2.2%)
10. The presenter today was knowledgeable about the topics.	1,789 (68.6%)	883 (49.4%)	801 (44.8%)	32 (1.8%)	3 (0.2%)	23 (1.3%)	32 (1.8%)
11. Following today's visit/session, I would recommend today's session to others.	1,771 (67.9%)	804 (45.4%)	824 (46.5%)	53 (3.0%)	12 (0.7%)	18 (1.0%)	38 (2.1%)
12. I value having a volunteer older person delivering these sessions to my community.	460 (17.6%)	199 (43.3%)	204 (44.3%)	31 (6.7%)	5 (1.1%)	5 (1.1%)	9 (2.0%)
13. The information today was presented in a way I could understand.	311 (11.9%)	93 (29.9%)	212 (68.2%)	2 (0.6%)	1 (0.3%)	1 (0.3%)	1 (0.3%)

Long-form survey question	Response rate	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't wish to answer
14. The person today was knowledgeable about the topics.	298 (11.4%)	82 (27.5%)	209 (70.1%)	3 (1.0%)	0 (0.0%)	2 (0.7%)	1 (0.3%)
15. Following today's visit/session, I would recommend others book in for a chat.	290 (11.1%)	87 (30.0%)	195 (67.2%)	1 (0.3%)	1 (0.3%)	0 (0.0%)	5 (1.7%)
16. I value having a volunteer older person talking to me about aged care services.	143 (5.5%)	19 (13.3%)	113 (79.0%)	7 (4.9%)	0 (0.0%)	0 (0.0%)	3 (2.1%)
17. It is important for workers to get out amongst my people and my community and share information about aged care supports.	568 (21.8%)	192 (33.8%)	328 (57.7%)	23 (4.0%)	2 (0.4%)	10 (1.8%)	9 (1.6%)
18. I am satisfied with the support and information I received during today's phone call.	53 (2.0%)	21 (39.6%)	30 (56.6%)	2 (3.8%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
19. The person understood my issues.	57 (2.2%)	27 (47.4%)	30 (52.6%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
20. I am better able to deal with issues that I sought help with.	59 (2.3%)	24 (40.7%)	32 (54.2%)	0 (0.0%)	1 (1.7%)	2 (3.4%)	0 (0.0%)

Note: overall response rates (shown in second column) are calculated out of all trial survey responses (n=2,608). Responses to all questions presented (e.g. regardless of indicated relevance of question). Responses of 'Don't know/not sure' have been factored into the percentages but are not shown, hence response percentages may total <100.0%. Q1–8 core questions intended to be answered by navigator service users following all trial activities. Remaining questions to be answered only following Group trial activities (Q9-11); volunteer-led Group trial activities (Q12); Individual trial activities (Q13-15); volunteer-led Individual trial activities (Q16); outreach trial activities (Q17) and trial activities delivered by telephone (Q18-20).

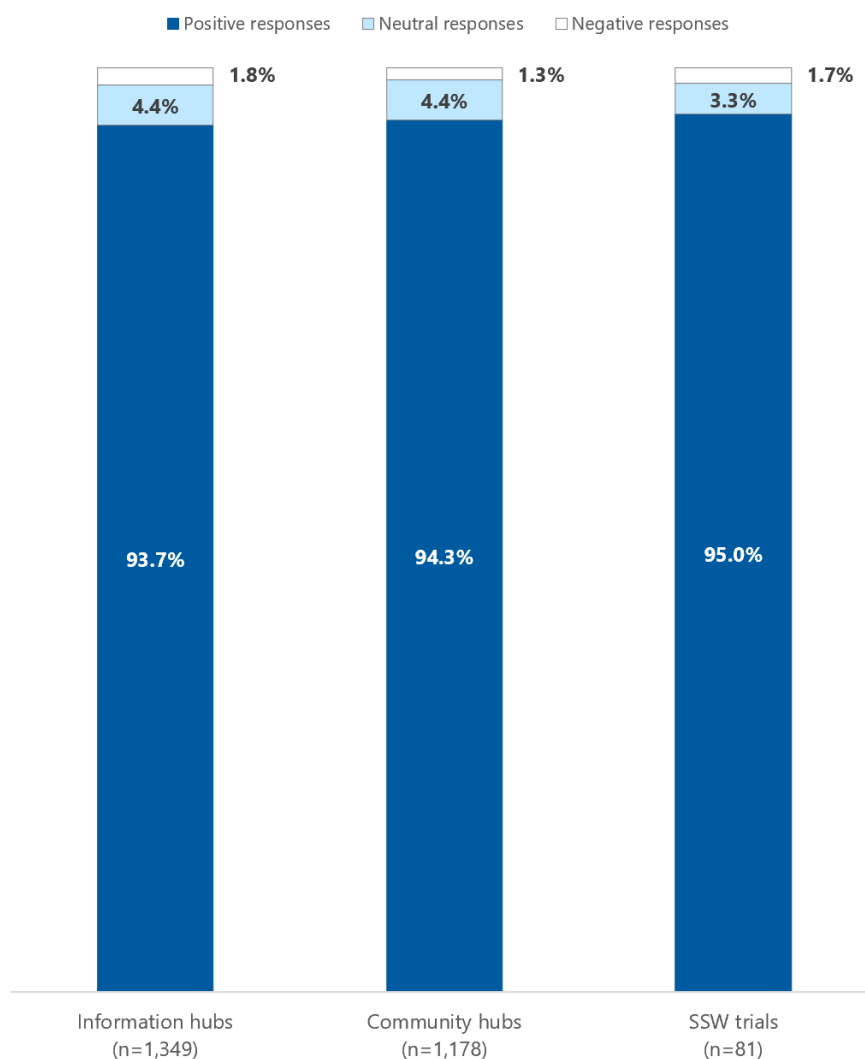
Trial types

Figure 3-4 shows the overall proportions of positive ('strongly agree'/'agree'), negative ('strongly disagree'/'disagree') and neutral ('neither agree nor disagree') responses from navigator service users, presented by trial type (omitting responses to Q8, which is not directly related to trial outcomes). (Note: no long-form survey responses were reported by the 2 Integrated Information hub/SSW trials).

While noting the comparatively low number of long-form survey responses from the SSW trials (n=81) compared to the Information hubs (n=1,349) and Community hubs (n=1,178), all 3 trial types reported similarly high levels of positive responses from navigator service users, with very few negative responses reported (Figure 3-4).

Similarly, when considering survey responses originating from Group (n=1,471) or Individual (n=347) trial activities, very similar levels of positive navigator responses were observed: 96.1% and 97.5%, respectively.

Figure 3-4: Distribution of positive, neutral and negative long-form survey responses, reported between February 2019 and August 2020, by trial type



Note: percentages calculated from total positive ('strongly agree'/'agree'), negative ('strongly disagree'/'disagree') and neutral ('neither agree nor disagree') responses. Responses to Q8 were not included as this question is not directly related to trial outcomes). N numbers in parentheses shown the number of long-form survey records reported by each trial type. The 2 Integrated Information hub/SSW trials reported zero survey records.

Trial activity types

Table 3-7 shows the overall proportions of positive, negative and neutral responses from navigator service users, presented by trial activity type. The number of long-form survey records associated with each trial activity type ranged from n=637 ('Seminars')* down to n=10 ('Assistance with filling in a form/application process') (Table 3-7).

*Note: survey response information related to 'Seminars' was not previously presented in the Interim Report due to a lack of exact matching of trial activity codes in the Group trial activities tab, and no survey records formally recording 'Seminars' as the associated trial activity type. However, as outlined in the limitations above, a modified review of trial activity session codes applying the search terms 'seminar' and 'sem' generated a number of records (n=637), which appeared to be approximate matches to 'Seminar' records reported in the Group trial activities tab. These records are included in Table 3-7 below.

While there were large disparities in the number of reported trial surveys associated with each trial activity type, as before, all trial activity types garnered similarly high levels of positive responses from navigator service users, with few negative, or even neutral, responses reported (Table 3-7).

In line with findings presented in the Interim Report, assessment of navigator service user responses to each of the 20 questions making up the long-form survey generated *no meaningful differences* when split by *trial type*, or *trial activity type* (including for 'Seminars' [see above]) (data not shown).

Table 3-7: Distribution of positive, neutral and negative long-form survey responses, reported between February 2019 and August 2020, by trial activity type

Trial activity (n)	Positive responses (%)	Neutral responses (%)	Negative responses (%)
Seminars (n=637)	94.4%	3.9	1.7%
Distribution of tailored information (n=295)	93.7%	5.5%	0.8%
Assistance with filling in a form/application process (n=10)	100.0%	0.0%	0.0%
Outreach (n=47)	97.9%	1.7%	0.4%
Support by a staff member (n=402)	95.6%	3.2%	1.2%
Peer support by a volunteer (n=25)	97.3%	2.7%	0.0%
Other activity (n=154)	96.0%	3.6%	0.3%

Note: percentages calculated from total positive ('strongly agree'/'agree'), negative ('strongly disagree'/'disagree') and neutral ('neither agree nor disagree') responses. Only responses to questions directly related to the trials are shown (e.g. responses to Q8 have been omitted). The 'n' numbers in parentheses shown the number of trial survey records submitted for each trial activity type.

Modes of trial activity delivery

As highlighted above, the majority of long-form survey responses – just over three-quarters – originated from trial activities that had been delivered face-to-face, with very low numbers reported for telephone (around 3%) or online (<1%). Due to these disparities in reporting rates, it has not been possible to utilise long-form survey responses to explore any potential differences in navigator service user outcomes based on mode of trial activity delivery.

As described above, navigator service users reported very similar levels of positive outcomes via the long-form survey, indicating high levels of satisfaction with their trial experiences, regardless of trial or trial activity type.

However, it has not been possible to evaluate whether these positive short-term outcomes (e.g. reported directly following a trial interaction) actually eventuated in easier or quicker access to aged care services over the medium to longer term.

To what extent, in what ways and why did reported satisfaction levels differ between populations?

As of August 2020, long-form survey responses reported vulnerable population information for only 17.9% (n=466) of navigator service users, which represented a *proportional decrease* in vulnerability information compared to in the Interim Report (20.5% [n=356]). Similarly, the reporting of diverse group information was also reduced: 44.6% (n=1,163) versus 50.3% (n=874) in the Interim Report.

As a result of these proportional decreases in reported vulnerability and diverse group information – and the general limitations associated with the long-form survey (see 'Were navigator service users satisfied with the services?' above) – little merit was seen in re-presenting findings in relation to trial outcomes of different 'target populations' using this survey tool.

Instead, the following section focuses on navigator service user outcomes reported in the simplified short-form survey, which was piloted in a *subsample* of partner organisations with a specific focus on CALD and Aboriginal or Torres Strait Islander populations. As highlighted in the previous subsection, this simplified tool was designed to be more culturally appropriate, with a focus on collecting *fewer, more meaningful* responses, in order to optimise the quality and completeness of reported trial outcomes in these 2 target populations.

Note: following the successful piloting of the short-form survey, a modified version was rolled out to *all* partner organisations for use across all 64 trials from September 2020 (e.g. the start of the eighth reporting period).

Mrs Koh's story

Mrs Koh resettled in Australia in the 2010s, after she and her family had spent time in a Bhutanese refugee camp in Nepal. She lived with her eldest son and his family, which is in line with cultural expectations. Neither Mrs Koh nor her family spoke English and Mrs Koh suffered from poor hearing (even with hearing aids) and was unable to use a telephone. The family provided considerable assistance with daily living tasks such as cooking, shopping, paying bills and the cleaning.

Mrs Koh's son was concerned that some tasks such as personal care had become difficult for Mrs Koh to manage on her own. For cultural reasons, her son found this issue challenging to address. He also wondered if his mother would enjoy reconnecting with her community as she had withdrawn from activities outside of the home and family. With his mother's permission, he sought to find aged care support for his mother.

Mrs Koh's son accessed navigator support through the Migrant Resource Centre (MRC Tas) in Hobart. The navigator assisted Mrs Koh's son to apply to register as a representative for her on My Aged Care, and arranged an interpreter to assist them to apply for an online assessment. The online assessment on My Aged Care required a follow-up phone call, and the ACSN supported the family through this. However, Mrs Koh was unable to hear or understand the TIS National Interpreter and a further referral from a GP was recommended by the My Aged Care operator. With consent, the ACSN followed up with Mrs Koh's GP to explain the purpose of the referral; this enabled the GP to not only complete the referral but also have a broader discussion with the family and Mrs Koh about how to maintain good physical and mental health as she ages.

Mrs Koh was subsequently connected with the Bhutanese Elders Social Group at MRC Tas. Though she didn't wish to attend at the time, she was aware that group and one-on-one supports were available in her language. Mrs Koh's son was also more aware of available supports that would complement their cultural expectation of caring for elderly family members.

Having the support of a navigator with an understanding of cultural needs and language support has been a great relief to Mrs Koh and her son.

Original short-form survey

Note: the following subsection is based on information collected via the original short-form survey between December 2020 and August 2021. See Appendix F for findings based on information collected from September 2020 via the modified short-form survey, which are arguably more robust and representative than the findings presented below.

As of August 2020, a total of 254 short-form survey responses had been reported by 5 partner organisations, originating from 6 Information hub and 3 Community hub trials:

- Information hubs: n=148 (58.3%)
- Community hubs: n=106 (41.7%)

The distribution of short-form survey responses reported was *relatively* even for 4 of the 5 partner organisations: between n=40 (15.7%) and n=90 (35.4%) records, while the fifth partner organisation only reported a single response (0.4%).

As the short-form survey responses (reported to date) are only derived from a small and select number of partner organisations/trials, this should be kept in mind when interpreting the following *preliminary* findings in relation to navigator service user outcomes from CALD and Aboriginal or Torres Strait Islander populations.

Original survey format

The original short-form survey tool was comprised of the following sections, with the intention that responses were provided in *all* sections (by navigator service users with or without the assistance of trial staff – for example, for pre-population of target population status, trial activity type, etc.):

- Navigator service user information:
 - Demographics, including diverse group and vulnerability information
 - Language/s spoken at home
 - Receipt of current aged care services
- Trial activity type (excluding mode of delivery)
- Trial outcomes, including:
 - direct and indirect outcomes
 - a free-text option to allow navigator service users to provide additional comments on their trial experience.

Overall

Just under two-thirds of original short-form survey respondents were female (63.8% (n=162]), with around half aged between 61–80 years (51.6% [n=131]). Only 7.5% (n=19) of navigator service users were reported to be receiving aged care services, compared to 47.6% (n=121) who were not (with the remainder unknown).

Note: although these proportions are somewhat at odds with the overall cohort of navigator service users (see Table 3-13), this observed difference may be an artefact of the very limited sample of navigator service users completing the short-form survey as part of the pilot.

Over 90% of short-form survey respondents had received support via one of 2 types of trial activity:¹⁸

- Information materials, such as brochures or presentations (47.6%, n=121)
- Group activities (46.1%, n=117) (see below)

Table 3-8 shows the diverse groups and vulnerable populations reported in the short-form survey (data not mutually exclusive).

Table 3-8: Diverse groups and vulnerable populations reported short-form survey respondents

Population group	n (%)
Do not wish to disclose	30 (11.8%)
Diverse group*	No group total individual groups shown below
CALD	150 (59.1%)
Aboriginal or Torres Strait Islander	65 (25.6%)
Rural/remote	9 (3.5%)
Accessibility (vision/hearing impairment)	3 (1.2%)
LGBTI	0 (0.0%)
Vulnerable population	No group total individual groups shown below
Financially and socially disadvantaged	8 (3.1%)
Care leaver	7 (2.8%)
Veteran	6 (2.4%)
Disability	5 (2.0%)
Socially isolated or at risk of social isolation	4 (1.6%)
Mental health challenges	4 (1.6%)
Forced adoption	1 (0.4%)
Cognitive impairment (including dementia)	0 (0.0%)
Homeless (or at risk of homelessness)	0 (0.0%)

Note: percentages are out of all survey records (n=254, which included n=9 records with no diverse group/vulnerability information recorded). *The short-form survey did not include an option for reporting the diverse group 'Accessibility (digital barrier)'. Data are not mutually exclusive.

¹⁸ Note: the short-form survey provided 4 options for trial activities, which didn't wholly align with trial activity types reported elsewhere in the COTA Australia data set: 'Distribution of tailored information'; 'Group activities'; 'Information materials, such as brochures or presentations' and 'Help with filling out application forms'.

As expected, navigator service users from 'CALD' and 'Aboriginal or Torres Strait Islander' populations comprised the largest proportions of respondents: 59.1% and 25.6%, respectively. Though the latter was only ever reported as a single diversity, a degree of intersectionality with other groups was observed in the 'CALD' population (albeit at very low levels: $\leq 3.1\%$ of records per reported combination).

Table 3-9 shows the most frequently reported languages that navigator service users spoke at home. A total of 28 languages/language combinations were reported by survey respondents, creating a long tail in the data (not shown).

Table 3-9: Language/s spoken at home, reported short-form survey respondents

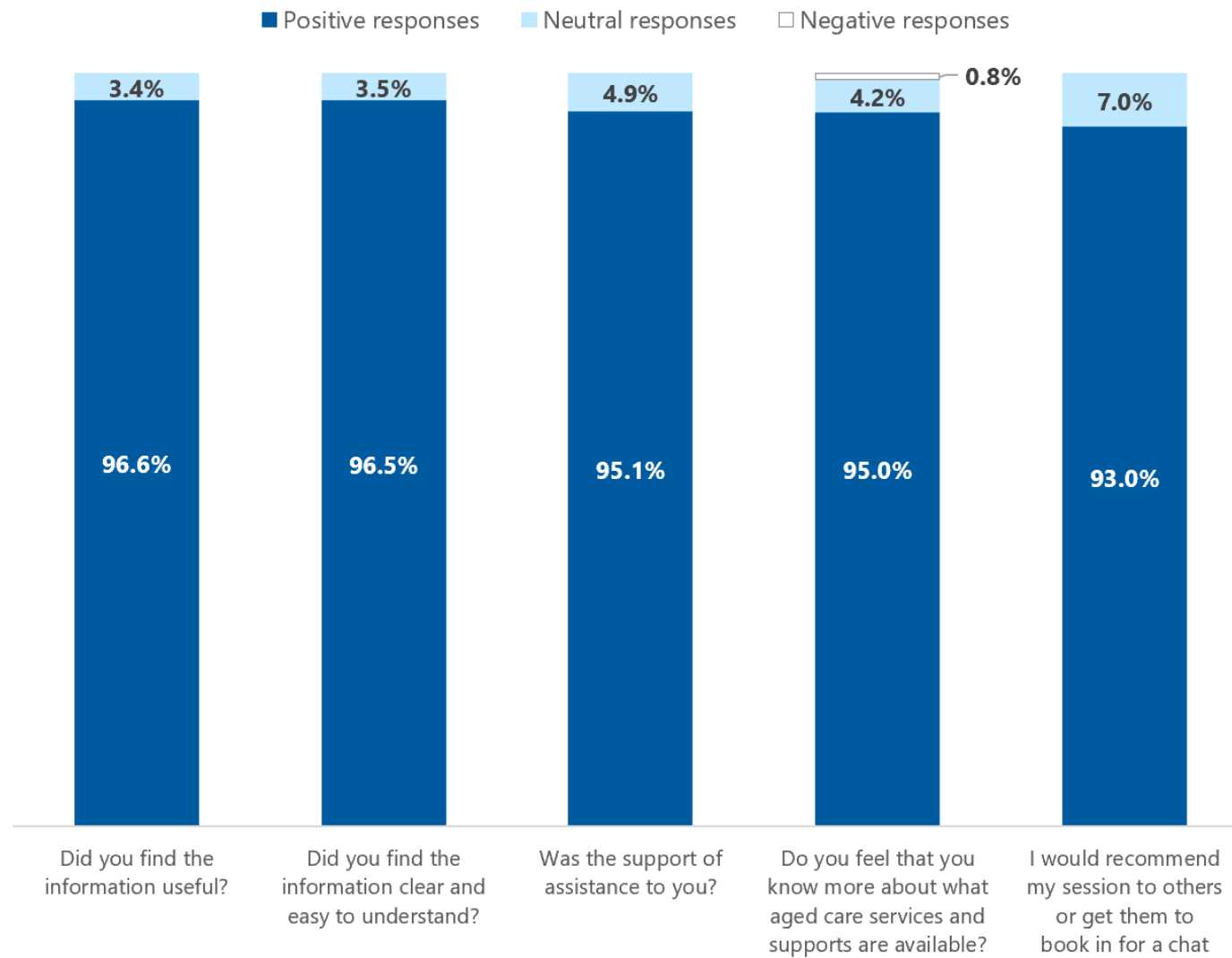
Language	n (%)
English	88 (34.6%)
Karenni	41 (16.1%)
Vietnamese	27 (10.6%)
Cantonese	24 (9.4%)
Mandarin	13 (5.1%)
Chinese	11 (4.3%)
Korean	8 (3.1%)
Matu	7 (2.8%)
Filipino	3 (1.2%)
No data reported	4,577 (4.3%)

Note: language/s spoken at home reported for $\geq 1.0\%$ of navigator service user respondents shown; percentages are out of all survey respondents (n=254).

Figure 3-5 and Figure 3-6 show the proportions of positive ('strongly agree'/'agree'), negative ('strongly disagree'/'disagree') and neutral ('neither agree nor disagree') responses to the 5 survey questions in relation to *direct* trial outcomes, reported by 'CALD' (n=150) and 'Aboriginal or Torres Strait Islander' (n=65) respondents (where responses reported).

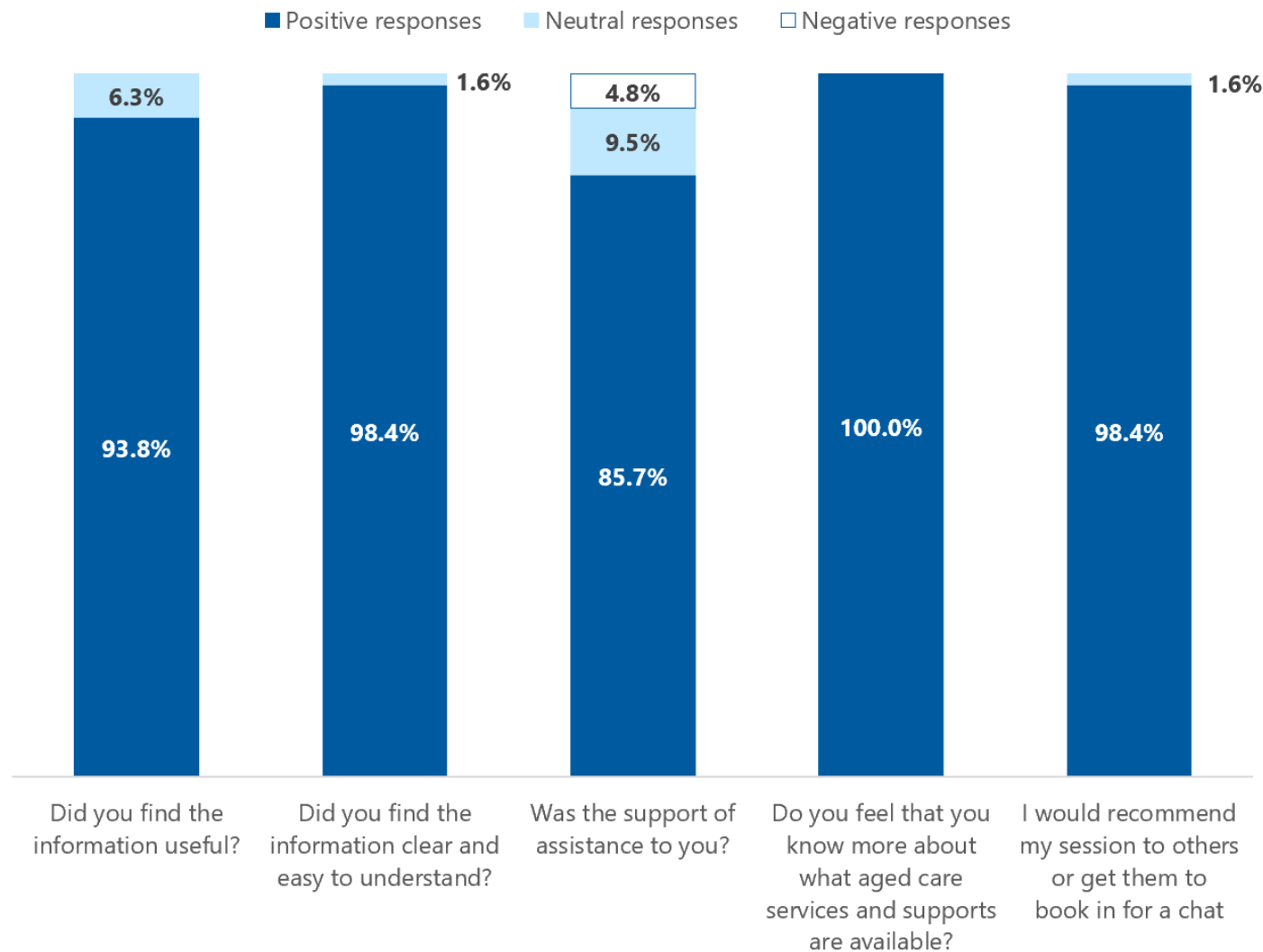
Navigator service users from 'CALD' and 'Aboriginal or Torres Strait Islander' populations reported similarly high levels of positive responses in relation to direct trial outcomes, with very few negative responses reported (Figure 3-5 and Figure 3-6). These findings are very much in line with findings reported for the long-form survey tool (see 'Were navigator service users satisfied with the services?' above).

Figure 3-5: Distribution of positive, neutral and negative short-form survey responses – CALD respondents



Note: percentages calculated from total positive ('strongly agree'/'agree'), negative ('strongly disagree'/'disagree') and neutral ('neither agree nor disagree') responses.

Figure 3-6: Distribution of positive, neutral and negative short-form survey responses – Aboriginal or Torres Strait Islander respondents



Note: percentages calculated from total positive ('strongly agree'/'agree'), negative ('strongly disagree'/'disagree') and neutral ('neither agree nor disagree') responses.

Russell's story

Russell was an Aboriginal man who lived by himself in a retirement village. He had lived there for some time and had access to some supports within the village; however, due to his deteriorating health, he wanted some home help.

Navigators from a local ACSN trial were invited to have a yarn with some Elders after they had finished an organised exercise session. The navigators had been made aware in advance that the Elders were a bit anxious when they heard that 'people from aged care' were coming. However, once introductions had been made and the Elders had shared some of their stories including where their mobs were from, they relaxed a little. After the session, Russell asked for a one-on-one follow up because he wanted to know more about aged care, and what the processes involved.

Because they were able to connect with Russell in a culturally appropriate way, the navigators were able to break down barriers and he was open to having a further discussion. Russell said that he had wanted home help for a while but just didn't know how or what to do. After having a yarn with the navigator, Russell was assisted with a referral for an assessment.

Being an independent person, Russell was happy to be able to remain living at home. Having home help allowed him to continue with his weekly routines and enjoy doing what was important to him.

Two short-form survey questions in relation to direct trial outcomes elicited *some* negative responses (though the n numbers were very low):

- 'Do you feel that you know more about what aged care services and supports are available?' (n=1 response (0.8%) of 'strongly disagree' from a CALD respondent.)
- 'Was the support of assistance to you?' (n=3 responses (4.8%) of 'disagree' from Aboriginal or Torres Strait Islander respondents.)

I have had so many challenges providing assistance to [my] client. I didn't know where to refer him to because of his cultural and language needs. I am so glad he and his family can now also speak with your services.

– Navigator service user (service provider)

The short-form survey also included one final question in relation to trial outcomes: 'Do you feel that it is easier for you to access aged care services and supports?'. Asking navigator service users to respond to this question as part of the survey may be considered somewhat premature, given the reasonable likelihood of them being unable to accurately assess this outcome immediately following a trial interaction. Further, this trial outcome is, at least in part, an *indirect* one because in some circumstances it is likely to depend on factors which are *outside of the trials' control* – for example, the availability of local aged care services and supports.

Table 3-10 shows navigator service user responses to this question, as reported in the short-form survey.

Table 3-10: Distribution of short-form survey responses to the question 'Do you feel that it is easier for you to access aged care services and supports?', by population group

Population group	Strongly agree	Agree	Neither agree or disagree	Disagree	Strongly disagree
CALD (n=117)	57 (48.7%)	50 (42.7%)	7 (6.0%)	3 (2.6%)	0 (0.0%)
Aboriginal or Torres Strait Islander (n=63)	44 (69.8%)	18 (28.6%)	1 (1.6%)	0 (0.0%)	0 (0.0%)

Despite the limitations described above, the vast majority of 'CALD' and 'Aboriginal or Torres Strait Islander' respondents reported positive responses (e.g. 'strongly agree'/'agree') to the question '*Do you feel that it is easier for you to access aged care services and supports?*': 91.5% (n=107) and 98.4% (n=62), respectively (Table 3-10). A few respondents reported neutral or negative responses – accounting for 6.1% (n=11) of respondents overall. However, as mentioned above, it may have been too early for navigator service users to accurately assess changes in their ease of access to aged care services, and, importantly, access would also be contingent on the inherent availability of local services.

We get very few services in our area, so it is really hard to know who to go to for help.

– Navigator service user (CALD, rural/remote)

Trial activity types

As highlighted above, the majority of short-form survey respondents had received support via 2 trial activity types: receipt of 'Information materials, such as brochures or presentations' and 'Group activities' (mode of delivery unknown). The split of trial activities received by 'Aboriginal or Torres Strait Islander' survey respondents was 60:40 in favour of 'Group activities', but the opposite was observed for the CALD respondents.

Variations in trial activity uptake aside, there was little difference in the survey responses associated with these 2 trial activities, as indicated below:

'Group activities' – overall positive reporting rate: 100.0% for 'CALD' and 97.3% for 'Aboriginal or Torres Strait Islander' respondents.

'Information materials, such as brochures or presentations' – overall positive reporting rate: 91.8% for 'CALD' and 93.5% for 'Aboriginal or Torres Strait Islander' respondents.

As described above, navigator service users from a subsample of 'CALD' and 'Aboriginal or Torres Strait Islander' populations presenting at the trials reported very similar levels of positive outcomes via the short-form survey, indicating high levels of satisfaction with their trial experiences. However, as for the long-form survey, it is important to note that this version of the survey only gathered information on *short-term* outcomes. As such, the positive survey responses cannot be used to predict longer-term outcomes; that is, changes in ease of access to aged care services following a trial interaction.

That important point aside, the roll-out of a modified version of the short-form survey to all 64 trials (from September 2020) is an opportunity to build on the findings presented above, particularly in relation to the other 'target populations' presenting at the trials. The first portion of trial-wide short-form survey responses was due for submission in December 2020, and has been used, where feasible, to assess any observed differences in the short-term outcomes of different 'target populations', as presented in Appendix F.

3.5.2 Who are the trials reaching (and who may not be reached)?

The information presented below is *primarily* derived from quantitative data collected and reported in the COTA Australia data set, although qualitative information – from partner organisation consultations and submitted case studies – are also reflected, where available.

Given the acknowledged limitations of the COTA Australia data (as detailed in the Interim Report and outlined in Section 2.6), the reliance on it as a *primary data source* here means that caution should be exercised when interpreting the findings presented below, particularly in relation to *vulnerability* and *diverse group* information.

What are the characteristics of people using each trial activity?

In line with findings presented in the Interim Report by November 2020 (e.g. inclusive of quarter 8 data) aged care consumers comprised the *largest proportion of navigator service users* receiving individual support from the trials: 44.0% (n=6,828), including 43.7% (n=6,784) who presented unaccompanied (see Table D-5, Appendix D).

The proportion of aged care consumers presenting at the trials does *appear* to have reduced over time. For example, the overall attendance rate reported in the Interim Report (April 2020) was 56.2%; however, this reduction appears to be driven by far higher proportions of Individual trial activity records with missing data (one-quarter of records), rather than proportional increases in other navigator service user types, such as family members.

Interestingly, some partner organisations, notably those targeting CALD populations, reported that the shift from face-to-face communication to phone and online modes communications in response to COVID-19 had necessitated a shift towards engaging with *younger family members* (e.g. those more likely to be proficient in English and/or computer literate). However, as outlined above, this was not reflected in the COTA Australia data set

In line with navigator service user status information (above), around 60% of navigator service users were aged between 60 years and 90 years (see Table D-7, Appendix D) with females comprising the largest cohort overall: 51.2% (n=7,937) (see Table -6, Appendix D). Around 40% of navigator service users were reported to have been born in Australia, followed by Italy (around 9%),¹⁹ the UK (3%) and Greece (1%) (see Table D-8, Appendix D).²⁰

The next subsections focus on the 'target populations' presenting at the COTA Australia-led trials. It is, again, important to note that given the observed *quantum* of vulnerability and diverse group information reported in the COTA Australia data set at November 2020 – and the introduction of the redefined trial activity types at quarter 8 – it has not been possible to explore how each 'target population' has interacted with the trials at a *trial activity-level*.

As such, the below information presents the 'target populations' presenting at the trials, *overall*, and by *trial type*.

¹⁹ Note: 905/1,021 records of 'Italian' nationality were reported by one partner organisation that is an Italian-Australian service provider.

²⁰ Note: country of birth not collected in refined COTA Australia data set (reporting quarter 8 [September 2020] onwards).

Vulnerable populations

As documented in the Interim Report (and outlined in Section 2.6), partner organisations have encountered numerous challenges when attempting to collect navigator service users' vulnerability information. As a result, the overall reporting rate for *material* vulnerability information – that is, all responses other than 'Unsure', 'Not stated or inadequately described' or where no data were reported – remains relatively low as of November 2020:

- Overall reporting rate: 37.8% (n=5,859 records)
- Information hubs: 30.9% (n=1,686)
- Community hubs: 9.2% (n=288)
- SSW trials: 59.8% (n=2,948)
- Integrated Information hub/SSW trials: 47.0% (n=937)

As reported previously, the SSW trials (and, to an extent, the Integrated Information hub/SSW trials) had much higher reporting rates for material vulnerability information (see above). This is likely to be a result of the more *intensive* one-on-one support these trials are expected to be delivering, which in turn may result in lengthier, more trusted relationships being formed between trial staff and navigator service users.

Since the Interim Report, the reporting rate of material vulnerable population by Community hubs had decreased dramatically, from 28.2% down to just 9.2%. (shown above). This was driven primarily by a substantial increase in the number of Individual trial records with no data reported. The reason for this disproportionate reduction in data reporting by the Community hub trials is unknown.

Table 3-11 shows the most common vulnerabilities reported for navigator service users in the COTA Australia data set.

Table 3-11: Distribution of the most common vulnerabilities reported for navigator service users, between February 2019 and November 2020

Vulnerability	n (%)
Socially isolated or at risk of social isolation	1,421 (9.2%)
Financially and socially disadvantaged	1,023 (6.6%)
Cognitive impairment (including dementia)	592 (3.8%)
Disability	550 (3.2%)
Mental health challenges,	268 (1.7%)
Homeless (or at risk of homelessness)	238 (1.5%)
Financially and socially disadvantaged, Socially isolated or at risk of social isolation	225 (1.5%)
Financially and socially disadvantaged, Homeless (or at risk of homelessness)	219 (1.4%)
Cognitive impairment (including dementia), Socially isolated or at risk of social isolation	168 (1.1%)

Note: data are mutually exclusive; percentages are out of all navigator service users receiving Individual trial activities; material vulnerabilities reported for ≥1.0% of these navigator service users.

In line with previous reports, 'Social isolation or at risk of social isolation' (as a single vulnerability) was the most commonly reported vulnerability across the trials: 9.2% (n=1,421) of navigator service users (Table 3-11). Further, when 'Social isolation or at risk of social isolation' was also reported in combination with other vulnerabilities, the proportion increased to 41.6% (n=2,440) of navigator service users. The next most common vulnerabilities (reported singularly or in combination with others) were also the same as those presented in the Interim Report: 'Financially and socially

disadvantaged' (38.2% [n=2,239]), 'Cognitive impairment (including dementia)' (18.1% [n=1,062]), 'Disability' (14.0% [n=822]), 'Homelessness (or at risk of homelessness)' (11.2% [n=659]) and 'Mental health challenges' (11.1% [n=651]) (data not mutually exclusive). The remaining vulnerabilities (as listed in Section 3.3.2) were reported less frequently in Individual trial activity records.

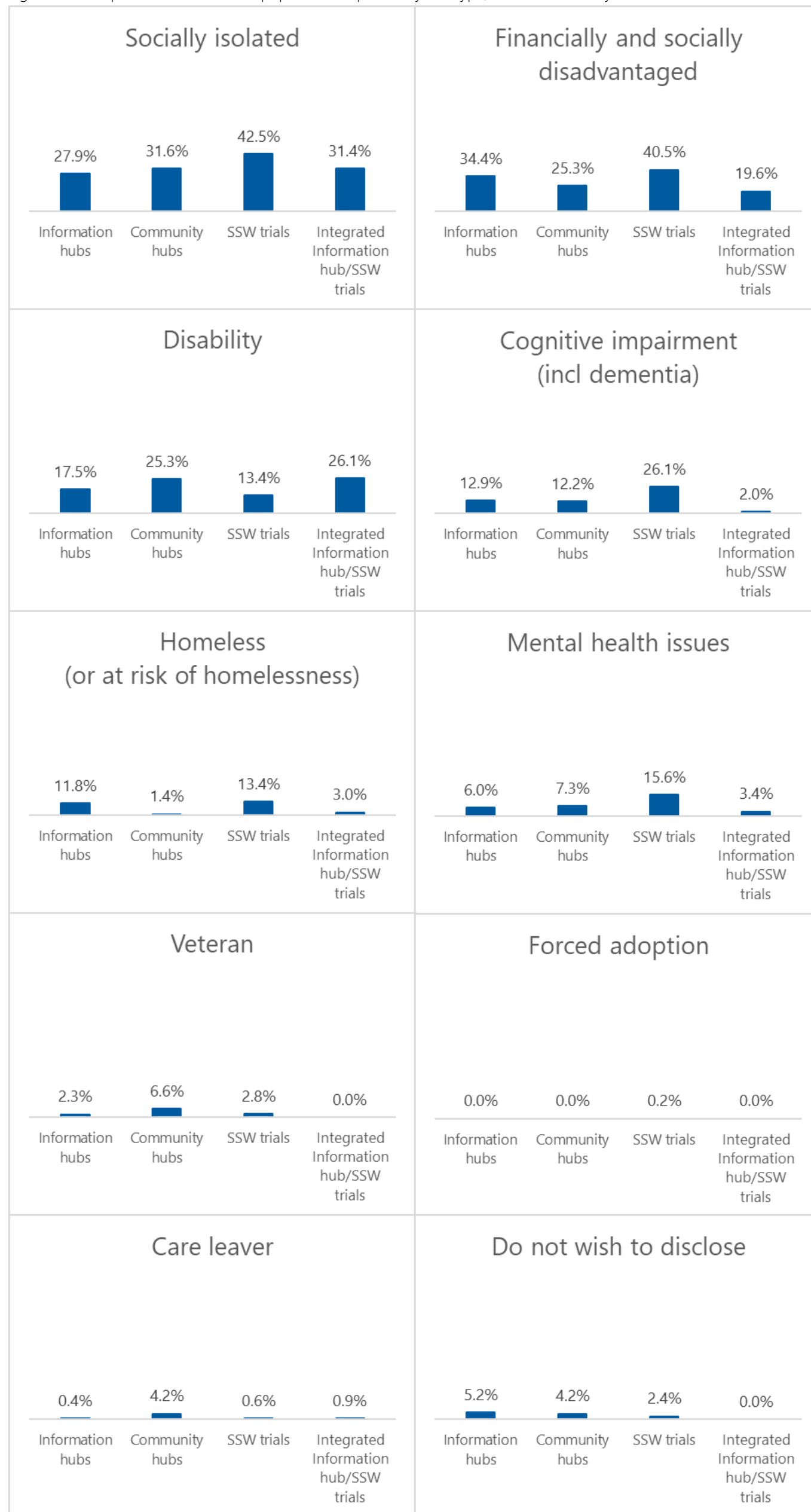
Figure 3-7 shows vulnerability information reported by navigator service users, as a proportion of all navigator service users presenting at each trial type (excluding records with missing information or where the information was reported as uncertain or not available).

Broadly, the Information hubs, Community hubs and SSW trials reported similar proportions of navigator service users from each population group – with a few exceptions:

- The SSW trials reported disproportionately more individuals who were 'Socially isolated or at risk of social isolation' (although this had reduced to just over 40% compared to earlier reports [>50%]), had 'Cognitive impairment (including dementia)' and 'Mental Health challenges'. As reported previously, this pattern may reflect that the SSW trials' service offerings were particularly suited to engaging these specific vulnerable groups.

Compared to previous reports, the SSW trials also now reported the highest proportion of navigator service users who were 'Homeless (or at risk of homelessness)'. This was due to a small drop-off in numbers reported by the Information hubs – including the one delivered by a homelessness support organisation (Figure 3-7).

Figure 3-7: Proportions of vulnerable populations reported by trial type, between February 2019 and November 2020



Note: for any given trial type, navigator service users with multiple vulnerabilities will appear in > 1 vulnerability category.

As before, Community hubs reported the highest proportions of navigator service users who reported that they had a Disability, were Veterans and/or were Care leavers.

Generally speaking, the 2 Integrated Information hub/SSW trials reported a lower proportion of vulnerable navigator service users than the other trial types (Figure 3-7).

Diverse groups

Partner organisations also faced challenges when collecting 'diverse group' information for navigator service users. Although the associated reporting rates for *material* diversity information (e.g. responses other than 'Not stated or inadequately described' or no data reported) were somewhat higher compared to those for vulnerability data (see subsection above), they again remained somewhat low as of November 2020:

- Overall reporting rate: 52.9% (n=8,201 records)
- Information hubs: 59.2% (n=3,228)
- Community hubs: 24.4% (n=764)
- SSWs: 65.7% (n=3,238)
- Integrated Information hub/SSW trials: 48.7% (n=971)

In line with findings presented previously, the SSW trials reported the highest rates for material diverse group information (68.3%, above). As described in the subsection above, higher reporting rates may reflect the more in-depth support that these trials deliver, permitting the establishment of deeper, more trusted, connections between SSWs and navigator service users.

Interestingly, since the Interim report, the reporting rate of diverse group information had increased substantially for the Information hubs (46.4% versus 59.2% [above]) and decreased substantially for the Community hubs (43.5% versus 24.4% [above] – and followed a similar pattern to the reporting of vulnerability information). The reasons for these observed differences in material data reporting rates over time remain unknown.

Table 3-12 shows the most common diverse groups that navigator service users identified with, as reported in the COTA Australia data set.

Table 3-12: Distribution of the most common diverse groups reported for navigator service users, between February 2019 and November 2020

Diverse group	n (%)
CALD	2,759 (17.8%)
Rural/remote	1,449 (9.3%)
Accessibility (digital barrier)	1,235 (8.0%)
Aboriginal or Torres Strait Islander	812 (5.2%)
Accessibility (digital barrier), Accessibility (vision/hearing impairment)	533 (3.4%)
CALD, Accessibility (digital barrier)	245 (1.6%)
Accessibility (vision/hearing impairment)	203 (1.3%)
LGBTI	151 (1.0%)

Note: data are mutually exclusive; percentages are out of all navigator service users receiving Individual trial activities; material diverse group information reported for ≥1.0% of these navigator service users.

As before, the group comprising 'CALD' individuals (as a single group) was the most commonly reported across the trials: 17.8% (n=2,759) of navigator service users (Table 3-12), including when *combinations* of diverse groups were considered: 21.1% (n=3,270).

The next most common diverse groups (reported singularly, or in combination with others) were 'Accessibility (digital barriers)' (17.0% [n=2,641]), 'Rural/remote' (12.3% [n=1,910]), 'Aboriginal or Torres Strait Islander' (8.1% [n=1,256]) and 'Accessibility (vision/hearing) impairment' (7% [n=1,079]) (data not mutually exclusive).

As outlined previously, the remaining diverse group – 'LGBTI' – was reported infrequently: 1.0% (n=153) of navigator service users (reported singularly or in combination with other groups). (Note: due to the large number of *combinations* of diverse groups reported in the COTA Australia data set creating a long tail in the data [e.g. <1.0% records per reported combination], 'LGBTI' – reported as a single group – still appears as one of the most commonly reported, as shown in Table 3-12).

Figure 3-8 shows the diverse groups reported by navigator service users, as a proportion of all navigator service users presenting at each trial type (excluding records with missing information or where the information was reported as not available).

Some diverse groups continued to *predominate* in certain trial types, particularly 'CALD' at Information hubs and 'Accessibility (digital barriers)' at SSW trials. Elsewhere, Community hubs reported disproportionately more individuals identifying as 'LGBTI', the SSW trials more individuals reporting 'Accessibility (vision/hearing impairment)' issues and from the 2 Integrated Information hub/SSW trials, more from individuals from 'Aboriginal or Torres Strait Islander' backgrounds and/or those from 'Rural/remote' areas (Figure 3-8).

How do the characteristics of the trial participants differ from what was expected?

The COTA Australia-led trials were expected to primarily focus on supporting individuals who had not yet accessed aged care services – although those who had already accessed aged care services would not be excluded from receiving support.

However, findings presented in the Interim Report noted that individuals *already receiving aged care services* comprised the largest cohort of navigator service users (37.0%). As of November 2020, this group was still the largest, although the proportion had reduced to 33.0% (n=5,118) (see Table 3-13).

On review, the proportion of navigator service users who had yet to access services, including those who had been assessed but were on a waiting list, was similar compared to previous reports: approximately 27% (Table 3-13), versus 31%. The reduction noted appeared to be related to a proportionate increase in Individual trial activity records with missing data (27.0% [Table 3-13] versus around 20%, as reported in the Interim Report).

Table 3-13: Status of aged care services received by all navigator service users, presenting at the trials between February 2019 and November 2020

Aged care service status	n (%)
Currently receiving services	5,118 (33.0%)
Assessed, on a waiting list for services	711 (4.6%)
Not yet assessed for services	3,502 (22.6%)
Unsure or not adequately stated	1,988 (12.8%)
No data reported	4,193 (27.0%)
Total	15,512 (100.0%)

The information presented in Table 3-13 underlines the notion that once individuals are ‘in the aged care system’, ongoing navigation support is still required – and not necessarily just in response to changing aged care need. Indeed, during consultations, partner organisations noted that people require support *throughout the process*, and often *far beyond* registration with My Aged Care and service commencement.

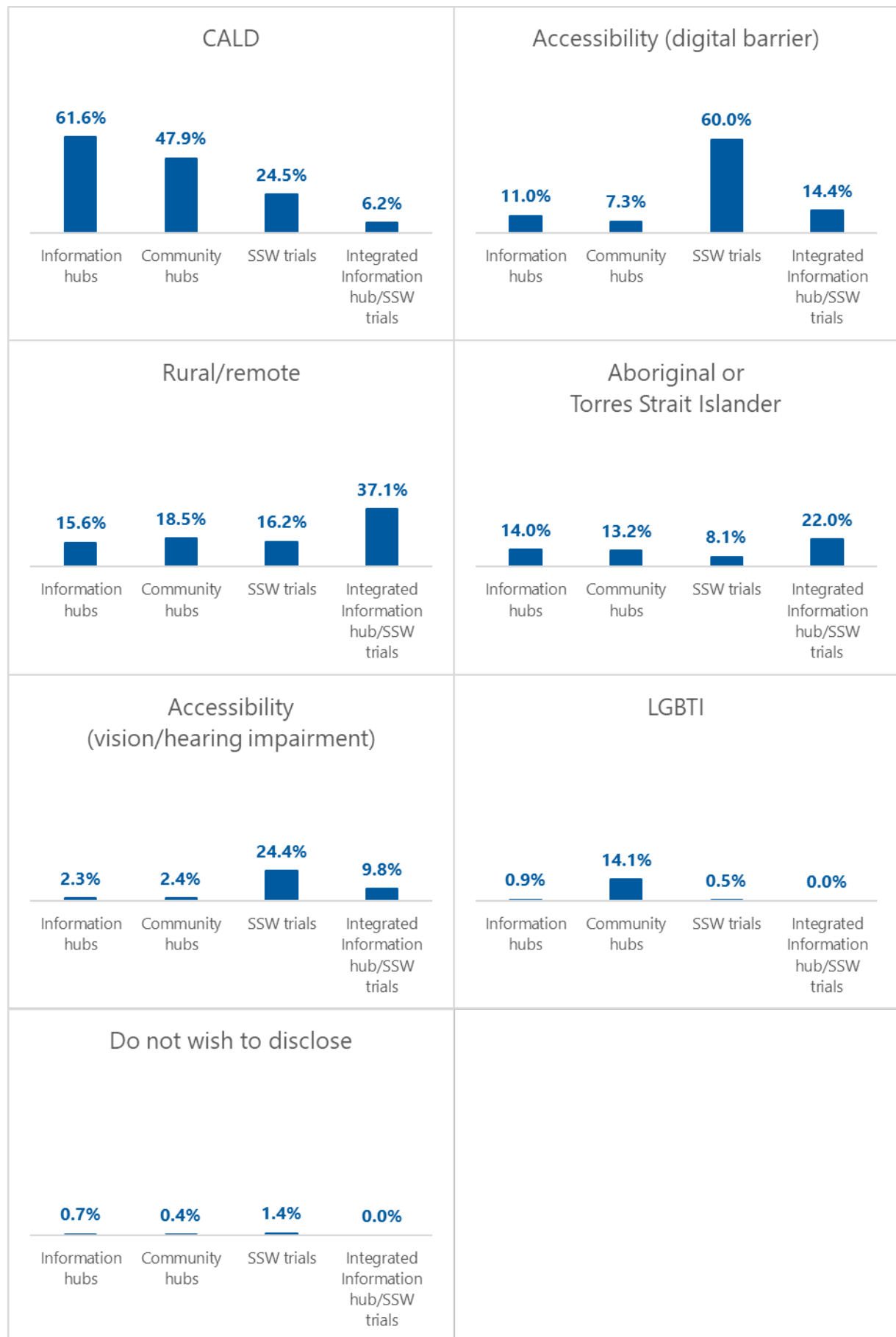
We find that all the way along, there are people floundering. They don't know where they're at, they don't know what package they're on. We are helping people through the whole process.

– Partner organisation representative

A number of case studies highlighted that trial staff were involved in assisting navigator service users address concerns and complaints about service providers – which is outside the scope of the trials as originally envisaged.

As discussed in ‘Which populations may not be accessing each trial, and why? What are the gaps?’ below, some ‘target populations’ *appeared* to be underrepresented in the COTA Australia data set. Given this is likely to be due to a number of factors (covered in the sections mentioned), it is difficult to evaluate how the characteristics of the navigator service users – in terms of ‘target populations’ – differed from what was expected at trial outset.

Figure 3-8: Proportions of diverse group populations reported by trial type, between February 2019 and November 2020



Note: for any given trial type, navigator service users with multiple diversities will appear in >1 diverse group category.

Mary's story

Mary's father, Ben, had Lewy body dementia. He lived alone but had become increasingly isolated. He had been receiving social support through the CHSP to attend bowls. Over time, Mary realised that Ben wasn't happy with the services he was receiving. Despite being promised the same workers each week, and his preference for male workers, different workers attended each week, and Ben was frustrated that they didn't understand his interests. Over time, he stopped attending bowls.

Mary met with the navigator at the Dementia Australia Information hub. The navigator helped Mary work out how to raise these issues with Ben's provider, noting how important it is for people with dementia to have consistency of carers. The discussion also explored the importance of consumers taking control of their experience and speaking up when services don't meet their expectations. The navigator gave Mary the details for Advocare, in the event that Mary could not resolve the issue independently. Mary was also given information about the local Independent Living Centre for assistive technology ideas, and the National Dementia Helpline.

As a result of her engagement with the trial, Mary felt more empowered to represent her father in discussions with the service provider.

Which populations may not be accessing each trial, and why? What are the gaps?

Vulnerable populations

As indicated in Figure 3-7, and assuming the data limitations (as outlined there and in Section 2.6) apply equally across the collection of vulnerability data, the following vulnerable population groups may be underrepresented in the overall navigator service user cohort (which was predominately composed of older individuals [see Table D-7, Appendix D]):

- Veterans: 2.4% of navigator service users (n=142)
- Care leavers: 1.0% (n=56)
- [Those affected by] forced adoption: 0.1% (n=6)

As reported in the original/updated trial profile documentation, fewer trials have set out to target 'Veterans' (n=25/n=25 of 64 trials), 'Care leavers' (n=24/n=24) and those affected by 'Forced adoption' (n=21/n=21), compared to, say, 'CALD' populations (n=38/n=37).

However, as outlined in the Interim Report, there may be other reasons that these vulnerable populations appear to be underrepresented in the COTA Australia data set, including:

- Partner organisations and/or trials may be in inaccessible locations, or trials may be being delivered in inaccessible ways, meaning these vulnerable groups are unable to access trial services.
- These vulnerabilities may be less apparent compared to others, and so may not be reported if navigator service users choose not to voluntarily disclose them.
- These groups may comprise higher proportions of individuals who are particularly reluctant to engage with the idea of aged care services, making them hard to reach in the community, and meaning partner organisations have been unable to target them.
- In the case of veterans, aged care navigation support may be being sought from other specialist organisations, such as DVA or the Returned and Services League of Australia (RSL).
- As suggested in Section 3.4.1, 'Was each trial delivered to the planned target populations?', partner organisations may have 'selected' these groups as 'target populations', meaning they would not turn them away should they present at the trials, but, in reality, have not set out to proactively engage with them.

Diverse groups

As indicated in Figure 3-8, and assuming the data limitations (as outlined there and in Section 2.6) apply equally across the collection of diverse group data, information from the COTA Australia data set suggests that individuals identifying as 'LGBTI' (1.0% [n=153]) are underrepresented in the overall navigator service user cohort.

Note: as highlighted above, though 'LGBTI' reported as a *single diverse group* still appears as one of the most commonly reported by navigator service users (see Table 3-12), this is an artefact of the large number of *combinations* of diverse groups reported in the COTA Australia data set, creating a long tail in the data.

Around a third of trials set out to target 'LGBTI' populations, so the reason/s for the *particularly low* reporting rate is unclear. However, it may be due, in part, to the *under-reporting* of this information, for example, where navigator service users who identify as LGBTI are not explicitly asked about this information, and/or they choose not to disclose it.

As indicated in Section 3.4.1, 'Was each trial delivered to the planned target populations?' and above, as part of the extension period, partner organisations were required to submit updated trial profile information, which included the number and types of 'target populations' they planned to engage between 1 July 2020 and 30 June 2021.

At the time of drafting this Final Report (February 2021), quantitative data from the COTA Australia data set was only available for one full quarter of the extension period (quarter 8). On review, it was too early to assess any changes in the types of 'target populations' presenting at the trials during the extension period – including in relation to partner organisation plans for engaging these populations.

However, Table D-4 in Section D.1.3 of the Appendices shows the *number* of different 'target populations' that partner organisations had reported as receiving Individual trial activities during quarter 8.

3.6 Findings: Effectiveness

This section presents evaluation findings on the effectiveness of the COTA Australia-led trials.

3.6.1 To what extent are the trials achieving their intended outcomes?

The evaluation is focused on 2 key short-term outcomes for navigator service users accessing the COTA Australia-led trials:

- Improved understanding of aged care services that are available, and how to access them.
- Improved confidence to engage with the aged care system.

Navigator service user feedback from the long-form and short-form surveys indicate that these outcomes are achieved in the vast majority of survey respondents (see Section 3.5.1, 'To what extent, in what ways and why did reported satisfaction levels differ between populations?' and 'Were navigator service users satisfied with the services?').

More generally, analysis of case studies reported by partner organisations also confirmed the achievement of these outcomes, broadly demonstrated by navigator service users:

- Registering with My Aged Care and/or being scheduled for assessment
- Receiving appropriate services, including home modifications and assistive technology
- Obtaining resolution for a negative outcome or situation, such as an unsuccessful assessment or selection of an inappropriate service provider.

To what extent have navigator service users' understanding and confidence changed as a result of the trials?

Navigator service users reported (short-term) changes in their understanding, knowledge and confidence in engaging with the aged care system immediately following a trial interaction via the long-form and short-form survey tools. As shown in Table 3-6, long-form survey responses indicated that navigator service users had greater levels of understanding, knowledge and confidence after receiving navigation support from the trials. Reassuringly, these improvements reported by the overall cohort were replicated in the subsamples of 'CALD' and 'Aboriginal or Torres Strait Islander' individuals providing their feedback via the short-form survey (see Figure 3-5 and Figure 3-6).

Elsewhere, navigator service user feedback has also been obtained via telephone consultations with AHA. At the time of drafting this Final Report (February 2021), a total of 31 consultations had been conducted (an increase of 16 since the Interim Report). However, as previously described, navigator service user feedback on trial experiences has often been limited, due to the following reasons:

- **Challenges with recall.**
Most consultations have occurred between 1 and 4 months after the trial interaction took place, which meant that many individuals could not readily remember the details of the trial support they had received.
- **The high number of 'touch points' associated with the aged care system.**
Many navigator service users have found it difficult to differentiate between the aged care navigation services they had received from the trials, and other types of services they had engaged with – which further compounded the challenges of recall (see above).

Despite these limitations – and where information was forthcoming – most navigator service users reported positive feedback in relation to their experiences of the trial, as indicated below.

She was very helpful and very informative. I felt comfortable to ask questions.

– Navigator service user

It's a good first step, as people have not really heard of My Aged Care.

– Navigator service user

She was very polite. Very knowledgeable. She explained things in the right way. Now I know where to go if I have more questions.

– Navigator service user

During consultations with AHA, partner organisations likewise reported that navigator service users expressed high levels of satisfaction with the support they received.

Most of the people who have come to the session have learned a great deal. It is amazing how little people in the community know.

– Partner organisation representatives

The vast majority of people from different cultural backgrounds who have accessed our trial sites have been fluent English speakers, but have not had confidence accessing the system. They have definitely benefited from our services. [Likewise for] people without access to internet or confidence using technology.

– Partner organisation representatives

It is important to reiterate that any reported improvements in navigator service users' understanding, knowledge and confidence following a trial interaction did not necessarily translate into improved access to the aged care system. However, case studies submitted by partner organisations indicated that this had occurred in a number of instances.

This often entailed trial staff educating and coaching navigator service users through the processes involved in accessing assessment and services, including proactively calling My Aged Care to request CHSP referral codes, and contacting CHSP services directly to enquire about service availability.

Examples such as Jean's story (below) demonstrate that the trials can be successful at supporting navigators to access aged care services in a more timely manner, but they also highlight the inherent complexities of the aged care system, which arguably, should be made simpler and more user-friendly.

Jean's story

Jean lived alone and was 98 years old. She had an extremely supportive son who was her only child. She had remained independent with support from her son to do her shopping.

However, Jean required support with cleaning – she had received an ACAT assessment 6 months previously and was told that she would have to wait for 12 months for a Level 2 HCP to become available. The ACAT Assessor had provided codes for CHSP services but did not notify Jean's son that these needed to be sourced by themselves. Instead, he assumed that someone would contact them automatically to offer interim domestic support until the HCP package was assigned. As a result, Jean was receiving no professional support. Jean's son made several subsequent attempts to access interim CHSP support and was told that there was nothing available in the system and Jean would be waiting for at least a year for any support.

Jean's son had seen information about the ACSN trials on a local TV news item and decided to get in contact. The trial navigator advised the son that new funding would most likely be released for CHSP domestic assistance in a few weeks, and if not then short-term support could be funded through local councils (depending on availability). The navigator also encouraged Jean's son to contact My Aged Care to request a code for individual social support to facilitate support for meaningful social engagement for Jean. Following this advice, the son was able to secure domestic assistance and individual social support to commence within 2 weeks.

Without information provided by the trial navigator, Jean would have faced a long wait for services to commence. Indeed, seeking trial support had produced an outcome for Jean and her son in less than an hour, with the latter commenting that he had been unable to achieve this via other avenues of support in the previous 6 months of trying.

Were partner organisations successful in supporting aged care consumers, carers and families to understand aged care services and engage with the aged care system? If so, what characteristics enabled success?

The flexibility of the trials to provide navigation support via different trial activity types (and different modes of delivery) was considered to be important for engaging with different types of individuals. For example, Group trial activities were singled out as particularly useful for some populations, such as those from 'CALD' backgrounds, who may find it reassuring to receive information and test ideas in the company of their peers.

One partner organisation also noted that 'CALD' individuals can feel 'targeted' with one-on-one (individual) delivery of aged care information, particularly as many are distrustful of government services. For other populations too, group activities are seen as a *gentle way* of introducing the concept of ageing and aged care.

On the other hand, some drawbacks of Group trial activities were observed by partner organisations. For example, it can be more difficult to ensure that all attendees understand the information, and some people may require *specific* or *personalised* information that cannot be delivered in a group setting. For this reason, setting aside extra time immediately following a group session for individual support, was seen by many partner organisations to be the *best of both worlds*.

Overall, partner organisations that achieved high levels of engagement with consumers, carers and families were generally those that were already trusted in the community, or those that worked hard to establish connections with organisations or individuals that were trusted. This sometimes required a number of attempts over time – as noted in the case study example above. Flexibility and willingness to try new approaches were also characteristics of partner organisations that achieved good engagement.

Vincent's story

Single older men living alone had been identified as a major at-risk and hard-to-reach cohort at the beginning of one of the ACSN trials. For this reason, the ACSN navigator targeted Men's Sheds as a way of connecting with this group.

Building trust with the convenor was an important step which took time; Men's Sheds can be a primary target for many health and community initiatives, so 'vetting' of any speakers is an important process. After some time, the trial navigator was invited to 'have a chat' with the men.

On arrival, Vincent gruffly asked the navigator why he was there. After explaining the purpose of the visit, and chatting with the men as a group, Vincent declared that he was over 65, a veteran, divorced, living alone, with no friends, and with ongoing health issues. He added that he was living on a pension that didn't stretch very far, and had had to give up his car because he couldn't afford it any longer.

Vincent concluded that perhaps this trial was targeted at people like him; and that in fact, learning more about aged care supports could be to his advantage. A number of other members of the shed also shared their experiences, especially as carers, and were appreciative of learning more about the supports that were available to them. The other members of the Men's Shed had also not initially seen why information about aged care supports was relevant to them, and were somewhat resistant. However, the information sharing that occurred in the group session, and the realisation that accessing a little support earlier could make a big difference, was a key positive outcome for this group.

What level of integration occurred between the different trials and with existing supports?

Information about integration between the COTA Australia-led trials with existing supports has been presented in Section 3.4.1 above.

However, quantitative *trial referral* information, as reported in the COTA Australia data set, can also be used to assess how well the trials have integrated – both with existing supports and with each other – as shown below.

Referrals in

Table 3-14 shows the most common *referral sources* for the COTA Australia-led trials, which followed the same general pattern as previously presented (with 2 exceptions, see below). As shown, *some* level of integration with *existing supports* was again indicated, with 2.6% (n=403) of referrals coming from allied health professionals and 2.1% (n=327) from GPs and hospitals (Table 3-14). However, it is important to note that in just under a third of cases, either no data were reported, or the referral source could not be established, meaning this information was substantially under-reported in the COTA Australia data set (data shown in table footnote below).

Though still comprising a relatively low proportion of referrals, those coming from the My Aged Care contact centre/website was higher compared to before: 1.5% versus 0.4% (Interim Report). On review, this was driven by a single Community hub, which reported more than half of these types of referral in the eighth reporting period. Interestingly, this trial was not part of the Advocates as Agents pilot (see Section 3.4.2, 'What worked well when implementing each trial, and what was the positive impact?').

Table 3-14: Most common referral sources for the COTA Australia-led trials

Referral source	n (%)
Self	2,579 (16.6%)
Trial's own promotional activities	2,118 (13.7%)
Family/friend	1,583 (10.2%)
Return visit to follow up on a previous or unresolved issue	1,357 (8.7%)
Other	1,009 (6.5%)
Allied health professional	403 (2.6%)
GP/hospital	327 (2.1%)
OPAN*	326 (2.1%)
Word-of-mouth	278 (1.8%)
Return visit to discuss a new issue	268 (1.7%)
My Aged Care contact centre/website	234 (1.5%)
Return visit following attendance for other activity	202 (1.3%)
Local community activity	188 (1.2%)

Note: data not mutually exclusive. Referral sources reported in $\geq 1.0\%$ of Individual trial activity records shown. Referral source information missing or could not be established for 31.6% (n=4,905/15,512) of records. *Referrals expected to be from non-trial-related activities for this partner organisation, given 'internal' trial referrals are reported separately.

Elsewhere, the proportion of navigator service users who had previously attended 'other' activities run by the partner organisation was also somewhat higher compared to before: 1.3% versus 0.5% (Interim Report).

In line with findings presented previously, the proportion of navigator service users referred from other trials – either from a different trial being delivered by the same or a different partner organisation, or from the FIS Officer trials (when in operation) – was very low: 0.6% (n=97) (data not shown above). However, it is again important to note the low overall reporting rate for referral source, meaning that this proportion is likely to be an *underestimation* of the true number of inter-trial referral sources, and, therefore, the true extent of integration between trials.

Referrals out

Table 3-15 shows the most common *onward referrals* made by the COTA Australia-led trials, which also followed the same general pattern as previously presented, although now with Community hubs also appearing in the list. As before, the data indicated that the trials continued to be generally well-integrated with other existing supports, with referrals being made relatively frequently to other internal and external services (Table 3-15).

However, as highlighted in the Interim Report, the proportion of Individual trial activity records with *missing* onward referral information had been relatively high – around 44% – and this had increased to just under 50% by November 2020. (data shown in table footnote below). This observed under-reporting of referral information in the COTA Australia data set should, again, be taken into account when considering referral information as a measure of trial integration.

Table 3-15: Most common onward referrals made by the COTA Australia-led trials

Onward referral destination	n (%)
No referral made	2,629 (16.9%)
SSW	1,657 (10.7%)
My Aged Care contact centre	1,416 (9.1%)
External service (different organisation)	906 (5.8%)
Other	613 (4.0%)
Information hub	546 (3.5%)
Community hub	205 (1.3%)
Same partner organisation (non-trial)	187 (1.2%)

Note: data not mutually exclusive. Onward referral information reported in ≥1.0% of Individual trial activity records shown. Onward referral information missing or could not be established for 48.3% (n=7,488/15,512) of records.

Figure 3-9 shows the distribution of 'internal trial' referrals made by each trial type. As outlined previously, each trial type *tended* to refer navigator service users back to the *same* trial type. For example, 98.3% of 'internal trial referrals' made by SSWs (and 98.7% made by Integrated Information hub/SSW trials)²¹ were made back to SSW trials, while 84.4% of those made by Information hubs were back to Information hubs (Figure 3-9).

Interestingly, although this pattern was not previously observed for the Community hubs, the proportion of their 'internal trial' referrals had more than doubled to 73.5% (compared to a pre-quarter 8 rate of 36.8%). The reason for this observed change in referral pattern is unknown.

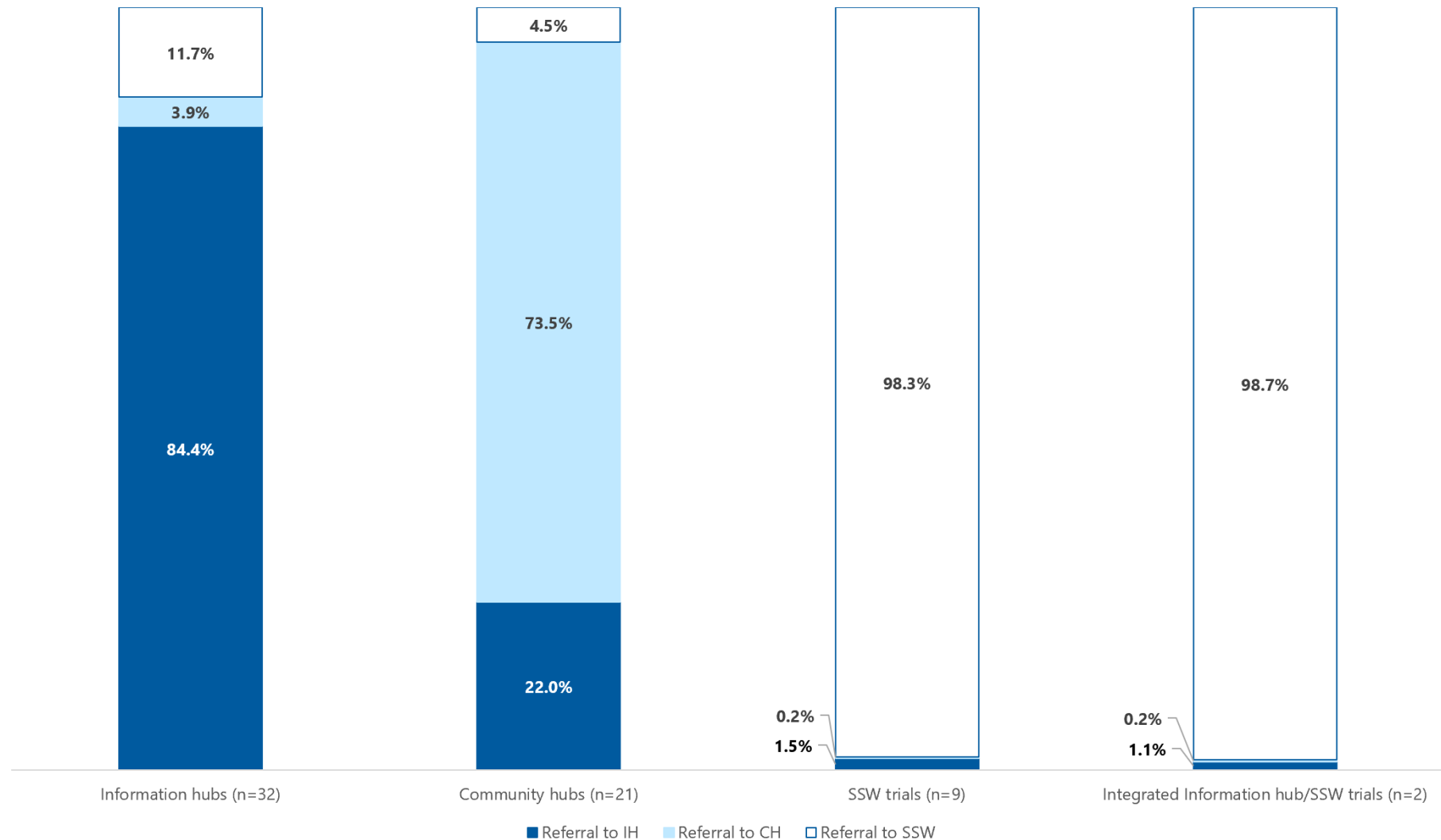
However, and as before, the proportion of referrals from Community hubs to Information hubs was still relatively high at 22.0% (Figure 3-9).

The general pattern of onward 'internal trial' referrals (where referral destination is known) appears to reflect that trials have been referring their navigator service users *back into their own trials* following an occasion of service, presumably because further support is required. Again, this is somewhat evidenced by information shown in Table 3-14, with just under 1 in 10 navigator service users *re-presenting* at the trials to follow up on a previous or unresolved issue.

Also of note is that the *direction* of the 'inter-trial' referrals shown in Figure 3-9 was rarely ever towards trial supports of *lower expected intensity* (as set out in Table 3-1 in Section 3.3). For example, SSW and Information hub referrals were seldom made to Community hubs.

²¹ Note: 'Integrated Information hub/SSW trial' was not available as a referral destination option in the COTA Australia data set.

Figure 3-9: Distribution of onward 'internal trial' referrals between February 2019 and November 2020, by trial type



Note: Figure shows proportion of onward referrals made to each trial type, presented by trial type. Referral to: IH = Information hub; CH = Community hub; SSW = SSW trial.

To what extent did each trial complement/build on existing aged care system navigator services?

As noted in the Interim Report, the COTA Australia-led trials were introduced into a landscape where a range of aged care navigator services (or similar supports) already existed, including:

- A number of Australian Government-funded programs that provide services similar to, or closely aligned with, navigator services (note that a number of partner organisations receive funding through these programs) including:
 - The PICAC program, which promotes provision of, and access to, culturally appropriate care
 - The NACAP, which supports consumers and their families and representatives to effectively access and interact with Commonwealth-funded aged care services and have their rights protected
 - Several service types and subprograms provided through the CHSP.
- Services provided through PHNs, local councils and fee-for-service operators.
- 'Linking Support', provided by RAS assessors for clients they consider need short-term case management to help them access aged care and other services.
- Informal, un-funded navigation support provided by community-based organisations as part of their standard operation. These include support provided by some partner organisations, which welcomed the recognition, through the ACSN Measure, of this 'hidden work'.

Partner organisations reported that over time, they have developed a shared understanding and good working relationships with these – and other – services. A number of partner organisations reported working closely with local RAS and ACAT assessment services, although there were also reports that some assessment staff do not have a good awareness or understanding of the trials.

Partner organisations in Victoria have continued to refer particularly complex clients to the Access and Support (A&S) program. Described in detail in the Interim Report, the A&S program is a long-established and well-regarded aged care navigator program operating only in Victoria.

The question of who is responsible for providing support to navigator service users in the period between assessment and aged care service commencement has not been fully resolved through the trials, although, as noted elsewhere in this report, many partner organisations have been providing this support. As discussed in Chapter 5, this issue is being considered as part of broader aged care reforms.

It's really important that we can refer them to the Access and Support [program], it has been essential...I don't know how it would go without that, and I'm wondering how the other states are going...

– Partner organisation representative

Duc and Mai's story

Duc was 50 years old and on a bridging visa. He had arrived in Australia from Vietnam a year and a half ago to provide full-time care for his mother, Mai, who was aged 80. Due to an ongoing dispute within the family, the pair shared a bedroom in a relative's house. Neither Duc nor Mai spoke English.

Mai had been on a Level 4 HCP for 2 years, which provided cleaning services, a hospital bed and assistive technology for mobility. Duc was interested in obtaining some extra cooking equipment, and an iPad for his house-bound mother so she could talk to her friends and family. Their existing service provider had said that the equipment was not justified, and Duc was reluctant to find an alternative provider as their services were provided in Vietnamese.

Duc attended an ACSN talk facilitated by a Vietnamese seniors group. He flagged his issues with a Vietnamese volunteer on the day before joining a follow-up session where, through an interpreter organised by an ACSN navigator, he conveyed his issues in more detail.

The navigator referred Duc and his mother to the Southern Migrant Refugee Centre (SMRC). The A&S workers there were able to successfully advocate on his behalf, securing the extra equipment he needed.

As a result, Mai became less socially isolated with her iPad, while Duc had extra cooking equipment which alleviated some of the strain in an already tense household.

In what ways does effectiveness vary between different trials, activity types and target population groups? What are the reasons for this?

As described in the Interim Report, a number of ongoing challenges have limited the ability to assess the effectiveness of trials, particularly in relation to the relative benefits of different trial types and trial activity types, and observed differences in relation to the trials' 'target populations'.

These well-documented challenges centre on:

- The observed lack of distinction between trial types, in particular the Information hub and Community hub trials
- Deficiencies in the availability of navigator service user feedback from across the 64 trials, primarily collected via the (long-form) survey tool.

However, anecdotally, face-to-face contact, targeted outreach, and the capacity to engage over multiple contacts were reported as critical factors for addressing the needs of navigator service users who are particularly vulnerable.

Enablers and barriers to success

Enablers and barriers to trial success are described in Section 3.4.2.

What are the unintended outcomes (positive/negative)?

In line with previous reports, the following unintended outcomes, were raised by partner organisations during consultations:

- By registering navigator service users with My Aged Care, partner organisations may risk increasing demand for services that are in limited supply or are not available.
- The trials may be creating unrealistic expectations about what aged care services a navigator service user may be able to receive, because:
 - Services may not be available or have long waiting lists
 - Services are allocated based on assessed need, and some clients may not be entitled to receive services.
- Importantly – for many partner organisations – the trials are serving to identify *structural* problems with the aged care system, which may influence reform.

Unintended trial outcomes arising from the COVID-19 pandemic included:

- Some partner organisations supporting individuals to 'reverse navigate' out of residential aged care facilities (see Section 3.4.1, 'Have all components of each trial been implemented?' above for more information).
- The introduction of 'welfare checks' for navigator service users, which provided an extra avenue of support for vulnerable individuals, while affording the partner organisations additional opportunities for engagement with navigator service users.

Positive unintended consequences

Some case studies discussed the potential future impact of the person's involvement with the trials, highlighting preventative benefits of the trials.

This [trial] has identified an extremely vulnerable individual who was not linked with appropriate support services. The SSW role was able to be the conduit to connect the two. The SSW role re-alerted the GP to her patient's living conditions [hoarding and squalor]. Difficult to quantify, but possibly this navigator intervention and subsequent support at home may prevent a hospital admission?

I helped to get Molly re-referred for Community Transport. The new referral was actioned quickly, which was a massive relief for Molly, who had been worried about having to call a taxi again for upcoming appointments... Without access to safe and affordable transport, Molly's physical health and personal wellbeing may have been compromised due to missing medical appointments and being completely isolated at home.

Moreover, many partner organisation staff derived job satisfaction from doing what they considered to be a much-needed role.

I would like to say that for the first time in 30 years I feel like I am making a difference, with real outcomes.

– Partner organisation representative

Negative unintended consequences

As noted elsewhere in this report, the lack of available CHSP services and HCPs created a major barrier to achieving longer-term outcomes. A negative unintended consequence reported by some partner organisations was that navigators could create unrealistic expectations about receiving services, because the services are not actually available.

Jacqueline's story

Jaqueline was a 64-year-old woman who contacted the Community hub to speak with a volunteer about accessing services for her parents, who were in their 80s and experiencing some deterioration in their ability to undertake tasks at home.

Her father was comfortable with accepting services, while her mother was not as she didn't see that these were needed. The trial volunteer talked to Jaqueline about wait times for services and suggested this as a way to encourage her mother to accept the initial assessment. The volunteer provided Jaqueline with the My Aged Care booklets covering CHSP and HCP, and also demonstrated the My Aged Care website, to enable Jacqueline to find service providers herself once services became available.

The cost structures for each type of service delivery were discussed and the volunteer emphasised that Jacqueline may need to request a lower level of service if there were substantial wait times for the level of service her parents had been assessed for.

3.7 Findings: Cost-effectiveness

Which trials/combination of trial activities represented the best value for money?

Based on available costing information (including that presented in Appendix D) and navigator service user outcomes (Appendix F and Section 3.5.1), it has not been possible to *reliably establish* which trial types and trial activity types – original and redefined – represent the *best value for money*.

However, as highlighted in Appendix F (as well as in Section 3.5.1), navigator service user feedback following trial interactions was universally positive, in relation to their *understanding* and *awareness* of the aged care system, and their *confidence* in seeking out services. Few – if any – meaningful differences were observed across trial types or trial activity types (or diverse groups/vulnerable populations) (see Appendix F).

It is also important to note that although indicative costings for trial navigation services are important to determine (where feasible), other key factors (besides *value for money*) also exist, as described throughout Chapter 5).

Throughout the evaluation of the trials under the ACSN Measure and the review of other system navigation models (see Chapter 6), it has become clear that a *one size fits all approach* to aged care navigation is unlikely to meet the needs of the spectrum of navigator service users requiring support. Rather, a flexible – potentially multi-modal – system that accommodates the different needs of individuals across their aged care journey is required (see Figure 6-2 in Chapter 6).

As shown in Appendix F, *a few small* differences were observed in navigator service users' reported outcomes. For example, the negative reporting rate associated with Group trial activities was a little higher compared to Individual trial activities. As postulated, this may be down to the relative *suitability* of group support for meeting the needs of *all* navigator service users, and particularly those with complex and/or multiple needs.

In line with the idea that different types/intensities of navigation support are required as part of a broader system, the 100.0% positive reporting rate for the SSW trials may reflect the higher levels of individualised – and, arguably, intensive – support typically provided to navigator service users accessing their services.

3.8 Findings: Opportunities to enhance the trials

The opportunities for improvement of the trials that were presented in the Interim Report remain relevant. Though some have been explored in the preceding sections (particularly in relation to data collection and reporting), there are avenues for continuous quality improvement in the following areas:

- Trial design, including:
 - Removing the distinction between trial types, where multiple trial types are delivered by a single partner organisation in a specific location
 - Maintaining focus on face-to-face engagement (with repeat interactions where necessary), (clearly defined) outreach, and targeted promotion to engage particularly hard-to-reach populations
 - Continuing to support navigator service users to the point of aged care service commencement.
- Data collection and management, including the continuation of:
 - Strengthening internal processes for data management within the organisation responsible for over-arching trial management
 - Supporting partner organisations to improve the accuracy and completeness of collected and reported data
 - Considering opportunities to further reduce the quantum of data collected through the trial data set.
- Governance and project coordination. The organisation responsible for over-arching trial management should:
 - Continue to raise awareness of the trials with My Aged Care, assessors and other related aged care services and programs
 - Support consistency of information provided through the trials. Given mixed views on the usefulness of the CoP and state/territory forums and the apparent limited uptake of the BoostHQ platform, it is suggested that the organisation seek input from partner organisations on the types of support that may best meet their needs.

Broader considerations for the future design of aged care navigation are discussed in Chapters 5 and 6.

Despite success in building navigator service users' capacity and confidence to make financial decisions regarding aged care, many navigator service users reported that they still faced challenges when trying to access and navigate aged care and, in particular, when trying to engage with My Aged Care.

Cost-effectiveness

Based on available financial information, trial unit costings could only be estimated using direct navigator service user interactions with FIS Officers, and so other costs associated with all other service delivery outputs – such as seminar delivery and promotional and outreach activities – were rolled up into these costing calculations.

As such, reported headline costs for *direct navigator service user interactions* with FIS Officers are likely to be a substantial *over-estimation*.

4 Findings: FIS Officer trials

4.1 Key messages

Implementation

730 people received support from the FIS Officer trials to make financial decisions in relation to planning and accessing aged care, generally on behalf of family members.

The FIS has a long history of providing independent financial information in relation to aged care (and other matters), making it very well-placed to deliver the trials. Despite this, awareness in the general population appears to be fairly low, and those who knew about the service often did not associate it with aged care.

Local promotion and outreach were successful in increasing uptake across the trials. Given the limited geographic reach of the 6 trials, promotional activities were targeted towards *local communities*, including vulnerable populations. FIS Officers who took a more *proactive* approach had particular success.

Competition from commercial financial planners meant that many people who may otherwise have benefited from the FIS did not *need* to access it or were not readily *able* to access it.

Appropriateness

The majority of navigator service users seeking support were found to have complex financial circumstances in relation to aged care due to their moderate (or higher) levels of wealth rather than due to particular cultural or personal vulnerabilities. However, this could be partly due to the under-reporting of vulnerability data.

Vulnerability information was under-reported in the trial data set ('DHS data set') largely because FIS Officers were reluctant to collect information about *cultural or personal vulnerabilities* from navigator service users.

Effectiveness

Navigator service users reported that, following their interaction with a FIS Officer, they had a greater understanding of financial arrangements and options, and greater confidence in making financial decisions when planning for and accessing aged care. Importantly, these improvements were *sustained* over time.

FIS Officer trial services were twice as long as standard FIS services, allowing FIS Officers to convey comprehensive information at an appropriate pace. Navigator service users were also provided with a written 'Record of Interview' (ROI) to take home. Both this additional time and supporting documentation were identified as being key to maximising navigator service users' understanding.

Navigator service users' general feedback was very positive, with their highest praise reserved for the FIS Officers. FIS Officers were reported as being professional, polite, helpful and respectful.

4.2 Introduction

Note: this chapter was first presented in the Interim Report (April 2020), and remains unchanged since then.

This chapter addresses the following evaluation questions in relation to the FIS Officer trials:

- Have the trials been implemented as planned?
- What lessons can be learned from trial implementation?
- How appropriate are the trials in meeting the needs of navigator service users (i.e. aged care consumers, carers and their families [particularly those who need additional support to understand, choose, and access aged care services])?
- Who are the trials reaching (and who may not be reached)?
- To what extent are the trials achieving their intended outcomes? What are the:
 - Enablers and barriers to success?
 - Unintended outcomes (positive/negative)?
- How cost-effective is each trial?
- What are the opportunities to enhance the trials?

This chapter is based on analysis of the following types of data sources:

- Contractual materials
- Quarterly extracts from the DHS data set
- Financial reports
- Qualitative data
- Consultation data
- Trial closure documents

A full list of data sources is presented in Appendix B.

Note: the terms 'interaction' and 'interview' have been used interchangeably in this chapter to refer to the in-person sessions of support delivered by FIS Officers to navigator service users at DHS service centres.

4.3 Trial overview

The Financial Information Service (FIS) was established in 1989 and is administered by Services Australia (formerly DHS).²² The FIS provides information on a wide range of financial matters (including, but not limited to, aged care) through seminars, face-to-face appointments and over the telephone. Services are provided by FIS Officers located in Services Australia centres across Australia. FIS services are free, independent and confidential, and are available to everyone.

The aim of the FIS Officer trials was to support aged care consumers, their family members and carers by providing information about financial matters that could affect their decisions about aged care. The trials represented an expansion of the standard FIS service – or FIS business as usual' (BAU).

²²On 29 May 2019, the Prime Minister announced that DHS was to be renamed Services Australia.

The FIS Officer trials comprised 6 dedicated FIS Officers with aged care expertise, who were located in DHS/Centrelink service centres in 7 Aged Care Planning Regions (ACPRs):

- Hunter, NSW
- Metro East and Hills, SA
- Mallee and Southern, SA (the same FIS Officer covered both SA regions)
- Eastern Metro, Vic
- Hume, Vic
- South East Sydney, NSW
- South Coast, Qld

DHS selected the ACPRs by reviewing data from My Aged Care and the Australian Bureau of Statistics Census 2016 to determine which regions would be a good fit in terms of population characteristics (including cultural diversity), availability of local aged care services, and potential unmet need.

The FIS Officer trials differed from the FIS BAU in the following ways:

- FIS Officers focused on financial matters solely relating to aged care.
- FIS Officers undertook promotional activities (including information sessions and seminars, outreach into Residential Aged Care Facilities [RACFs] and hospitals, etc.) in order to reach out to individuals who may benefit from participating in the trials as navigator service users.
- FIS Officers collected additional data from navigator service users in order to inform the evaluation (see Section 4.3.3).
- The average duration of navigator service user appointments (up to 2 hours) was longer than FIS BAU (one hour); however, like FIS BAU, these trial interactions were intended to involve a single session with a FIS Officer with no follow-up planned.

Administration of the trials began on 22 October 2018. Customer interviews commenced on 10 December 2018 and concluded on 30 September 2019.

At the end of the trials, the FIS Officers returned to their FIS BAU roles.

4.3.1 Target population

Like the COTA Australia-led trials, the Department defined the target populations for the FIS Officer trials as those who:

- Needed additional support to understand, choose and access aged care services, and had difficulty engaging through existing channels, and
- Had not yet accessed aged care services.

The target population for the FIS Officer trials also included a specific focus on individuals who needed to make complex financial decisions when planning for, and accessing, aged care services – either for themselves or others. Complex financial circumstances generally fell into 3 categories:

- **Financial.** Structural or circumstantial issues that created inherent complexity – for example, living in a granny flat, being a primary producer (e.g. farmer), having a moderate level of realisable financial assets.
- **Situational.** Personal circumstances that increased the complexity of decision-making – for example, being a second member of a couple entering care, having a blended family, having cognitive impairment or mental illness.

- **Cultural.** Complexity created due to conflicts between cultural mores and the concept and requirements of the aged care system (e.g. for people from Aboriginal or Torres Strait Islander or CALD backgrounds).

Similar to the COTA Australia-led trials, individuals who did not meet the above criteria were still able to receive support from the FIS Officer trials.

Further details about who participated in the FIS Officer trials are presented in Section 4.5.2.

4.3.2 Referral process

Individuals requiring support with financial decision-making in relation to aged care – and who lived in the vicinity of a FIS Officer trial – were generally booked in for face-to-face interactions via the centralised Centrelink telephone service, or via referral from FIS BAU. FIS Officers also booked appointments directly with interested individuals they met through outreach activities such as seminars, and took ad hoc appointments if they were available on site when individuals presented at the DHS service centre.

As highlighted in Section 4.3, interactions between FIS Officers and navigator service users were intended to be single sessions only, with no follow-up planned.

4.3.3 Data collection for the evaluation

FIS Officers collected data for the evaluation of the trials, as part of the DHS data set. This comprised information about:

- Interactions, including who attended as navigator service user(s), inward and onward referrals, whether those in attendance consented to participate in the surveys, and their responses (if applicable):
 - Pre-interview survey ('Survey 1'; conducted by the FIS Officer before commencing the interview)
 - Post-interview survey ('Survey 2'; conducted by a FIS support team member 2-3 days post-interview)
 - Recall survey ('Survey 3'; conducted by a FIS Support team member approximately 2 months post-interview)
- The aged care consumer (e.g. the person requiring aged care services), including marital and financial statuses, and information about circumstances that may increase the complexity of decision-making around their aged care.

AHA also collected information through consultations (via telephone and/or during site visits) with:

- FIS Officers
- FIS Operations team members
- Navigator service users
- DHS representatives.

FIS Officers were also required to submit weekly reports to DHS, comprising qualitative information about outreach activities, emerging issues and case studies. While these were not available as a data source to inform the evaluation, AHA was still able to gain a *comprehensive* and *accurate* view of FIS Officers' activities, challenges and lessons learned through our consultations with the FIS Officers and DHS representatives.

4.4 Findings: Implementation

This section presents evaluation findings on the implementation of the FIS Officer trials.

Overall, 730 navigator service users presented to the FIS Officer trials between 10 December 2018 and 30 September 2019. Further information about who the trials reached is provided in Section 4.5.2.

4.4.1 Have the trials been implemented as planned?

The FIS Officer trials were largely implemented as planned, as described in the following sections.

Have all components of each trial been implemented?

Governance arrangements

Governance arrangements for the FIS Officer trials were established according to plan, with the FIS Operations team within the DHS Service Delivery Operations Group responsible for the day-to-day running of the trials. The FIS Operations team was led by the Director of FIS Operations with support from an Assistant Director, while the day-to-day conduct of the trials was overseen by a Senior Project Officer. The National Manager of FIS Operations was the Senior Responsible Officer for the trials.

A steering committee, comprising the Senior Responsible Officer, representatives from the FIS Operations team and other (policy) personnel from DHS, along with the Department, met monthly for the duration of the trials. This was considered very useful for supporting trial implementation, especially in the early days.

There was ample opportunity to give feedback on the project artefacts and other aspects of the trials. When we had issues, we could use the committee as a sounding board.

– FIS Operations team member

Coordination activities

Overall, the FIS Officers involved in the trials reported that they were well supported by the FIS Operations team in their day-to-day coordination of the trials (see 'Are FIS Officers satisfied with overall management of the trials by DHS?').

During consultations with AHA (in May and June 2019), each FIS Officer demonstrated strong awareness and understanding of the purpose of the FIS Officer trials, the target population for the trials, the scope of the role and their responsibilities in relation to the trials (including reporting requirements).

Integration activities

Although the FIS Officer trials ran relatively independently from each other, the 6 officers were in regular communication via an online chat forum. The officers reported that the forum was a very useful tool for sharing successes, challenges and opportunities, and was an important support mechanism – particularly during the early stages of trial implementation.

Many of the FIS Officers reported good levels of integration with, and awareness by, FIS BAU, demonstrated by the number of referrals originating from non-trial staff co-located at their DHS service centres.

According to feedback from FIS Officers and the FIS Operations team, the extent of integration between the FIS Officer trials and the other trials under the ACSN Measure was mixed. Most progress had been made at the FIS Officer trial in Eastern Metro, Vic, where the FIS Officer had met with representatives from COTA Victoria and Housing for the Aged Action Group (HAAG) in order to identify opportunities for local trial collaboration. A FIS Operations team member reported that this resulted in a number of referrals into this FIS Officer trial.

FIS Officers in South Australia and New South Wales reported some *initial* collaboration efforts with COTA SA and COTA NSW, respectively, although it was unclear whether these had resulted in any cross-trial referrals. (Note: though quantitative information about inward and onward referrals between the FIS Officer trials and the Information hub, Community hub and SSW trials was not specifically captured in the DHS data set, it was captured in the COTA Australia data set (<1.0% of navigator service users in those 3 programs of trials [see Section 3.6.1, 'What level of integration occurred between the different trials and with existing supports?' above]).

Two main barriers to integration between the FIS Officer trials and the other 3 programs of trials under the ACSN Measure were identified during consultations with officers and the FIS Operations team:

- **Disparities in the timeframes for implementation of the trial programs**

The FIS Officer trials were planned to run between October 2018 and September 2019, while the Information hub, Community hub and SSW trials were planned to run between January 2019 and June 2020.

- **Disparities in trial locations**

Only 3 of the 6 FIS Officer trials were located in ACPRs where Information hub, Community hub or SSW trials were also located.

Communication and engagement activities

DHS project closure documents confirmed that FIS Officers had delivered a total of *41 seminars* and conducted *215 episodes of outreach* in their communities.

It is important to note that the DHS data set did not contain any information about 'non-interaction' trial activities such as the different types and numbers of outreach activities delivered. Though DHS project closure documents *did* report the overall number of 'non-interaction' trial activity types, it has not been possible to *quantify* the successes and challenges reported anecdotally in relation to the FIS Officers' engagement activities.

Many of the FIS Officers reported conducting extensive communication and promotional activities during the trials, with one officer devoting up to 60% of their time on active outreach. The FIS Operations team stressed the importance of the officers having a robust engagement strategy in order to drive 'proactive' referrals, rather than them relying on 'passive' referrals (e.g. those made ad hoc via the centralised Centrelink telephone service). For example, the DHS project closure report highlighted the development and use of information sheets – available in a variety of languages – to support FIS Officers' promotional activities.

Although the FIS Operations team reported some variability in FIS Officers' level of skill and ability to engage with their communities, the general success of engagement activities was evidenced by navigator service users' increased uptake of the trial over time (see Figure 4-3).

We are getting out and visiting aged care and other providers, and getting invited to events where we might be able to interact with the people (navigator service users) themselves.

– FIS Officer

One member of the FIS Operations team reported that outreach had been particularly successful in the Hunter, NSW FIS Officer trial. Here, the FIS Officer had attended a number of aged care expos, participated in a symposium for MS Australia, and worked hard to build strong relationships with aged care providers in the Hunter area as well as forging links with the Department of Veterans' Affairs (DVA). More broadly, the FIS Operations team reported that dementia and multiple sclerosis support groups, carer support groups, GPs, hospitals and social workers were very open to FIS involvement, and found the FIS very relevant to their members/aged care consumers.

Although many of the FIS Officers had devoted considerable time to *local* promotional and engagement activities, community awareness of the FIS Officer trials remained generally low throughout the trials (as confirmed during consultations with the officers, the FIS Operations team and navigator service users themselves). This was particularly apparent early on, with low levels of uptake across the FIS Officer trials during early implementation (see Figure 4-3). It is, however, important to note that a decision was made not to undertake a more *coordinated and widespread promotional campaign* to drive increases in trial uptake, for 2 key reasons:

- DHS needed to avoid the perception that the trials were offering some kind of *silver service* (e.g. an enhanced service, only available to a *select* set of individuals across Australia).
- DHS had initial concerns that the trials would be inundated with demand, meaning they took a cautious approach to engagement activities outside of FIS Officers' local efforts.

During follow-up consultations, one member of the FIS Operations team also made the point that any kind of widespread campaign to promote the ACSN Measure would have been expected to involve COTA Australia – a well-recognised advocacy organisation – as leader of the other trials. As a government agency, DHS needed to remain 'neutral' – and be seen to be 'neutral' – which precluded any kind of promotional activity in concert with COTA Australia.

Regardless, project closure documentation provided by DHS notes that the expected (and potentially unmanageable) demand for the service – identified as a key risk at the outset of the project – did not eventuate, and the risk mitigation to prevent this scenario (e.g. by limiting promotional activities) actually hampered the trial by leading to '*critically low*' numbers initially. Further details regarding navigator service user awareness of the FIS Officer trials, and the potential implications for the reach and uptake of the FIS Officer trials, are presented in Section 4.5.2.

Data collection/reporting arrangements

As noted in Section 4.3.3, FIS Officers had additional reporting requirements to support the evaluation, compared to FIS BAU. A number of FIS Officers noted that the reporting requirements of the trials were somewhat onerous, with one commenting: 'It's double the amount of reporting compared to in the normal FIS Officer role.' Despite this, the officers indicated that they understood that the extra

reporting was necessary to support the evaluation of the trials, and were generally accepting of these requirements.

All types/modes of trial activity

The fundamental components of the FIS Officer trials were the face-to-face interviews with navigator service users and external outreach and promotional activities. All of these trial activities were broadly implemented as planned. As described in Section 4.3, navigator service users were booked in for appointments at DHS service centres via the centralised Centrelink telephone service, or via referral from other officers in FIS BAU. Where required, FIS Officers sometimes collected additional information from navigator service users prior to their appointments and/or provided follow-up information afterwards via telephone. The officers' promotional and outreach activities (e.g. delivering seminars, building relationships and linkages with service providers, and generating referrals) were generally conducted in person in the community.

Has each trial been staffed and resourced as intended? If not, why not?

All 6 FIS Officer trials were staffed and resourced as intended, with 1 FTE officer per trial. There were 2 changes in FIS Officer personnel during the early stages of trial implementation, following which all 6 FIS Officers remained in the role until the trials concluded. Changes in FIS Officer personnel did not lead to any noticeable disruptions to trial activities.

Five of the 6 FIS Officers had been selected for the trials due to their extensive experience in FIS BAU and their expertise and understanding of the aged care system. The remaining officer was new to the FIS Officer role but had extensive financial and accounting experience in a previous position within DHS.

Was each trial delivered in the planned location? If not, why not?

The FIS Officer trials were delivered in the planned locations; that is, the 7 selected ACPRs (see Section 4.3). Some FIS Officers provided trial services from multiple DHS service centres within their designated ACPR in order to maximise trial reach and meet customer demand. Table 4-1 shows the DHS service centres where FIS Officers were *primarily* based during the trials.

Table 4-1: Main DHS service centres used in FIS Officer trials

State	Designated ACPRs	Main DHS service centres
NSW	South East Sydney	Maroubra/Rockdale
NSW	Hunter	Wallsend
Qld	South Coast	Biggera Waters/Southport
SA	Metro East and Hills	Norwood
SA	Mallee and Southern	Norwood
Vic	Eastern Metro	Oakleigh
Vic	Hume	Seymour/Shepparton

Was each trial delivered to the planned target population(s)? If not, why not?

The FIS Officer trials were specifically targeted at individuals who needed to make *complex financial decisions* when planning for and accessing aged care services, either on behalf of themselves or others (see Section 4.3.1).

Representatives from the FIS Operations team confirmed that the inclusion criteria for receiving trial services as a navigator service user were sufficiently broad that – similar to the COTA Australia-led trials ‘no-one was turned away’.

More information about the extent to which the FIS Officer trials were successful in reaching their target populations, including who presented at the trials as navigator service users, is described in Section 4.5.2.

Was each trial delivered within required/planned timeframes? If not, why not?

The first reported navigator service user interaction occurred on 10 December 2018. Although this occurred later than expected, a member of the FIS Operations team noted that this lag did not have a significant impact on trial outcomes, especially given the relatively low uptake observed in early trial implementation.

The early delays were reportedly due to specific challenges faced by the newly-formed FIS Operations project team. In particular, due to the team’s relative inexperience in implementing previous projects within DHS’ frameworks, there were initial gaps in understanding the requirements around compliance with DHS policy. The 2 key challenges the team faced were:

- Implementing an appropriate consent process for collecting navigator service users’ data for evaluation purposes.
- Ensuring the privacy and confidentiality of navigator service users’ personal information.

As planned, FIS Officers concluded their interactions with navigator service users on 30 September 2019. After these interactions concluded, the FIS Operations team undertook project closure activities, including submission of a final extract from the DHS data set and development of a project closure report.

Was Commonwealth funding appropriately dispersed to deliver the trials as planned?

DHS received an appropriation of Commonwealth funding to deliver the FIS Officer trials, consistent with timeframes set under the ACSN Measure, and managed this funding accordingly. A letter of agreement was put in place between the Department and DHS to outline the commitments of the 2 parties in relation to the trials. This set out the objectives, roles and responsibilities, governance arrangements, and data and reporting arrangements. It also specifically acknowledged that DHS had received an appropriation of Commonwealth funding to deliver the FIS Officer trials and was responsible for managing this appropriation. No specific issues or concerns were raised in relation to the dispersal of Commonwealth funding to deliver the FIS Officer trials.

Further information about the *cost-effectiveness* of the FIS Officer trials is presented in Section 4.7.

4.4.2 What lessons can be learned from trial implementation?

What were the challenges to implementing the trials, and how were they addressed?

The challenges in relation to trial implementation reported by FIS Officer trial representatives are shown below.

Low levels of navigator service user awareness

Awareness of the existing FIS BAU offering – and by extension, the FIS Officer trials – was identified as being low in the general community, despite local promotional activities by the FIS Officers, and information about FIS and the trials being posted on the DHS and My Aged Care websites.

It is not well known at all.

– Navigator service user

Promotion of the trials

As highlighted in Section 4.4.1, the FIS Operations team noted that widespread promotion of the trials was avoided, because of concerns about generating unmanageable demand, along with the need to maintain *competitive neutrality*²³ and to avoid any perception that the trials were offering some kind of *silver service*. This limited the scope of awareness-raising activities by the FIS Officers and probably contributed to the slow start in trial uptake observed in the early months of implementation.

The FIS Operations team also noted that the prevalence of commercial financial services – including many with pre-existing arrangements with aged care facilities and providers – made it difficult to promote the FIS offering into some areas.

Further, though *some* cross-trial promotion between the FIS Officer trials and the Information hub, Community hub and SSW trials did occur, integration efforts were significantly constrained due to the independent set-up of the FIS Officer trials versus the other 3 programs of trials. In particular, disparities in the *implementation timeframes* and *geographic locations* between the 6 FIS Officer trials and the COTA Australia-led trials were highlighted as key barriers to trial integration.

Advertise it! We had no idea it existed.

– Navigator service user

Referrals in and follow-up processes

The FIS Officers consistently commented that the establishment of a trial-specific telephone appointment line for navigator service users may have increased trial uptake. They further pointed to the existing centralised Centrelink telephone appointment line as being a barrier to uptake, because callers needed to know to say 'Financial Information Service' when prompted in order to be appropriately routed. That said, the FIS Operations team confirmed that the centralised Centrelink telephone line had to be utilised for appointment booking, as the potential benefits of establishing a *trial-specific* telephone line were outweighed by the associated administrative burden. Some FIS

²³ [Competitive neutrality policy](#) dictates that government agencies should not have a competitive advantage (or disadvantage) over the private sector, solely due to their government ownership.

Officers also commented that the use of the centralised telephone line meant that the trials remained aligned with standard FIS processes, and, therefore, navigator service users were not deemed to *be* “jumping the queue”.

Elsewhere, though the trials were originally designed to deliver one-off sessions of in-person FIS Officer support, some navigator service users reported they had had follow-up phone conversations or repeat face-to-face interactions with the officers. The reasons for this follow-up included to clarify information provided at the initial interaction, to obtain additional information, and/or to obtain new information in light of changing circumstances. Interestingly, and in line with the previous point, one navigator service user reported needing further assistance following their first interaction, but was initially unable to reach the original FIS Officer via the centralised Centrelink appointment line.

In order to circumvent this issue, AHA understands that some FIS Officers sometimes relied on more direct routes of communication with navigator service users, for example, provision of their direct telephone number to facilitate follow-up, if this was indeed required. However, this practice was not approved by the FIS Operations team.

If follow-up had been simple, it would have been even better.

– Navigator service user

Project management

As highlighted in Section 4.4.1, the FIS Operations team reported some early difficulties with navigating the DHS’ internal frameworks – including review and approval processes – which were attributed to the team’s relative inexperience and an underestimation of the trials’ project management complexity. This led to knock-on delays in overall trial implementation (of around 2 months), and delays in the development of some trial resources, such as consent forms and promotional material. The FIS Operations team also recognised that these delays did not affect the overall success of the FIS Officer trials, and that – similar to the COTA Australia-led trials – the original implementation timeframes may have been somewhat ambitious.

What worked well when implementing the trials, and what was the positive impact?

Successes of the FIS Officer trials’ implementation included:

- The ability of the FIS Operations team to quickly identify and harness existing aged care expertise and capability within their service, and tailor it for the purpose of the trials.
- The strong focus on building FIS Officers’ capacity and capability to deliver external-facing activities (namely, promotional work and outreach activities), which was highlighted by the FIS Operations team as a new, and increasingly important, way for FIS BAU to be engaging with diverse communities.
- FIS Officers reporting high levels of interest and enthusiasm in supporting navigator service users, as they faced complex financial decisions in relation to aged care. Indeed, through consultations, FIS Officers expressed high levels of satisfaction with the intensity of service they were able to provide through the trials.
- FIS Officers were observed to deliver relatively consistent and structured approaches to conducting FIS Officer trial interviews during site visits, while also having the flexibility to tailor their respective approaches to meet the needs of individual navigator service users (see Section 4.5.1).

- The provision of a hard copy 'Record of interview' (ROI) for navigator service users to take away at the conclusion of their FIS Officer interaction was found to be a very useful tool, and supported navigator service users' longer-term understanding and knowledge of the content presented during the interview.
- FIS Officers achieving good rates of response for the initial and follow-up surveys of navigator service users, despite some challenges, as highlighted in Section 4.5.1.
- The FIS Operations team reporting that the working relationship between DHS and the Department had always been very positive and constructive throughout every phase of the FIS Officer trials.

Were some trials (or combinations of trials) more successfully implemented than others? If so, how and why?

Despite the low levels of trial uptake in the early months, which affected some trials more than others (see Section 4.5.2), overall, the 6 FIS Officer trials were implemented consistently and successfully.

What opportunities exist for improving trial implementation?

Representatives from the FIS Officer trials suggested the following opportunities to improve trial implementation:

- Increased promotion of the FIS to the general population, and of the FIS Officer trials to the target populations, is expected to have increased navigator service user awareness. A focus on targeting people early in their aged care journey (e.g. at the time of the life event that may precipitate the need for aged care) was seen as an important approach to improving service uptake.
- Alignment of implementation timeframes and physical geographical locations would have facilitated integration between the FIS Officer trials and the other trials under the ACSN Measure.
- Although the FIS Officer trials were intended to deliver one-off in-person interactions, some follow-up with navigator service users was inevitable, and this could sometimes have been better facilitated by a more standardised process for follow-up.

Elsewhere, one navigator service user did comment that it might have been preferable for their FIS Officer interview to have been conducted in a *more private setting* given the financially sensitive nature of the discussion. However, it was also acknowledged that it was likely that most people in attendance in the open-plan Centrelink setting were likely to be discussing personal, and private, matters, and therefore, the setting "*was probably appropriate*".

It wasn't a very private place to discuss things, but I suppose everyone there was 'in the same boat'.

– Navigator service user

Are FIS Officers satisfied with overall management of the trials by DHS?

The FIS Officers generally reported positive feedback in relation to DHS' overall management of the FIS Officer trials. It is fair to note that the delays to early trial implementation (as highlighted in Section 4.4.1), did lead to some initial frustration with DHS among some officers, however, this was generally overcome once the trials became fully operational.

The Senior Project Officer is very supportive, and the managers are open to feedback, input and suggestions.

– FIS Officer

Is DHS satisfied with the Department's overall management of the ACSN Measure?

DHS reported positive working relationships with their colleagues in the Department, and considered the FIS Officer trials to be a valuable – and somewhat rare – opportunity for interdepartmental collaboration. Indeed, the Senior Responsible Officer reported that their relations with the Department had been incredibly *positive* and *constructive* right from the start. Despite the early challenges faced by the FIS Operations team, the Department had always remained 'supportive and accommodating', with one team member commenting 'we couldn't have been happier with the approach they have taken'.

We kept the Department in the loop; they were very helpful and understood that we faced some challenges and complexities.

– FIS Operations team member

It was also acknowledged that while DHS tended to be *service-driven*, the Department is *policy-driven*, and therefore, both entities were used to approaching projects in different ways, which required some 'gentle merging'.

However, the high levels of 'openness, communication and information sharing' that was achieved between the 2 government departments were considered to be 'unprecedented', in the opinion of one member of the FIS Operations team.

One of the great things has been the relationship with the Department of Health. It really laid some groundwork for future work that we may need to do.

– FIS Operations team member

4.5 Findings: Appropriateness

This section presents evaluation findings on the appropriateness of the FIS Officer trials.

4.5.1 How appropriate are the trials in meeting the needs of navigator service users?

Analysis of the various FIS Officer trial data sources indicated that the trials were appropriate for meeting the needs of navigator service users. AHA observed customer interactions at 5 of the 6 FIS Officer trial sites between June and July 2019, which demonstrated that the officers delivered services which were *appropriately tailored* to meet the needs of each navigator service user. FIS Officers achieved this by using consistent and structured approaches, while ensuring flexibility to personalise each interaction.

During consultations with navigator service users, most commented that options for funding aged care and the aged care system itself were *confusing, overwhelming, and difficult*, but that their FIS Officer had provided information and education about aged care financial matters in a way that met their needs.

Aged care options are confusing, and I think the system is a bit flawed. But the FIS Officer did a good job of explaining a difficult concept.

– Navigator service user

Further details about the appropriateness of the FIS Officer trials are presented under each of the evaluation sub-question headings, below.

Were DHS and the FIS Officers trusted/considered accessible/supported by the target populations?

Overall, navigator service users considered that DHS and Centrelink were trusted, accessible and supportive.

Trust

Emerging strongly from consultations with navigator service users was their high regard for the FIS Officers, who they trusted to provide accurate information. This was in line with feedback reported in the survey responses (see Q13–16 in Table 4-10). However, the findings from consultations were slightly more mixed when it came to whether DHS/Centrelink were considered to be trusted entities.

For example, most navigator service users acknowledged that Centrelink was an appropriate and trusted source of information, and their experience with visiting Centrelink to access FIS Officer trial support was generally positive.

It was just the right place to go... now I tell my friends and family that they should go to Centrelink, too.

– Navigator service user

However, one navigator service user commented that they found it 'difficult to trust any government body', while another reported that 'people don't know what to ask for, and are at the mercy of those giving them information at Centrelink'.

One FIS Officer also offered the anecdotal view that some vulnerable population groups, who have had past negative experiences with government organisations, may actively avoid visiting *any* government agency due to *fear and a lack of trust*.

Still, another officer emphasised that the FIS Officer trials were an important opportunity to create a positive first-time experience of Centrelink for navigator service users, particularly for people facing barriers, for example, those in rural and remote areas: 'Farmers and people in rural areas may not have had a great deal of experience with Centrelink in the past. When dealing with Centrelink rules, forms, and phone calls, it brings most of the proudest farming people to their knees. I spend a lot of time with them...making this first contact as painless and seamless as possible'.

Accessibility

As highlighted in Section 4.4.2, 'What were the challenges to implementing the trials, and how were they addressed?', FIS Officers expressed some concerns that the use of the centralised Centrelink telephone appointment line created a barrier to trial access. However, this was not reflected in feedback from navigator service users, who generally considered the trials – and their DHS service centre locations – to be accessible.

In relation to the DHS service centres, one FIS Officer noted there may be some perceived or actual accessibility barriers to attending appointments at these locations: 'People with mobility issues or who lack transportation may not go to a Centrelink office and therefore will not learn about the FIS... people from CALD backgrounds may not attend a place where they need to speak without an interpreter, or may not feel comfortable asking for one'.

That said, information about the FIS is available on the Services Australia (formerly DHS)²⁴ and My Aged Care websites – including in a variety of translated resources – and via the centralised Centrelink telephone service, meaning that the general public can learn about the service, without having to pay an in-person visit to a Services Australia centre.

Support

The vast majority of navigator service users consulted expressed that they felt well supported by the FIS Officers, which was very much in line with the feedback provided via the surveys (see Table 4-10). However, one navigator service user made the broader point that the systemic barriers to accessing My Aged Care, and the requirement for such navigator services, placed additional burden on Centrelink. This was perceived to be a barrier to receiving support: 'Everything hinges off Centrelink, because you can't [physically] go to My Aged Care...I think Centrelink is overloaded'.

Were navigator service users satisfied with the services?

Evaluation of both qualitative and quantitative data revealed that navigator service users were highly satisfied with the FIS Officers' service offerings, across all trial sites.

During consultations with navigator service users, many reported that the information and options presented to them were *informative, thorough, comprehensive* and *clear*. Many of those who were

²⁴ On 29 May 2019, the Prime Minister announced that DHS was to be renamed Services Australia.

consulted also commented on the positive personal qualities of the FIS Officers, and how their conduct had a direct positive impact on navigator service users' outlook post-interaction.

It was me and my adult daughter attending. It was a very murky minefield. Once we came away from that meeting, we were a lot happier, and it was clearer what had to be done and what our part in it was.

– Navigator service user

Both navigator service users and officers highlighted that the one-on-one interaction component of the trials, along with FIS Officers' important community work (e.g. seminar delivery), were key elements that contributed to the trials' success in terms of satisfaction levels. As one navigator service user commented: 'The one-on-one with the FIS Officer really made it. You can give out pamphlets about aged care but that doesn't consider the human side of things at all, and everyone's situation is different'.

Navigator service users also consistently reported that the ROI was a really useful tool in helping consolidate in their minds, the information that had been conveyed verbally by the FIS Officers during the interaction.

A representative from the FIS Operations team noted that they intended to consider options for different modes of service delivery in future, including the potential adoption of a triage-type system. This would allow those with very basic needs – and, importantly, those who were willing and able – to potentially *self-serve*, for example, by accessing the information they required on the DHS (now Services Australia) website. However, the continued provision of a more intensive one-on-one service would remain in order to support individuals with more complex issues.

Findings from the DHS data set in relation to navigator service user satisfaction, are presented in Section 4.6.1.

To what extent, in what ways and why did reported satisfaction levels differ between populations?

Although a key focus of the ACSN Measure underpinning the trials was the specific targeting of support to vulnerable populations and people who face barriers to accessing aged care, the achievement of this objective in relation to the FIS Officer trials proved a challenge to evaluate.

The reason for this is because information about the factors creating financial complexity for navigator service users only tended to be reported in the DHS data set when they related to *structural* or *circumstantial* issues, and certain types of *situational* matters (see Section 4.3.1). Conversely, other *situational* matters – such as aged care consumers having cognitive impairment or mental illness – and *cultural* matters, for example individuals that identify as LGBTI, or being from a CALD background, were generally not recorded in the DHS data set.

Though the intention was for FIS Officers to collect this type of information, they reported that they would only collect it if it had been volunteered by navigator service users; that is, they would not set out to proactively seek it out. The reasons given by FIS Officers for not collecting this information were that they generally deemed it too *personal* to ask, and/or *irrelevant* to the discussion with navigator service users.

Once the under-reporting of the vulnerability data was identified as a potential issue, the FIS Operations team worked with the officers in an attempt to address this point. However, it is evident

from the information presented in Table 4-8 and Figure 4-2 that personal vulnerability information has been substantially under-reported in the DHS data set.

It's clear from the first evaluation report that there has been a misunderstanding around collection of vulnerability data.

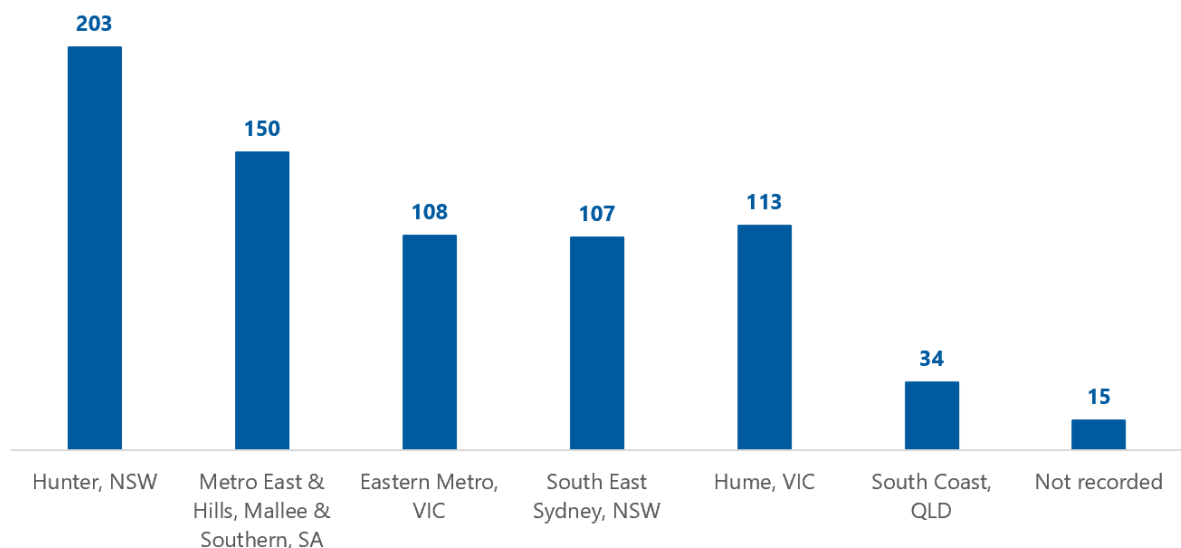
– FIS Operations team member

As such, the paucity of data reported in relation to navigator service users' vulnerabilities prevented any in-depth analysis, or comparison, of satisfaction – or other – information in different populations.

4.5.2 Who are the trials reaching?

Overall, 730 navigator service users presented to the FIS Officer trials between 10 December 2018 and 30 September 2019. The frequency of navigator service users presenting at each of the 6 FIS Officer trials is shown in Figure 4-1.

Figure 4-1: Frequency of navigator service users presenting at each FIS Officer trial



The FIS Officer trial in Hunter, NSW saw the highest number of navigator service users (n=203), followed by the trials in South Australia (n=150). Three FIS Officer trials saw similar numbers of navigator service users – just over 100 – while South Coast, Qld saw the fewest (n=34). Further information about trial uptake is presented in Section 4.6.

What are the characteristics of people using each trial activity?

FIS Officers collected information about the *relationship* of the individual who presented at the FIS Officer trials – that is, the navigator service user – to the consumer requiring aged care services, under the following 7 categories in the DHS data set:

- Aged care consumer (e.g. self)
- Partner
- Adult child
- Other family member
- Enduring Power of Attorney (EPOA)
- Nominee (e.g. an authorised representative to act on the aged care consumer's behalf)
- Professional representation

Information about who presented at the FIS Officer trials is shown below.

Relevant information about the personal, financial and complex situations of the *aged care consumer* was also collected from the presenting navigator service user (who may also be the aged care consumer). This information comprised:

- Marital status
- Payment type (e.g. government income source, such as DHS Age Pension)
- Home ownership status
- Assets
- Complex situations

Information collected about the characteristics of aged care consumers is shown below.

Navigator service users presenting at the FIS Officer trials

The type/s of navigator service users presenting at the FIS Officer trials was reported for 96.6% (n=772) of interactions. Where known, the information about presenting navigator service user/s is shown in Table 4-2.

Table 4-2 Distribution of navigator service user types presenting at the FIS Officer trials

Attendee Type/s	n	%
Adult Child, EPOA	105	13.6%
Adult Child, EPOA, Nominee	87	11.3%
Aged Care Consumer	78	10.1%
Adult Child, Nominee	71	9.2%
Partner	71	9.2%
Nominee	65	8.4%
Adult Child	36	4.7%
EPOA	34	4.4%
EPOA, Partner	26	3.4%
Adult Child, EPOA, Nominee, Other Family Member	20	2.6%
Nominee, Partner	16	2.1%
EPOA, Nominee	15	1.9%

Attendee Type/s	n	%
Adult Child, Aged Care Consumer	12	1.6%
Other Family Member	12	1.6%
Adult Child, EPOA, Other Family Member	11	1.4%
Nominee, Other Family Member	11	1.4%
Aged Care Consumer, Partner	11	1.4%
EPOA, Other Family Member	10	1.3%
Adult Child, Partner	10	1.3%
Adult Child, Nominee, Other Family Member	9	1.2%
EPOA, Nominee, Other Family Member	8	1.0%
Adult Child, Nominee, Partner	8	1.0%
Adult Child, EPOA, Partner	7	0.9%
Adult Child, Other Family Member	6	0.8%
Adult Child, Aged Care Consumer, EPOA	6	0.8%
Aged Care Consumer, EPOA	5	0.6%
Adult Child, Aged Care Consumer, Nominee	3	0.4%
Other Family Member, Partner	3	0.4%
Adult Child, Aged Care Consumer, EPOA, Nominee	2	0.3%
Adult Child, Aged Care Consumer, Partner	2	0.3%
EPOA, Nominee, Partner	2	0.3%
Adult Child, Aged Care Consumer, Other Family Member	1	0.1%
Aged Care Consumer, Nominee	1	0.1%
Adult Child, EPOA, Nominee, Professional Representation	1	0.1%
Adult Child, Other Family Member, Partner	1	0.1%
Adult Child, EPOA, Other Family Member, Partner	1	0.1%
Aged Care Consumer, EPOA, Partner	1	0.1%
Adult Child, Aged Care Consumer, EPOA, Partner	1	0.1%
EPOA, Other Family Member, Partner	1	0.1%
Adult Child, EPOA, Nominee, Partner	1	0.1%
Partner, Professional Representation	1	0.1%
Total	772	100.0%

Note: navigator service user type/s was reported for n=772 (96.6%) of interactions. Where >1 navigator service type reported, attendee number may not always be determinable, e.g. 'Adult child, EPOA' may refer to one or 2 individuals presenting at the trials.

Where reported, the most frequently presenting navigator service user type/s was 'Adult child, EPOA' – although it is important to note that this category was still only reported in 13.6% of interactions (n=105) (Table 4-3). The reason for this relatively low rate for the most frequently reported navigator service user type/s is the *large number of combinations of types* reported in the DHS data set, which created a long tail in the data. Indeed, of the 41 different records reported for presenting navigator service user type/s, 35 were reported in less than 5.0% of interactions (Table 4-2).

Where navigator service user type was known, aged care consumers were only present at 15.9% of interactions (n=123), including 10.1% (n=78) where they presented *alone as navigator service users*. Interestingly, these findings are somewhat at odds with anecdotal observations from the FIS Officers, who noted that while aged care consumers were seldom in attendance at the FIS Officer interactions, when they were present, they were usually *accompanied* by others.

Where aged care consumers *were* accompanied by others (5.8% of interactions, n=45), the types of accompanying individual/s are shown in Table 4-3.

Table 4-3: Distribution of individuals accompanying aged care consumers in the FIS Officer trials

Relationship to consumer	n (%)
Adult child	12 (26.7%)
Partner	11 (24.4%)
EPOA, Adult child	6 (13.3%)
EPOA	5 (11.1%)
Nominee, Adult child	3 (6.7%)
Other	8 (17.8%)
Total	45 (100.0%)

Note: the table shows the types of individual/s accompanying aged care consumers during interactions with FIS Officers, where data were available; the categories of individuals are mutually exclusive; the 'Other' category comprises accompanying individual/s reported in <5.0% of interactions (34 categories); when >1 accompanying individual reported, number of accompanying individuals may not be determinable, e.g. 'EPOA, Adult Child' may refer to one or 2 individuals.

Around half of aged care consumers' accompanied interactions comprised either an 'Adult child' (26.7% of interactions, n=12), or a 'Partner' (24.4%, n=11) (Table 4-3). The remaining accompanied interactions were made up of a variety of combinations of adult children, partners, other family members, EPOAs and/or nominees.

Aged care consumer characteristics

Table 4-4 shows the payment types (e.g. government income sources) of aged care consumers for the 6 FIS Officer trials. Overall, 80.1% of aged care consumers (n=585) were receiving the DHS Age Pension, with 7.7% (n=56) receiving no form of payment. The remainder of consumers were receiving payments either via a Commonwealth Support Health Card (CSHC) (5.8%, n=42), DVA pension (4.0%, n=29), Disability Support Pension (DSP) (2.1%, n=15) or Carer Payment (0.4%, n=3).

Across each trial, aged care consumers were also similar in terms of their marital status (see Table 4-5), and home ownership status (Table 4-6). Most aged care consumers were either married (37.5%, n=274) or widowed (48.1%, n=351), and a similar overall proportion were home owners (83.0%, n=606). However, some differences between trials were observed for asset levels, with aged care consumers from the South East Sydney, NSW trial reporting a somewhat higher proportion of total assets – on average – than the other trials (Table 4-7).

4. Findings: FIS Officer trials

Table 4-4: Distribution of aged care consumers' payment types, by FIS Officer trial

Payment type	Hunter, NSW	Metro East & Hills, Mallee & Southern, SA	Eastern Metro, Vic	South East Sydney, NSW	Hume, Vic	South Coast, Qld	Not recorded
Age pension	172 (84.7%)	111 (74.0%)	82 (75.9%)	84 (78.5%)	96 (85.0%)	30 (88.2%)	10 (66.7%)
CSHC	6 (3.0%)	17 (11.3%)	12 (11.1%)	7 (6.5%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Carer payment	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	3 (2.7%)	0 (0.0%)	0 (0.0%)
DSP	3 (1.5%)	3 (2.0%)	3 (2.8%)	1 (0.9%)	4 (3.5%)	0 (0.0%)	1 (6.77%)
DVA	6 (3.0%)	3 (2.0%)	6 (5.6%)	9 (8.4%)	2 (1.8%)	1 (2.9%)	2 (13.3%)
None	16 (7.9%)	16 (10.7%)	5 (4.6%)	6 (5.6%)	8 (7.1%)	3 (8.8%)	2 (13.3%)
Total	203 (100.0%)	150 (100.0%)	108 (100.0%)	107 (100.0%)	113 (100.0%)	34 (100.0%)	15 (100.0%)

Table 4-5: Distribution of aged care consumers' marital status, by FIS Officer trial

Marital status	Hunter, NSW	Metro East & Hills, Mallee & Southern, SA	Eastern Metro, Vic	South East Sydney, NSW	Hume, Vic	South Coast, Qld	Not recorded
De facto	1 (0.5%)	3 (2.0%)	2 (1.9%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Divorced	5 (2.5%)	4 (2.7%)	9 (8.3%)	3 (2.8%)	1 (0.9%)	3 (8.8%)	1 (6.7%)
Married	77 (37.9%)	76 (50.7%)	41 (38.0%)	27 (25.0%)	37 (32.7%)	12 (35.3%)	4 (26.7%)
Separated	5 (2.5%)	2 (1.3%)	2 (1.9%)	3 (2.8%)	7 (6.2%)	0 (0.0%)	0 (0.0%)
Single	8 (3.9%)	7 (4.7%)	14 (13.0%)	5 (4.7%)	10 (8.8%)	6 (17.6%)	2 (13.3%)
Widowed	107 (52.7%)	58 (38.7%)	40 (37.0%)	69 (64.5%)	58 (51.3%)	13 (38.2%)	6 (40.0%)
Not recorded	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	2 (13.3%)
Total	203 (100.0%)	150 (100.0%)	108 (100.0%)	107 (100.0%)	113 (100.0%)	34 (100.0%)	15 (100.0%)

4. Findings: FIS Officer trials

Table 4-6: Distribution of home ownership status, by FIS Officer trial

Home ownership	Hunter, NSW	Metro East & Hills, Mallee & Southern, SA	Eastern Metro, Vic	South East Sydney, NSW	Hume, Vic	South Coast, Qld	Not recorded
Home owner	180 (88.7%)	124 (82.7%)	91 (84.3%)	95 (88.8%)	76 (67.3%)	30 (88.2%)	10 (66.7%)
Non-home owner	23 (11.0%)	26 (17.0%)	15 (13.9%)	11 (10.3%)	37 (32.7%)	4 (11.8%)	4 (26.7%)
Not recorded	0 (0.0%)	0 (0.0%)	2 (1.9%)	1 (0.9%)	0 (0.0%)	0 (0.0%)	1 (6.7%)
Total	203 (100.0%)	150 (100.0%)	108 (100.0%)	107 (100.0%)	113 (100.0%)	34 (100.0%)	15 (100.0%)

Table 4-7: Distribution of total assets, by FIS Officer trial

Total assets	Hunter, NSW	Metro East & Hills, Mallee & Southern, SA	Eastern Metro, Vic	South East Sydney, NSW	Hume, Vic	South Coast, Qld	Not recorded
0	0 (0.0%)	1 (0.7%)	0 (0.0%)	1 (0.9%)	0 (0.0%)	0 (0.0%)	1 (6.7%)
>\$0 <\$250,000	24 (11.8%)	12 (8.0%)	16 (14.8%)	5 (4.7%)	38 (33.6%)	6 (17.6%)	2 (13.3%)
≥\$250,000 <\$500,000	48 (23.6%)	32 (21.3%)	11 (10.2%)	13 (12.1%)	40 (35.4%)	8 (23.5%)	3 (20.0%)
≥\$500,000 <\$750,000	56 (27.6%)	30 (20.0%)	10 (9.3%)	8 (7.5%)	17 (15.0%)	9 (26.5%)	4 (26.7%)
≥\$750,000 <\$1,000,000	37 (18.2%)	22 (14.7%)	18 (16.7%)	23 (21.5%)	5 (4.4%)	4 (11.8%)	1 (6.7%)
≥\$1,000,000 <\$1,250,000	19 (9.4%)	16 (10.7%)	23 (21.3%)	20 (18.7%)	5 (4.4%)	3 (8.8%)	1 (6.7%)
≥\$1,250,000	19 (9.4%)	37 (24.7%)	30 (27.8%)	37 (34.6%)	8 (7.1%)	4 (11.8%)	3 (20.0%)
Total	203 (100.0%)	150 (100.0%)	108 (100.0%)	107 (100.0%)	113 (100.0%)	34 (100.0%)	15 (100.0%)

Note: total assets include all realisable assets, non-realisable assets and home value (where applicable).

Complex situations

Of all the complex situations reported for aged care consumers across the FIS Officer trials (n=1,862), the most common types were *financial/situational*, with the complex situation of ‘Moderate asset level outside of the family home’²⁵ the most frequently reported by far (see Figure 4-2).

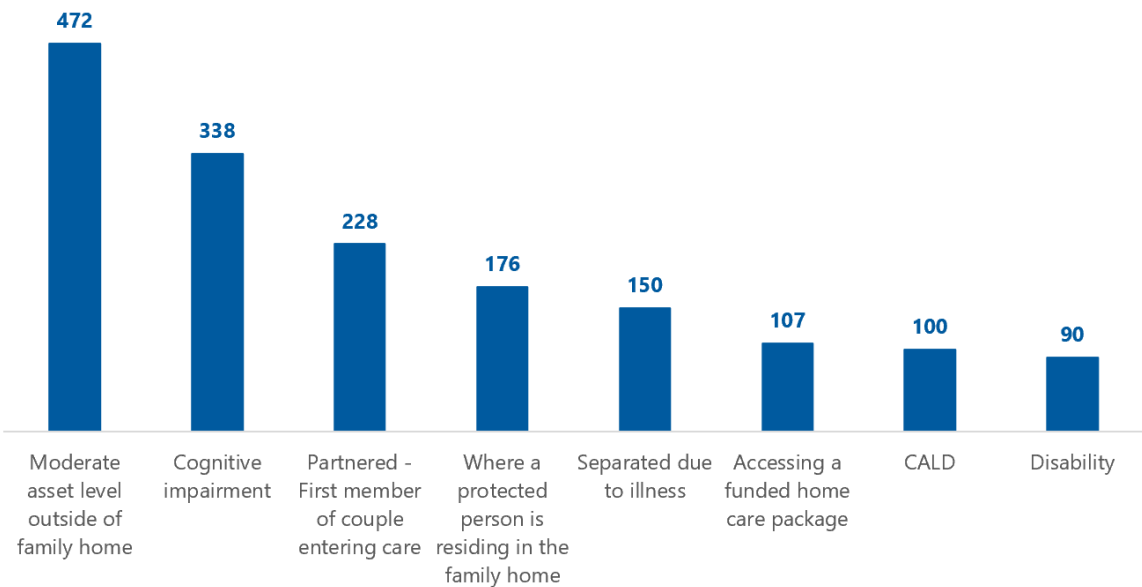
There were general similarities in the frequency of types of complex situations reported across the 6 FIS Officer trials (see Table 4-8). For example, ‘Moderate asset level outside of family home’ was the most frequently reported complex situation for 5 of the 6 trials, with ‘Cognitive impairment’ also reported relatively frequently (see Table 4-8).

The frequency of complex situations shown in Table 4-8 are in line with comments from a number of FIS Officers, with typical consumers described as ‘middle-class, home owners, and with other assets’, meaning they had to manage particular complexities when it came to aged care decision-making.

We do consider anyone looking at aged care to have a ‘financial vulnerability.

– FIS Operations team member

Figure 4-2: Distribution of the most commonly reported complex situations



Note: Complex situations shown were reported in ≥10.0% of consumers requiring aged care services.

²⁵ ‘Moderate asset level outside of family home’ denotes that the consumer requiring aged care services would be liable to part pay a refundable accommodation deposit when entering residential care.

Table 4-8: Distribution of complex situations, by FIS Officer trial

Complex situation	Hunter, NSW	Metro East & Hills, Mallee & Southern, SA	Eastern Metro, Vic	South East Sydney, NSW	Hume, Vic	South Coast, Qld	Not recorded
Accessing a funded home care package	46 (22.7%)	28 (18.7%)	4 (3.7%)	5 (4.7%)	16 (14.2%)	8 (23.5%)	0 (0.0%)
CALD	11 (5.4%)	44 (29.3%)	9 (8.3%)	25 (23.4%)	7 (6.2%)	3 (8.8%)	1 (6.7%)
Cognitive impairment	127 (62.6%)	95 (63.3%)	7 (6.5%)	48 (44.9%)	42 (37.2%)	14 (41.2%)	5 (33.3%)
Customer receiving Carer Payment/ Allowance where care recipient is over 80	16 (7.9%)	32 (21.3%)	0 (0.0%)	2 (1.9%)	3 (2.7%)	6 (17.6%)	1 (6.7%)
Disability	45 (22.2%)	25 (16.7%)	2 (21.9%)	2 (1.9%)	6 (5.3%)	5 (14.7%)	5 (33.3%)
Granny flat	4 (2.0%)	0 (0.0%)	0 (0.0%)	1 (0.9%)	1 (0.9%)	0 (0.0%)	1 (6.7%)
Identifies as Aboriginal or Torres Strait Islander	1 (0.5%)	1 (0.7%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	1 (2.9%)	0 (0.0%)
LGBTI	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)	0 (0.0%)
Mental illness	1 (0.5%)	3 (2.0%)	0 (0.0%)	3 (2.8%)	10 (8.8%)	2 (5.9%)	1 (6.7%)
Moderate asset level outside of family home	135 (66.5%)	81 (54.0%)	61 (56.5%)	84 (78.5%)	92 (81.4%)	13 (38.2%)	6 (40.0%)
Owns farm/primary production/business	3 (1.5%)	4 (2.7%)	0 (0.0%)	0 (0.0%)	12 (10.6%)	0 (0.0%)	1 (6.7%)
Partnered First member of couple entering care	68 (33.5%)	66 (44.0%)	39 (36.1%)	18 (16.8%)	23 (20.4%)	11 (32.4%)	3 (20.0%)
Partnered Second member of couple entering care	25 (12.3%)	9 (6.0%)	6 (5.6%)	5 (4.7%)	2 (1.8%)	0 (0.0%)	0 (0.0%)
Separated due to illness	31 (15.3%)	68 (45.3%)	4 (3.7%)	19 (17.8%)	23 (20.4%)	4 (11.8%)	1 (6.7%)
Where a protected person is residing in the family home	59 (29.1%)	56 (37.3%)	2 (1.9%)	28 (26.2%)	23 (20.4%)	6 (17.6%)	2 (13.3%)
None recorded	5 (2.5%)	0 (0.0%)	0 (0.0%)	1 (0.9%)	2 (1.8%)	0 (0.0%)	3 (20.0%)
Total	577	528	134	245	274	73	31

Note: Multiple complex situations could be recorded for each navigator service user, hence categories are not mutually exclusive and percentages will not necessarily add up to 100%.

Vulnerable population groups

Away from the more *financial* or situational factors that create complexity around aged care decision-making, FIS Officers had been tasked with focusing their efforts on engaging with those who may face more cultural challenges when accessing aged care. Examples of these groups include, but are not limited to, people from Aboriginal or Torres Strait Islander or CALD backgrounds, and those who identify as LGBTI.

As discussed in Section 4.5.2, these types of populations are likely to be underrepresented in the DHS data set. For example, only 0.4% (n=3) of all aged care consumers were reported to identify as 'Aboriginal or Torres Strait Islander', while population figures indicate that 1-2% of people who may require aged care services will identify as such.²⁶ Elsewhere, only 2.7% (n=20) of aged care consumers were reported to have mental illness, which is well below the reported prevalence rates for mental illness in the general Australian population.²⁷ Other indicators that are likely to have been under-reported include people who identify as LGBTI, people from a CALD background, and people with disability, which has prevented more in-depth evaluation of the appropriateness and effectiveness of the trials in meeting the needs of these distinct groups.

How do the characteristics of the trial participants differ from what was expected?

As described in Section 4.3 the locations of the FIS Officer trials were selected partly based on the demographics of the local populations in those areas. Where possible to comment, the characteristics of navigator service users appeared to be broadly in line with expectations. However, given the under-reporting of certain vulnerability information (see Section 1.1.1), it has not been possible to obtain a true picture of navigator service users' characteristics.

In line with this point, the comparatively high proportion of navigator service users with *higher levels of relative wealth* was expected – and, likely compounded by the relative overrepresentation of *situational* data collected, and reported, in the DHS data set. However, it does indicate that those with higher levels of relative wealth face a particular set of challenges when accessing aged care, which may be different to those faced by other groups – such as *vulnerable* and/or *diverse populations*.

Which populations may not be accessing each trial, and why? What are the gaps?

FIS Officers reported that it was difficult to know which populations were not accessing the trials, but speculated that a service gap may exist for certain population groups. These included Aboriginal or Torres Strait Islander people, people from CALD backgrounds, and people facing particular barriers – such as the socially isolated, and those with literacy and/or accessibility difficulties.

It's hard to know who the trials have not touched.

– FIS Officer

²⁶ Source: GEN Aged Care Data (2016). Australia census 2016 population overview – who might require aged care services? Retrieved from [GEN Aged Care Data - My aged care region tool](https://www.gen-agedcaredata.gov.au/My-aged-care-region) (https://www.gen-agedcaredata.gov.au/My-aged-care-region).

²⁷ Australian Bureau of Statistics (2015). 4364.0.55.001 - National Health Survey: First Results, 2014-15. Retrieved from [Australian Bureau of Statistics - Mental and behavioural conditions result](https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2014-15~Main%20Features~Mental%20and%20behavioural%20conditions~32) (https://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2014-15~Main%20Features~Mental%20and%20behavioural%20conditions~32).

Despite this, FIS Officers reported a number of successes with engaging individuals from certain community groups. For example, a number of trial referrals had been generated directly from FIS Officers' outreach to *non-government* and *not-for-profit organisations*, including the MS Society, as well as Dementia Australia and the Housing for the Aged Action Group (HAAG) – 2 of the partner organisations delivering other trial programs under the ACSN Measure (see Section 3.3.1). Further information about the FIS Officer trials' communication and engagement activities is shown in Section 4.4.1.

When I started, I went out into the community and spoke to advocacy groups and service providers, they are the ones dealing with at-risk communities.

– FIS Officer

That said, some FIS Officers reported difficulties when trying to build relationships with service providers working with specific populations. For example, the FIS Officer from Hume, Vic, who covers an area with large Aboriginal or Torres Strait Islander populations, had struggled to generate many referrals from these communities. By way of example, this officer commented that they had been unable to deliver seminars at a local RACF for Aboriginal or Torres Strait Islander people, because “*they do not like outsiders*”.

In order to try and solve this, one of the FIS Operations team indicated that the following strategies should be considered in the future, in order to address service gaps for vulnerable populations:

- Training to increase the FIS Officers' understanding of vulnerable populations, and the specific barriers they face in relation to aged care.
- Develop *systematic* and *proactive* strategies to improve engagement with vulnerable populations though:
 - Building of partnerships and linkages with primary care and hospital services, non-government, and not-for-profit sectors (with a focus on those organisations that engage with specific vulnerable population groups)
 - Provision of information/education about the FIS to other relevant support sectors, in order to facilitate appropriate, bidirectional referrals between them and the FIS
 - Strengthening of relationships with other Service Australia (formerly DHS) programs such as Community Specialist Outreach Programs.

We have learned a lot from the trials in terms of the better targeting of vulnerable populations. We need to go from being passive to proactive.

– FIS Operations team member

As reported by navigator service users, the biggest barrier to accessing the FIS Officer trials was their initial lack of knowledge and awareness about the FIS. For example, one navigator service user expressed some confusion regarding the eligibility criteria for accessing these services: 'We got the impression it was available to us because we were a client of Centrelink. Until now I wouldn't have assumed it was available to everyone'. Based on these findings, it is likely that through increased targeted promotion to improve community awareness, the FIS will be able to increase its reach into the wider population, including vulnerable communities.

The FIS Operations team reported that the FIS could focus on engaging with consumers at the point where they are first considering aged care – such as during hospitalisations, or when receiving an initial aged care assessment. They noted that once consumers are established in the aged care system, they may be harder to reach because many aged care providers and facilities have established relationships with commercial financial planning services. A couple of FIS Officers suggested that there may be opportunities in the future to target individuals even earlier in the aged care decision-making process – for example, at the initiation of their DHS Aged Pension – in order to provide them with support for planning for their futures.

4.6 Findings: Effectiveness

This section presents evaluation findings on the effectiveness of the FIS Officer trials.

4.6.1 To what extent are the trials achieving their intended outcomes?

Trial uptake

The aim of the FIS Officer trials was to provide targeted face-to-face support to individuals making complex financial decisions when planning for and accessing aged care. As highlighted in Section 4.5.2, a total 730 navigator service users received support via a FIS Officer trial interaction. It is important to note that following an initial slow start in trial uptake, the outreach and promotional activities conducted by the officers led to a steady increase in navigator service users accessing support from FIS Officers over time (Figure 4-3).

The number of navigator service users receiving support via a FIS Officer interaction peaked in July 2019 (n=114), with numbers starting to tail off in the final 2 months. This may reflect the fact that the FIS Officers began to wind down their outreach and promotional activities to manage generated demand as trial closure approached.

As highlighted in Section 4.5.2, the Hunter, NSW FIS Officer trial provided support to the highest number of navigator service users, followed by the trials in South Australia (see Figure 4-1). The remaining trials reported lower numbers, with the trial in South Coast, Qld, reporting a markedly low Figure of 34 navigator service users. The reason that this latter trial particularly struggled to recruit was reportedly due to an issue that was also observed elsewhere, but compounded at this trial site:

FIS Officers reported that some RACFs in their trials' ACPRs were found to have existing – and exclusive – private arrangements with commercial financial advisors, meaning FIS Officers were unable to engage with aged care consumers associated with these establishments. This was only uncovered through the FIS Officers' outreach and promotional work, with RACFs originally intended to be a key focus for targeting potential navigator service users.

The inevitable detrimental effect on trial uptake was particularly magnified in South Coast, Qld, where the commercial financial services market was reported to be particularly competitive – given the popularity of this area with retired wealthy Australians.

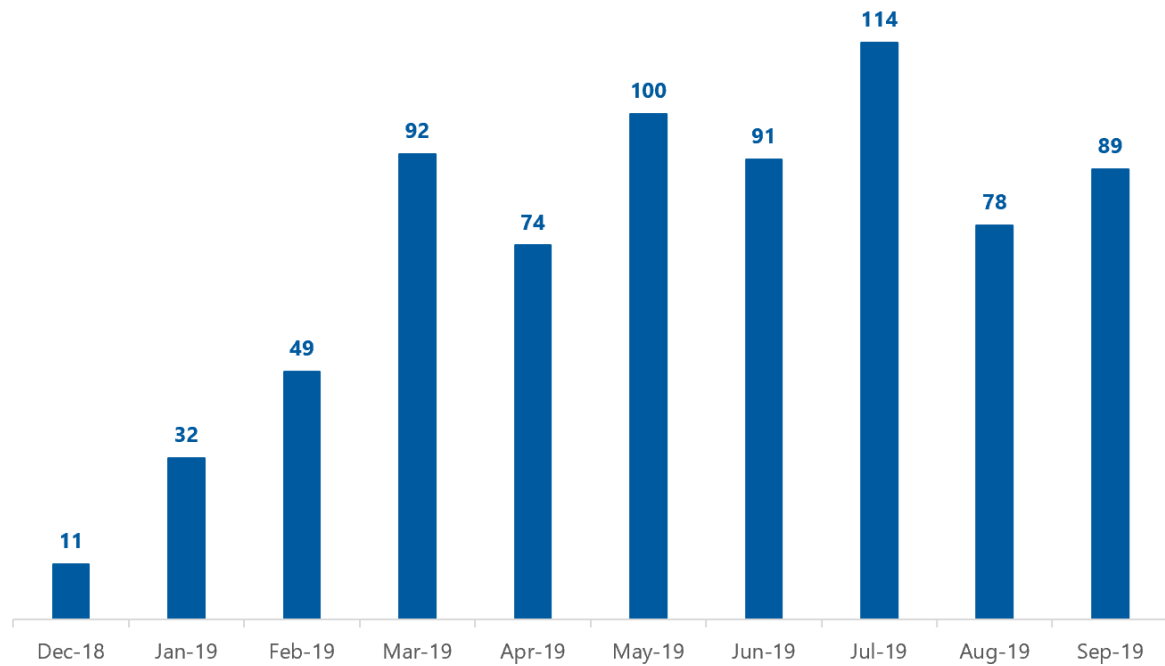
Here, more individuals appeared to be willing to pay to access commercial services, at the expense of using the FIS Officer trials. This was borne out in the DHS data set, which showed that the asset levels of aged care consumers who did access the trial in South Coast, Qld, were skewed to the lower value end compared to the other trials, that is, wealthier individuals tended not to access this trial (see Table 4-7).

Elsewhere, *some* officers did report good success with targeting RACFs, with at least a couple of navigator service users also commenting that they had accessed the FIS Officer trials based on a direct referral from a RACF.

[The trials] were recommended by the manager of the care home we visited.

– Navigator service user

Figure 4-3: Number of navigator service users receiving support over time



Trial interactions

A total of 799 interactions between the 730 navigator service users and FIS Officers were reported to have occurred between 10 December 2018 and 30 September 2019 (see Table 4-9). Indeed, although the trials were originally intended to deliver single sessions of support only, a few navigator service users accessed trial services on multiple occasions.

Table 4-9: Number of interactions reported, by FIS Officer trial

Navigator service user attendance	n	%
Hunter, NSW	228	31%
Metro East and Hills, Mallee and Southern, SA	166	23%
Eastern Metro, Vic	120	16%
South East Sydney, NSW	116	16%
Hume, Vic	115	16%
South Coast, Qld	37	5%
Not recorded	17	2%
Total	799	100%

4. Findings: FIS Officer trials

Findings from the DHS data set showed that the majority of navigator service users only presented once at a FIS Officer trial (n=670, 92%) with 53 (7%) presenting twice, 5 (1%) presenting 3 times, and 2 (0.3%) presenting 4 times. As highlighted in Section 4.4.2, the reasons that some navigator service users required additional sessions of support were reported to be their need to clarify information received during their initial interaction with an officer, to obtain additional information, and/or to obtain new information because their circumstances had changed.

It was helpful for me to better understand [our options] while my Mum is being cared for at home, although we will need to revisit the [available options] should Mum need to go into a nursing home.

– Navigator service user

In order to be able to maximise the value of the FIS Officer trials for navigator service users, the interactions were planned to be face-to-face, and this mode of delivery was by far the most common: 782 of the 799 interactions (98%) were in person. FIS Officers reported conducting 14 interactions (2%) via telephone, with 11 of these being first interactions – likely conducted in response to navigator service users' mobility issues. The other 3 telephone interactions came after an initial in-person interview at a DHS service centre. (Note the mode of delivery of the remaining 3 interactions could not be established from the DHS data set).

A crucial aspect of trial design was the planned extension of the standard interview time, from the usual one hour as conducted in FIS BAU. Being able to devote a longer time to each interaction allowed the officers to gain a deep understanding of navigator service users' needs, which could then inform the development all of the potential financial scenarios open to the individual. The additional time also meant that the FIS Officers could deliver their feedback at a pace that maximised navigator service users' understanding of their available options.

The mean duration of interactions ('interviews') reported in the DHS data set was 1.7 hours (or 104 minutes), with a minimum duration of 0.3 hours and a maximum of 2.6 hours reported. However, it is important to note that interaction duration information was only available for a very small proportion of the FIS Officer interactions (36 of 799 [5%]). That said, consultations with officers and navigator service users, along with on-site trial observations, indicated that interactions often ran to around the two-hour mark – considerably longer than the interviews conducted in FIS BAU. It is also important to note that the positive feedback received from navigator service users following their interviews (as exemplified in their survey responses [see Table 4-10]), demonstrates that having this extended time to receive support was seen as incredibly beneficial.

The officer went to great pains to help us, he was very patient. Everything was presented in writing, plus he gave us forms to take away for completion.

– Navigator service user

To what extent have navigator service users' understanding and confidence changed as a result of the trials?

During telephone consultations, navigator service users consistently reported that they were very happy with the information and support they had received from the FIS Officers in the trials. They often also commented that they had left with a better understanding of the financial implications of their decision-making with regard to aged care. Similar sentiments were also expressed immediately following the interactions observed by AHA, during the site visits to trial locations.

Satisfied? Yes, very much so!

– Navigator service user

Interestingly, a couple of the FIS Officers commented that some navigator service users asked to change their responses to the initial satisfaction survey ('Survey 1' [completed in person, immediately prior to the interaction]) at the end of their visit, because it was only *after* receiving support and information about financial decision-making that they truly realised how un-informed they had previously been.

Are changes sustained at follow-up?

Survey responses

In order to test whether any short-term changes in understanding and confidence levels reported *immediately* following a trial interaction were sustained over time, navigator service users were asked to complete 2 follow-up surveys:

- 'Survey 2', completed over the telephone, 2-3 days post-interaction.
- 'Survey 3', completed over the telephone, 2-3 months post-interaction.

Although the reported response rate for the pre-interaction survey ('Survey 1') was very high – all 5 questions being answered by 98% of navigator service users – the collection of response data for 'Survey 2' and 'Survey 3' was more challenging. Indeed, the roll-out of these surveys had to be temporarily halted by DHS, due to concerns around the potential risk of contacting individuals who had been recently bereaved. Once these concerns had been addressed, the 2 follow-up surveys recommenced, although with somewhat lower response rates compared to 'Survey 1'. For example, only 429 of 730 navigator service users (59%) answered one or more of the 18 questions in 'Survey 2', while 335 of 730 (46%) answered one or more of the 20 questions in 'Survey 3'. However, across the 2 surveys, response rates were still high enough in order to support the drawing of conclusions in relation to changes in navigator service users' understanding and confidence.

Table 4-10 shows the questions from the 3 surveys, along with the mean reported scores – out of a maximum (positive) score of 5 – for each question.

Table 4-10: 'Survey 1', 'Survey 2' and 'Survey 3' scores reported by navigator service users

Question	Mean score: 'Survey 1'	Mean score 'Survey 2'	Mean score 'Survey 3'
1. Do you think you have a strong understanding of the cost involved in entering aged care?	2.6 (n=720)	4.2 (n=428)	4.2 (n=335)
2. How well do you understand your options and choices to fund your aged care?	2.3 (n=720)	4.0 (n=426)	4.0 (n=335)
3. Do you think you are good at managing your money?	4.3 (n=721)	4.4 (n=425)	4.4 (n=333)
4. Do you think you can make the best decision about your aged care based on your finances?	3.7 (n=720)	4.2 (n=425)	4.4 (n=332)
5. Do you understand the impact of your future decision on your finances?	3.1 (n=719)	4.2 (n=426)	4.3 (n=333)
6. The information provided was relevant to me		4.8 (n=424)	4.8 (n=334)
7. The information provided was accurate		4.6 (n=421)	4.7 (n=331)
8. The options provided were clear and concise		4.6 (n=423)	4.6 (n=332)
9. I understood the options that were provided		4.5 (n=424)	4.5 (n=333)
10. I will be/was able to use the information that was provided		4.5 (n=425)	4.6 (n=331)
11. The service was easy to find when I needed support		3.7 (n=423)	3.7 (n=333)
12. The service was easy to access within a reasonable timeframe		4.4 (n=424)	4.5 (n=332)
13. The officer acted professionally		5.0 (n=424)	4.9 (n=333)
14. The officer was polite		5.0 (n=424)	5.0 (n=330)
15. The officer was helpful		4.9 (n=424)	4.9 (n=332)
16. The officer treated me with respect (or respected my culture)		5.0 (n=425)	4.9 (n=331)
17. The officer provided other support options		3.3 (n=424)	3.9 (n=328)
18. The officer made referrals to support options		2.5 (n=422)	2.8 (n=323)
19. Using this service helped me make my decision			4.6 (n=334)
20. Using this service increased my understanding of aged care financial matters			4.6 (n=327)

Note: A higher score (out of a maximum of 5) denotes a higher level of agreement with the question.

Out of a maximum possible score of 25, the mean *total* score for Q1-5 reported pre-interview was 16.0 (n=716), which rose to 21.2 (n=400) at 'Survey 2', and remained similarly high at 'Survey 3': 21.4 (n=303).

Perhaps unsurprisingly, given the anecdotal positive feedback provided to AHA during consultations, navigator service users consistently reported *improved* scores for all 5 of the common questions in the first post-interview survey ('Survey 2'), compared to pre-interview (Q1-5 in Table 4-10). Also of note was that the overall improvements reported for Q1-5 in 'Survey 2', were replicated – and, in some cases, even built upon – in 'Survey 3' (Table 4-10).

Figure 4-4 shows the proportions of navigator service users who reported the same score (e.g. no change in understanding or confidence levels), a higher score (e.g. an improvement) or a lower score (e.g. a worsening) 2-3 months post-interview, compared to pre-interview, for survey questions 1–5.

4. Findings: FIS Officer trials

In 4 of the 5 common survey questions, a majority of navigator service users reported having greater understanding of, and confidence in, financial decision-making in relation to accessing and navigating aged care (Figure 4-4). The one question where this was not the case was question 3: 'Do you think you are good at managing your money?', where the majority (58%) reported their levels of understanding and confidence remained the same (Figure 4-4). However, the mean score pre-interview was relatively high (4.3; see Table 4-10) compared to the other 4 questions, meaning there was essentially less scope for improvement.

Figure 4-4: Changes in understanding and confidence levels of navigator service users from pre-interaction ('Survey 1') to 2-3 months post-interaction ('Survey 3')

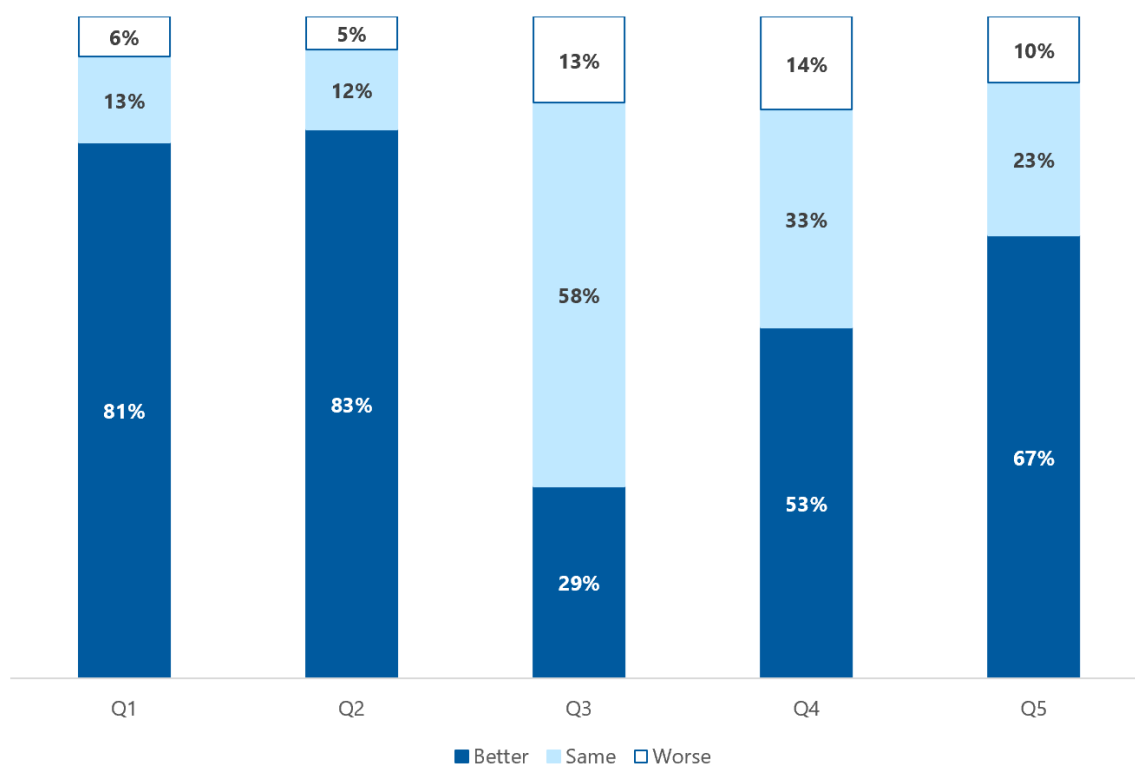


Table 4-11 shows the change in mean score for questions one to 5 reported in 'Survey 1' and 'Survey 3' by the 6 FIS Officer trials. In all trials, navigator service users reported overall improvements (e.g. a positive change in score) in their understanding and confidence levels.

Table 4-11: Change in mean score (Q1-5) between 'Survey 1' and 'Survey 3', by FIS Officer trial

FIS Officer trial	Change in mean score
Hunter, NSW	+1.1 (n=84)
Metro East and Hills, Mallee and Southern, SA	+1.0 (n=69)
Eastern Metro, Vic	+1.2 (n=56)
South East Sydney, NSW	+1.0 (n=52)
Hume, Vic	+1.1 (n=51)
South Coast, Qld	+1.4 (n=19)

Note: includes navigator service users who reported all 5 scores for Q1-5 in both 'Survey 1' and 'Survey 3'. A positive change in mean score denotes higher level of agreement with Q1-5 (see Table 4-10 for question wording).

4. Findings: FIS Officer trials

For the remaining questions in 'Survey 2' (Q6-18) and 'Survey 3' (Q6-20), again, navigator service users consistently reported high scores, demonstrating their reported satisfaction with the FIS Officer trials was sustained over time. It is, perhaps, particularly important to highlight that the questions in relation to the professionalism, politeness, helpfulness and respectfulness of the FIS Officers, garnered exceptionally positive feedback (Q13-16 in Table 4-10).

Looking at the feedback, the FIS Officer trials have really helped people. It doesn't surprise me because the FIS is known for doing that anyway, but it has reinforced that view.

– FIS Operations team member

The responses to the 2 questions in relation to the provision of other supports (Q17) and referral on to supports (Q18) generated somewhat lower scores compared to the other survey questions (see Table 4-10). Though it is important to note that the surveys did not include an option for navigator service users to record a response of 'not applicable', these lower scores suggest that FIS Officers were able to provide full support to navigator service users in that single interaction. However, as some navigator service users did return for repeat visits, this could indicate that – at least for some navigator service users – the provision of other supports, or referral on to supports, *may* have been beneficial.

That said, taking the survey data, along with anecdotal information collected during telephone consultations and site visits to the FIS Officer trials, there is clear evidence that the improvements in navigator service users' understanding of financial arrangements and options – and in their confidence in making financial decisions when planning for and accessing aged care – was *sustained* over the time that these were measured.

Were FIS Officers successful in supporting aged care consumers, carers and families to understand aged care services and engage with the aged care system? If so, what characteristics of the trials enabled success?

Based on information collected during consultations and surveys of navigator service users (Table 4-10), the FIS Officers were found to have been very successful in increasing the knowledge and understanding of *family members and carers*. As the consumers requiring aged care services generally did not present at the trials (Table 4-2), it is not possible to report direct findings in relation to their understanding. However, it is clear from navigator service user feedback that following an interaction with a FIS Officer, individuals felt more empowered to make financial decisions when planning for and accessing aged care, especially on behalf of another individual.

One particular feature of the trials which enabled success was where navigator service users had EPOA and/or nominee status for the aged care consumer. In this circumstance, the FIS Officers were able to access a broad range of supporting personal information pertaining to the aged care consumer from various Centrelink databases, even in their absence.

The officer could access Mum's files and gave me [information] on how things would work out for Mum. It was so helpful as it's a very stressful time when you're a carer.

– Navigator service user

4. Findings: FIS Officer trials

The process of FIS Officers demonstrating the functionality of the My Aged Care website, in real-time during the interaction, was also reported – on the day – to be useful by navigator service users for building their capacity and capability to engage with this interface in the future.

It made us feel more comfortable and empowered.

– Navigator service user

That said, feedback from telephone consultations with navigator service users following their interaction, highlighted that broader, more systemic, issues with My Aged Care meant that they still faced considerable challenges when trying to engage services (see *Enablers and barriers to success*, below).

Elsewhere, the provision of the completed ROI for navigator service users to take away as an information resource – along with the extended duration of interview time compared to FIS BAU (as described above) – were considered to be key characteristics of the trials that maximised the capability and capacity of navigator service users to engage with the aged care system.

What level of integration occurred between the different trials and with existing supports?

Inter-trial existing supports

With regard to the respective financial supports offered by each of the 6 trials, their disparate locations across Australia limited their ability to integrate internally, meaning that the 6 FIS Officers operated with a fair degree of autonomy during trial implementation. However, this was how the trials were planned to operate. Further, and as highlighted in Section 4.4.1, the officers were in regular contact via an online forum, which allowed them to share information about their respective successes, challenges faced and opportunities they had identified to enhance their own support offerings to navigator service users.

Further, during AHA's site visits to trial locations – and where the opportunity presented – FIS Officers were observed to promote the trials at other locations, for example to navigator service users with family members who were interstate.

If your brother over there is facing a similar issue, we have a trial in SA. Tell him to go!

– FIS Officer (Victoria)

Other existing supports

Other existing supports providing financial information were typically found to be private financial advisors offering commercial services to clients. However, to avoid conflicts of interest and maintain competitive neutrality, DHS deemed it inappropriate for any attempt at integration between the FIS Officer trials and these types of commercial entities. As such, no integration with these types of supports occurred.

As set out in Section 4.4.1, integration with the existing supports delivered under the ACSN Measure (e.g. the Information hub, Community hub and SSW trials), was generally very limited. Where feasible, attempts had been made at cross-trial integration, with 4 of the 6 FIS Officers reporting *some* level of engagement with the other 3 trial programs. However, as noted in Section 4.4.1, Have all components of each trial been implemented? integration between the FIS Officer trials and the other 3 trial programs was difficult to realise due to the lack of alignment between the trial programs' respective timelines and locations.

To what extent did each trial complement/build on existing aged care system navigator services?

FIS

The trials were an extension of, and sat squarely within, the FIS which has always supported individuals who need to make financial decisions relating to aged care. As such, by definition, the FIS Officer trials were designed to complement, and build on, these existing services. Indeed, during consultations the FIS Officers highlighted that many navigator service users had been cross-referred from co-located officers in FIS BAU. In this circumstance, individuals had been booked in for a standard FIS BAU interview to access support in relation to aged care decision making. However, the officer, in recognising that the individual would likely benefit more from the enhanced and specialised service, would then refer them on to the co-located FIS Officer trial.

Other services

As highlighted above, where individuals had engaged commercial financial information services (e.g. for a fee), this generally made them unlikely to also seek out free financial services, such as those provided by the FIS. As such, the trials were unable to build on, or complement, these types of other navigator services. Moreover, FIS Officers reported that they were unable to engage with consumers in some aged care facilities, because of pre-existing arrangements with financial advisors in those settings.

In what ways does effectiveness vary between different trials, activity types and target population groups? What are the reasons for this?

Unlike the COTA Australia-led trials, the service offerings of the FIS Officer trials were common to all 6 trials; that is, they did not generally differ from each other, other than in the *quantum* of activities delivered. Quantitative information to support the evaluation was generally limited to *interaction data*, as reported in the DHS data set. For this reason – along with the limited vulnerability data available – it has not been possible to form conclusions about how effectiveness varied between different trial activity types and target population groups.

Enablers and barriers to success

Enablers

A number of *enablers* to the success of the FIS Officer trials have already been discussed in this chapter, and are listed below.

- The harnessing of existing aged care expertise and capability within the FIS, and its tailoring to meet the needs and purpose of the FIS Officer trials (see Section 4.4.2).
- The building of FIS Officers' capacity and capability to deliver external-facing activities – namely, promotional work and outreach activities to drive trial uptake (see Section 4.4.2).
- The demonstrated positive engagement between FIS Officers and navigator service users during their interactions (see Section 1.1.1).
- The extended duration of interviews compared to those conducted in FIS BAU (see Section 4.4.2).
- FIS Officers' consistent and structured, yet flexible approaches to conducting trial interactions (see Section 4.4.2).
- The provision of a hard copy ROI for navigator service users to take away at the conclusion of their FIS Officer interaction (see Section 4.5.1).
- FIS Officers achieving good rates of response for the initial and follow-up surveys of navigator service users (see Section 4.6.1).
- The facility for FIS Officers to be in regular communication via the online chat forum, to share ideas, successes and challenges (see Section 4.4.2).
- The positive working relationship between DHS and the Department throughout every phase of trial implementation (see Section 4.4.2).

Barriers

The main barrier identified during the evaluation of the FIS Officer trials (as discussed above) was the under-reporting of certain situational and cultural circumstances of aged care consumers. This meant that these circumstances were *underrepresented* in the DHS data set, compared to consumers' financial circumstances (see Section 4.5.2).

Another barrier already highlighted (see Section 4.4.2), was the difficulty some navigator service users had with using the centralised Centrelink telephone service to access trial services. This was in line with feedback from FIS Officers themselves. Indeed, it was only due to navigator service users' perseverance that they were ultimately able to make an appointment with a FIS Officer.

It was really bad, it took me about 5 different transfers because I couldn't find any option that said financial advisor.

– Navigator service user

One navigator service user also reported encountering an issue when trying to book a *follow-up* interview with their FIS Officer. As they commented: 'I understand the need for sorting out who has access to that service, but I just wanted to make another appointment for further clarification. I couldn't make that appointment over the phone'. While the individual was at pains to say that they had been more than satisfied with their dealings with the FIS Officer, their experience of rebooking had been unsatisfactory.

Despite these issues, the FIS Operations team confirmed that the potential benefits of establishing a *trial-specific* telephone booking line were outweighed by the associated administrative burden.

Other barriers

A common theme arising from the navigator service consultations was that while the FIS Officers trials were viewed as being very successful in supporting individuals making complex financial decisions, they did not, and could not, solve the perceived problems associated with navigating and accessing services via My Aged Care. Indeed, one navigator service user described the system as 'just a phone answering service; it doesn't solve problems, it just directs. It's like going around in circles'. A common theme coming through the consultations with navigator service users was a view that until a time when these fundamental issues with My Aged Care – and the aged care system, more broadly – were addressed and *resolved*, navigator services such as the FIS Officer trials, could only 'do so much' to help aged care consumers access the services they need. FIS Operations noted that the FIS did help to identify these systems issues – such as the lack of transparency around some aged care providers' fee structures.

If I had to summarise it, My Aged Care is too hard to access. I don't know how people do it; I guess they have to rely on their children to help.

– Navigator service user

4.6.2 Unintended outcomes

As described in detail in Section 4.4.1, the FIS Officer trials were generally implemented as planned. As such – and based on the findings from the DHS data set, and information gleaned from consultations – the trials were found to have been very successful in achieving their *overarching outcomes* of improving the knowledge base and confidence of navigator service users facing complex financial decisions.

No particular *unintended* outcomes of the trials were identified by FIS Officer trial representatives, or navigator service users.

4.7 Findings: Cost-effectiveness

4.7.1 How cost-effective is each trial?

A rudimentary evaluation of cost-effectiveness/costings for the FIS Officer trials is presented below. The evaluation is based on the following available data: high-level financial inputs into the trials and trial outputs – as recorded in the DHS data set, and financial summary information reported by DHS following the trials' closure.

As such, it is important to acknowledge the following primary limitation when considering FIS Officer trial costing information:

- Based on available information, unit costings could only be estimated using direct navigator service user interactions with FIS Officers, and so the costs associated with all other service delivery outputs – such as seminar delivery and promotional and outreach activities – have been rolled up into these costing calculations.

It is also important to note that GST is not applicable to the overall funding allocation for the FIS Officer trials, or any other costs presented in this section of the report.

Finally, findings in relation to FIS Officer trial cost-effectiveness/costings should not be used to draw any conclusions about the broader service they sit in, given the differences in trial service offerings versus FIS BAU (e.g. the trials' exclusive focus on aged care (thereby narrowing the target population), their focus on promotional activities and outreach, longer interview duration, increased reporting obligations of FIS Officers etc.).

How have Commonwealth funds been used to deliver the trials?

Table 4-12 and 4-13 shows the *planned* distribution of funding for each component of the FIS Officer trials, overall, and split by financial years (2018-2019 and 2019-2020). The total Commonwealth funding to deliver the FIS Officer trials was \$1.5 million (Table 4-12 and 4-13).

Table 4-12: Planned distribution of funding for the FIS Officer trials: service delivery

Trial component	Financial year 1 (2018-19)	Financial year 2 (2019-20)	Total
FIS Officer salaries and training costs	\$520,799	\$165,816	\$686,615
Trial administration costs	\$34,851	\$11,617	\$46,468
Trial communication costs	\$285,000	\$0	\$285,000
Total	\$840,650	\$177,433	\$1,018,083

Note: GST is not applicable to the costs presented in the table.

Table 4-13: Planned distribution of funding for the FIS Officer trials: project administration

Trial component	Financial year 1 (2018-2019)	Financial year 2 (2019-2020)	Total
Project administration and overhead costs	\$380,520	\$99,269	\$479,789
Total	\$1,221,170	\$276,702	\$1,497,872

4. Findings: FIS Officer trials

The FIS Officer trials were planned to run between October 2018 and September 2019, and this was reflected in the allocation of funding across the 2 financial years the trials spanned, that is, roughly 75% of funding was allocated to the first financial year, and 25% to the second (Table 4-12 and 4-13). The exception to this was the funding to support trial communications (see Table 4-12). These costs were 'front-loaded' into the first financial year, in order to support timely promotional activities and drive navigator service user uptake, while the trials were in full operation.

Although the planned allocation of funding for project administration was \$479,789 (Table 4-12 4-13), the actual figure (reported in project closure documents) was a little higher at \$502,085. Reflecting this adjustment, the actual allocation for service delivery was a little lower: \$995,915 versus \$1,018,083 (planned) (Table 4-12).

It is important to note that as service delivery was conducted in a *trial environment*, FIS Officers were required to undertake a range of additional trial-related activities, which they would not otherwise have undertaken during service delivery. As such, the actual service delivery funding of \$995,915 was further broken down into 2 cost allocations for FIS Officers:

- Trial administration duties (25.6% of activities): \$254,954.
- Direct service delivery activities (74.4% of activities): \$740,961.

Direct service delivery activities included all FIS Officers' interview preparation and conduct, seminar delivery, promotional work and community outreach. Therefore, the associated funding allocation of \$740,961 represents the most *meaningful cost* for delivering these activities outside the confines of a trial environment.

What was the cost (actual and in-kind) of delivering each trial/trial activity?

A unit cost of a FIS Officer trial interaction (interview) was loosely estimated by dividing the total – and subtotal – trial funding amounts by the number of interactions reported in the DHS data set (n=799; see Section 4.6.1). The same approach was used to estimate a rough cost per navigator service user accessing the trials (n=730; see Section 4.6.1). However, in line with the limitations set out above, it is *imperative* to note that because unit costings were not available for the non-interaction activities conducted by FIS Officers (such as seminar delivery [n=41] and outreach [n=215] etc.), these cannot be factored separately in costing calculations. This means that the calculated costings for interactions and navigator service users will be *artificially inflated*.

Table 4-14 shows the estimated unit cost of an interaction, as well as the estimated cost per navigator service user accessing the FIS Officer trials, based on *direct service delivery funding* (\$740,961). The unit costs were calculated to be \$927 for a FIS Officer trial interaction, and \$1,015 for a navigator service user (Table 4-14).

Table 4-14: Calculated unit costs of FIS Officer trial interactions and costs per navigator service user, based on direct service delivery funding

Unit	Cost
Interaction	\$927
Navigator service user	\$1,015

Note: costing data for non-interaction trial outputs were not available to inform the costings calculations, and therefore, the costs shown will have been artificially inflated. GST is not applicable to the costs presented in the table.

It is important to acknowledge that the costs shown in Table 4-14 will have been directly impacted by the observed lag in the number of navigator service users presenting at the FIS Officer trials during the trials' early establishment (see Section 4.6.1). Indeed, as shown in Figure 4-3, following a slow start, navigator service user numbers increased substantially in March 2019 and remained consistently high

over the remaining months to when navigator service user interactions concluded (30 September 2019).

Given this, it is not unreasonable to assume that the level of FIS Officer trial uptake observed from March 2019 – that is, once trials had become established in their respective regions – is a more accurate reflection of *true* trial uptake. Taking this into account, adjusted unit costs based on the number of interactions (n=698) and navigator service users (n=638) presenting between March and September 2019 are shown in Table 4-15.

Table 4-15: Adjusted unit costs of FIS Officer trial interactions and costs per navigator service user, based on direct service delivery funding, using March to September 2019 data

Unit	Adjusted cost
Interaction	\$619
Navigator service user	\$677

Note: Costing data for non-interaction trial outputs were not available to inform the costings calculations, and therefore, the costs shown will have been artificially inflated; adjusted costs are based on number of interactions (n=698) and navigator service users (n=638) presenting at the trials between March and September 2019, and an expected direct service delivery funding allocation representing 6 months (\$432,227) of the 12-month allocation (\$740,961). GST is not applicable to the costs presented in the table. Information about in-kind costs related to the FIS Officer trials was not reported in the DHS data set.

Were some trials and trial activities cheaper/more expensive to deliver than expected? If so, why?

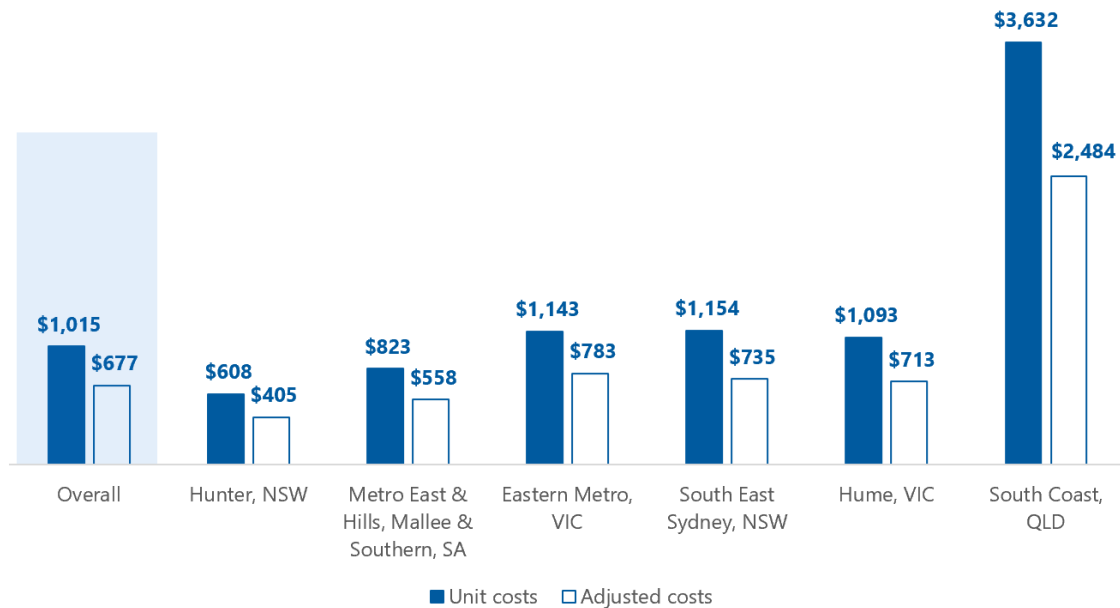
On the face of it, the overall estimated costs – including adjusted costs – of delivering the FIS Officer trials appear to be high (see Table 4-14 and Table 4-15). However, as highlighted in the sections above, because the costs of delivering non-interaction trial activities have been bundled up into total costs, this, at least in part, explains the relatively higher figures (Table 4-14 and Table 4-15).

As shown in Figure 4-5, there was some variation in the number of navigator service users presenting at the 6 FIS Officer trials, which directly impacted unit costs for service delivery at a *trial level*. Figure 4-5 shows the calculated unit costs per navigator service user at each of the 6 FIS Officer trials (where information was known [n=715/730 records]).

Given 5 of the 6 FIS Officer trials reported *broadly similar* numbers of navigator service users, their unit costs – including adjusted costs – were largely in line with the overall calculated costs (see Table 4-14, Table 4-15, and Figure 4-5). As discussed in Section 4.6.1, the exception was the South Coast, Qld trial – which, partly due to the relative high wealth of the local population – conducted substantially fewer interactions with navigator service users overall – meaning this trials' unit costs were much higher compared to the other trials, and, importantly, would have caused the overall costs to *inflate* (see Figure 4-5).

4. Findings: FIS Officer trials

Figure 4-5: Calculated unit costs of FIS Officer trial interactions overall, and by FIS Officer trial, based on direct service delivery funding (including adjusted costs)



Note: costing data for non-interaction trial outputs were not available to inform the costings calculations and, therefore, the costs shown will have been artificially inflated. Costs shown in light green/blue are based on overall navigator service user numbers/overall trial funding; costs shown in dark green/blue have been adjusted in line with the number of navigator service users presenting at the trials between March and September 2019, and an expected direct service delivery funding allocation representing 6 months (\$432,227) of the 12-month allocation (\$740,961). Trial site location not available for n=15 interactions. GST is not applicable to the costs presented in the figure.

Which trials/combination of trial activities represented the best value for money?

Unlike the COTA Australia-led trials, the service offerings of the overall FIS Officer trial program were common to the 6 trials, although the number of trial activities delivered differed (e.g. interactions, as reported in the DHS data set [see Table 4-9]), or were likely to have differed (e.g. seminar delivery, promotional work and outreach [not reported]), across the FIS Officer trials. As such, an evaluation of *best value for money* for the FIS Officer trials or their activities delivered was not possible.

What can be concluded from the available data, however, is that navigator service users reported a better understanding of, and confidence in, accessing and navigating aged care services, following an interaction with a FIS Officer – arguably the key trial output underpinned by Commonwealth funding. Importantly, these improvements in understanding and confidence were sustained over time (e.g. ‘Survey 3’ responses, reported at 2-3 months post-interaction), and were mirrored across the 6 FIS Officer trials (see Table 4-11), indicating all 6 trials delivered *value for money* in the context of navigator service user satisfaction.

4.8 Findings: Opportunities to enhance the trials

Opportunities to enhance the FIS Officer trials have been described in detail throughout this chapter and are summarised below:

- Increased promotion of the FIS Officer trials – and the FIS more broadly – to the general population, in order to improve future navigator service user awareness and increase uptake of navigator services. The importance of engaging with consumers *early* in their aged care journey was noted.
- Alignment of implementation timeframes and physical geographical locations would have facilitated integration between the FIS Officer trials and the other trials under the ACSN Measure.
- The FIS Officer trials were intended to deliver one-off in-person sessions of support; however, a proportion of navigator service users required additional follow-up and these individuals may have benefited from a more standardised approach for making repeat bookings.
- A focus on building relationships with organisations working with specific populations, to improve engagement with vulnerable populations and reduce service gaps in these populations – while noting the time required to build trust.
- The constructive working relationship which developed between DHS and the Department has set a good foundation for future potential collaborations in the area of aged care navigation.

5 Opportunities for the future of aged care navigation

5.1 Key messages

A number of system navigation models have been developed in aged care and other sectors in Australia and overseas. However, there are a number of factors that make it difficult to evaluate the relevance of these models to the Australian aged care setting. For example, there is:

- Great diversity among existing system navigation models
- No agreed definition of 'a system navigator', or clarity regarding the boundaries between system navigation and other types of support and service provision
- Little evidence of the impacts of system navigator services that is directly relevant to the aged care setting.

Despite this, through evaluation activities AHA has identified some key strengths and weaknesses (both theoretical and experiential) of the various existing models.

Overall, stakeholders favoured professional navigation models, noting that peer models could be used alongside a professional navigator model to perform complementary functions or provide lower-level support to consumers.

Face-to-face service delivery was considered vital in order to meet the needs and preferences of older people generally. Outreach was also considered essential to address the aged care sector's current lack of engagement with vulnerable population groups. Online support was deemed least appropriate, although stakeholders noted that this may change for future generations of aged care consumers.

Financial navigation was considered an important offering, though stakeholders noted that the skill set required to provide this service may be considerably different to that required for aged care system navigation more broadly.

Stakeholders strongly supported a model built on robust, strategic design principles, and identified recruitment, training and support of a quality workforce as the most important of these.

The majority of stakeholders felt that services needed to be flexible and holistic in order to meet the needs of a diverse population. A model that uses multiple modes of service delivery was reported to be most relevant to the Australian aged care setting.

Good models of aged care navigation already operate across Australia, and stakeholders are keen to avoid duplication/repetition of effort in progressing a nationally consistent model of aged care navigation.

5.2 Introduction

This chapter presents findings about various models of system navigation including their components, design principles, strengths and weaknesses, and implementation challenges. It incorporates information from:

- The research/environmental scan
- Discussion paper responses
- Stakeholder consultations
- Trial data.

The Australian Government's funding commitment of \$10 million to support CALD system navigator services is also noted (Australian Government Department of Health 2020).

5.3 Models of system navigation

What aged care or other system navigator models exist in Australia and internationally?

- How have they been designed and implemented?
- How are they funded?
- How are 'successful' outcomes of the models assessed?
- What are the similarities and differences compared to the ACSN Measure?

For the service sector models identified:

- What lessons can be learned?
- What barriers/enablers affect outcomes?

A number of system navigator models (in aged care and other relevant sectors) were identified through the environmental scan and consultations with external stakeholders. The key types of system navigation models identified (commonly developed in sectors other than aged care) are summarised in Table 5-1.

In addition to the trials being undertaken through the ACSN Measure, a number of navigation models specific to aged care were identified (both in Australia and overseas). These, in effect, provide services similar to one or more of the models described in Table 5-1 and are implemented by various organisational bodies – most notably, local governments, PHNs and aged care service providers.

Further detail about the design and implementation of a number of aged care system navigator models is included in the discussion paper (Report Attachment A to this Final Report) and in Appendix E. These sources highlight, where possible, how the models have been designed and implemented, how they are funded, and how 'successful' outcomes have been assessed. However, the diversity and overlap of the models described in Table 5-1, the lack of an agreed definition of system navigators (and the boundaries with other types of support and service provision), and lack of research related to aged care system navigation, make evaluation of the models difficult.

Specific elements of system navigator models – including principles, components, strengths and weaknesses, relevance to the Australian aged care context and implementation considerations – are discussed in the following sections.

One defining element of system navigator models is the professional qualifications and experience of the navigator. Broadly, navigator services can be provided by a:

- Professional (e.g. nurse, allied health care worker, other professional with relevant qualifications)
- Lay person (e.g. paid worker or volunteer without directly relevant professional experience)
- Peer navigator (someone with lived experience relevant to the setting or target population group).

Table 5-1: Identified models of system navigation

Model & element	
Patient navigators	
Target population	Vulnerable populations/people experiencing barriers to health care
Aims	To ensure continuity of care, including prevention, detection, diagnosis, treatment, and survivorship to the end of life
Delivered by	Professionals (e.g. nurses) and lay navigators (depending on type of navigator activity)
Service intensity	Flexible level of service intensity and duration, depending on patient needs
Modes of delivery	Ongoing, one-on-one, face-to-face service delivery, including outreach
Nurse/professional navigators	
Target population	People with complex physical health conditions, vulnerable populations, and/or people with complex needs
Aims	To assist patients to move more easily through the health care system, including between hospital and community settings
Delivered by	Professionals only (e.g. nurses, allied health)
Service intensity	Flexible level of service intensity and duration, depending on patient needs
Modes of delivery	Ongoing, one-on-one, face-to-face service delivery, including outreach
Family navigators	
Target population	Youth/families with developmental/mental health difficulties
Aims	To assist youth/families to navigate the complex youth mental health and addictions system
Delivered by	Professionals (e.g. psychologists, allied health)
Service intensity	Flexible level of service intensity and duration, depending on patient needs
Modes of delivery	Telephone screening/assessment; ongoing, one-on-one and face-to-face service delivery, including outreach
Peer navigators	
Target population	Specific population groups (including but not limited to carers, people with a disability/chronic physical health condition, people from CALD backgrounds)
Aims	To assist people to access information, education, and training and/or to connect with different types of systems of care or services
Delivered by	Navigators with lived experience (paid worker or volunteer)
Service intensity	One-off or ongoing
Modes of delivery	One-on-one telephone; individual or group face-to-face (including outreach in some cases); hubs (community/online); or a combination of these

Model & element**Village and hub models**

Target population	General community
Aims	To improve social engagement/connectedness and provide services/supports
Delivered by	Lay/peer navigators (paid or unpaid)
Service intensity	One-off or ongoing group interactions
Modes of delivery	Community hubs (physical/online)

Financial navigators

Target population	Vulnerable populations and people requiring support to make a financial decision
Aims	To assist people to understand their financial options and the potential impact of financial decisions
Delivered by	Range of qualifications; unclear from the literature
Service intensity	One-off or ongoing interactions
Modes of delivery	One-on-one, telephone or face-to-face service delivery (including some outreach), or a combination of these

5.3.1 Strengths and weaknesses of navigator models

Despite the variation in as well as overlap between navigator models (as outlined in the discussion paper and listed above), stakeholders noted a number of strengths and weaknesses associated with each model. These are summarised in Table 5-2 and discussed below. It should be noted that many of the strengths and weaknesses described here reflect stakeholders' views of the applicability of the models to the Australian aged care context rather than in their original settings. Where relevant, concordance between external stakeholder views' and the literature is noted.

Table 5-2: Key strengths and weaknesses of system navigator models

Model	Strengths	Weaknesses
Patient navigator	<ul style="list-style-type: none"> • Uses professional and lay navigators supported by quality training (the question of who should provide navigation is decided by the level of skills required at a given phase of a patient's disease trajectory or care journey) • Delivered face-to-face • Supports flexible, person-centred, holistic care • Improves patients' health literacy, engagement and self-management • Promotes linkages between relevant service providers • Draws on navigators' knowledge of/ integration with other services/sectors • Includes outreach • Targets vulnerable populations 	<ul style="list-style-type: none"> • Focus is clinical, disease-specific • Lay navigators may lack necessary skills/ knowledge/experience • There is a lack of evidence regarding outcomes (e.g. regarding cost-effectiveness) • Model is relatively resource-intensive

Model	Strengths	Weaknesses
Nurse/ professional navigator	<ul style="list-style-type: none"> Utilises the knowledge/expertise/skill/ dedication of professional navigators (e.g. nurses, social workers, allied health workers) Delivered face-to-face Supports flexible, person-centred, holistic care Improves service users' health literacy, engagement and self-management Draws on navigators' knowledge of/ integration with other services/sectors Includes outreach Targets vulnerable populations 	<ul style="list-style-type: none"> Clinical, disease-specific focus may overlook importance of 'soft skills' of navigators Navigators may lack capacity to provide navigator services due to other responsibilities (e.g. clinical practice) There is a potential lack of cultural awareness/safety/acceptability compared with peer models Delays may occur in consumers being linked to a navigator due to consumer demand There is a lack of evidence regarding outcomes (e.g. cost-effectiveness) Model is relatively resource-intensive
Family navigator	<ul style="list-style-type: none"> Focuses on holistic care, service matching Considers importance of carers and families and their needs (in addition to consumers' needs) Provides a central, known contact for family Delivered face-to-face Includes outreach Focuses on building relationships with the service provider Uses a multidisciplinary approach May be particularly useful for service users experiencing cognitive decline, dementia or mental illness 	<ul style="list-style-type: none"> Assumes consumer has family and wants them involved in decision-making regarding care There may be conflict between consumer and family preferences and priorities Potential for elder abuse issues to impact care decisions (in aged care context) There is a lack of evidence regarding outcomes (e.g. cost-effectiveness) Model is relatively resource-intensive
Peer navigator	<ul style="list-style-type: none"> Focuses on empowerment Uses shared language, experiences, cultural identity, etc., which engenders trust, engagement, rapport and empathy May reach service users unlikely to seek out a professional service Can provide personal/emotional support May cost less (compared with professional navigator models) Promotes flexibility – can involve outreach Targets vulnerable populations 	<ul style="list-style-type: none"> May be an unclear scope of practice across models Risk of inaccurate information being provided Inconsistent or lack of skills/experience/ objectivity Requires professional support/supervision Volunteers may be hard to source and retain Requires ongoing navigator training and support There is a lack of evidence regarding outcomes (e.g. cost-effectiveness)

Model	Strengths	Weaknesses
Village and hub	<ul style="list-style-type: none"> • Visible community presence, can be co-located with relevant services/organisations • Flexibility of service provision (e.g. from seminars to one-to-one support) • Supports community capacity-building • Facilitates integration into other community supports • Has the ability to reach large numbers of people • Attracts word-of-mouth promotion • Places few restrictions on eligibility for assistance 	<ul style="list-style-type: none"> • May not meet the needs of people in complex situations • Relies on volunteers (issues with ongoing training, turnover etc.) • Lacks specialist navigation support (depending on model) • Requires physical access/transport • May best support individuals who are already well connected • Supports information provision rather than navigation • Difficult to evaluate effect • Membership fees may be required, presenting a financial barrier for some people from vulnerable populations • There is a lack of evidence regarding outcomes (e.g. cost-effectiveness)
Financial navigator	<ul style="list-style-type: none"> • Removes financial uncertainty as a barrier to accessing aged care • May help avoid/identify/address financial elder abuse 	<ul style="list-style-type: none"> • Requires a different skill set to other system navigation models • There may be compliance/quality control concerns (e.g. for private providers) • Fee-for-service models may not be affordable for some • There is a potential lack of actual or perceived independence

Patient navigator

The advantages of patient navigator models were reported to be the use of both professional and peer navigators, supported by standardised training and clear scopes of practice. This approach allows the strengths of both navigator types to be utilised, and potentially mitigates some of the weaknesses of each. These issues are further discussed in later sections of this report. The perceived relevance of a hybrid model is discussed in Section 5.4.1.

The patient navigator model is designed to improve service users' health literacy, engagement with health care and self-management capabilities. Some stakeholders noted that this approach has parallels with current concepts in aged care, particularly wellness and reablement approaches.

However, evidence regarding patient navigator models derives from the cancer care literature in the United States. While it has since expanded into other areas of chronic disease, and into other countries, it has not been specifically applied in the aged care context. Stakeholders reported that the disease-specific, clinical focus of the patient navigator model may limit its relevance to the aged care setting. A lack of independence of navigator services from service providers was also noted.

The existence of an evidence base to support implementation of the patient navigator model was identified as a strength, particularly in health care settings. On the other hand, the lack of data regarding patient outcomes and experiences, and the cost-effectiveness of the model, was seen as a weakness.

Nurse/professional navigator

Stakeholders reported that the key strength of the professional navigator models was the knowledge, skill and professional supports provided by nurses and other professional navigators (such as allied health professionals). This included their knowledge of and integration with other services and sectors (e.g. through established referral pathways).

Such a model allows an experienced, independent allied health professional to work one-on-one and walk alongside a consumer to support them to understand how and where their needs can be met.

– *Independent aged care consultancy representative*

Professional navigators have the knowledge, values, expertise and ability to connect vulnerable and isolated people to suitable services.

– *Government representative*

As with patient navigator models, however, the literature examining the implementation, appropriateness and effectiveness of nurse/professional navigation models is primarily chronic disease-specific. Stakeholders suggested nurse-led services in particular were likely to have a clinical bias that was less relevant to the aged care setting. They argued that multidisciplinary services may allow for greater flexibility in identifying and providing relevant supports for individual consumers. It was noted that an aged care nurse navigator might be appropriate in rural communities to perform a broader role.

An aged care nurse navigator model in rural communities would be very beneficial. They are a resource for their community not only for clients but for carers and families and other health professionals in the community. They can advocate not only for the individual but for aged care across the community.

– *Government representative*

Professionals' potential lack of capacity to fulfil a navigator role (e.g. due to clinical or other competing responsibilities) was noted as a weakness of these models, which was consistent with the literature. Stakeholders also noted that the nurse navigator role may be limited in its capacity to provide holistic, community-based services.

Family navigator

Although the family navigator model emerged in the literature in the context of youth mental health services, its relevance to the aged care setting was noted by many stakeholders.

Discussion of family navigator models generally raised similar themes to those relating to the professional navigator model, with the added benefits and risks of involving family members in the process. In particular, stakeholders noted the specific value of a family navigation model in supporting consumers experiencing cognitive decline, dementia or mental illness, and as a way of upskilling and empowering families to navigate the aged care system.

Carers and family members are critically important and should be considered in-scope for any future navigator models. They need access to timely, accurate and responsive support so they can ultimately take over the navigator role and relieve pressure on the system.

– Aged care service provider

Lay/peer navigator

Although professional navigators were felt to be most valuable in the Australian aged care context, it was frequently noted by stakeholders that they could be supported by lay or peer navigators, for example to provide:

- Advice on less complex issues
- Support to less vulnerable people
- Basic information and complementary (e.g. social) support.

‘Peer navigators can augment, not replace, professional and family navigators.’

– Government representative

A peer workforce could also be engaged to promote the availability of a professional navigator service (e.g. through community networks and hubs) and support consumers in interpreting information through shared language or culture. Gatekeeper models (described as organised outreach efforts designed to build the capacity of community members to recognise and reach at-risk older people who may require assistance but have little social contact) were seen as beneficial in this context.

The Gatekeeper Program is a fantastic model as it connects with multiple touchpoints in the community to support those in need or at risk.

– Aged care service provider

Peer navigator models were noted to be particularly important for CALD communities and people who may be distrustful of professionals and service systems (including Aboriginal or Torres Strait Islander people, Forgotten Australians, and people who are LGBTI).

Some volunteers are community and peer leaders who are trusted members of the community ... this means that people in need are often identified from “within” the community by the leaders.

– *Partner organisation representative*

In a CALD context, peer navigators could be useful but more as ‘spotters’ than navigators. Community leaders could be selected for training in basic aged care information, identifying possible clients and referring them to the nearest [navigator].

– *Aged care service provider*

An important consideration is whether a lay/peer navigation model is staffed by paid workers, peer volunteers (who may be relatively unskilled/inexperienced) or professional/experienced volunteers (e.g. those with relevant background qualifications and/or experience).

Difficulties around recruiting, training and retaining volunteers, and maintaining professional boundaries and scope of practice, were consistently raised by stakeholders as key issues with this model.

Peer roles and volunteers may not necessarily ensure best outcomes for clients, and may put them in a disadvantaged position, due to lack of or limited knowledge of the service system.

– *Government representative*

Positive CALD Ageing Network (PCAN) representatives (comprising external stakeholders and partner organisation representatives) advised that peer/volunteer-only models that service culturally diverse populations carry the following risks:

- **Peers/volunteers may themselves be vulnerable.** Representatives argued that CALD volunteers/peers may have a history of trauma, arising from their lived experiences. They felt that peers/volunteers should be supported by paid professionals in order to minimise the burden or ‘emotional load’ for volunteers
- **Reliance on volunteers may devalue the CALD workforce.** Representatives suggested that peer/volunteer-only models potentially devalue the professional CALD workforce and perpetuate acceptance that this work should be unpaid.

Providing bilingual workers is our in-kind contribution. But it would be great if that could actually be recognised and acknowledged and funded.

– *Partner organisation representative*

This type of pro bono work is a big contribution and it needs to be acknowledged. We and the other organisations have been advocating for the government to recognise this.

– *Partner organisation representative*

Village and hub models

As with peer navigators, village and hub models of system navigation support were seen by many stakeholders as important additions to professional navigator support. Views on the strengths and

weaknesses of such approaches varied depending on stakeholders' views of what these models involved. Given the significant variation in operation, it is difficult to summarise perceived strengths and weaknesses.

A key consideration, highlighted in the discussion of peer/lay navigator models above, is whether a hub is staffed by paid workers, peer volunteers or professional/experienced volunteers.

A benefit of village models highlighted was the social connection and engagement they could support, rather than direct assistance navigating the aged care system. However, such engagement may indirectly promote consumer empowerment and therefore access to aged care.

Village and hub models appear most useful for those with low-level concerns, who are planning for future care and seeking information rather than services or are seeking simple (possibly episodic) services.

– Aged care service provider

A particular benefit of village and hub models was establishing a visible physical community presence to enable promotion/awareness-raising and community engagement. It was also reported that village and hub models could utilise professional *and* peer navigators as well as financial navigators (or links to such services).

Stakeholders noted that the grassroots nature of these models makes them a useful complement to professional navigator models. They may also be particularly relevant in rural or remote communities where complementary hub-style services/locations are already established.

Councils and community centres can be a neutral place for people to find information, access basic support and then be linked in to 'system navigation'.

– Aged care service provider

Some external stakeholders and discussion paper respondents noted that while village and hub models may be working best for those who are already linked in to either social or mainstream supports, they may not be sufficient to improve access for people who are vulnerable and do not have such connections.

Very few comments were made in responses to the discussion paper regarding virtual hubs. Much of the discussion regarding online navigator service delivery is relevant in this context (see Section 5.3.3, subsection Mode(s) of delivery below), suggesting that virtual hubs alone would not be a useful strategy for consumer engagement, particularly in the short term.

Virtual hubs have their place in the service system, but they are unsuitable to be the sole provider of information, and may not 'work' for special needs groups.

– Peak body representative

Financial navigators

Independent aged care financial navigation was generally supported by stakeholders, but it was noted that it likely requires a separate skill set to other navigation types. Assistance in accessing both

community-based and residential aged care was considered to be important, due to the complexities relating to both eligibility (e.g. pensions, income and asset-testing) and costs (e.g. bonds and contracts). It may also help to remove cost as a barrier to accessing aged care for potential consumers. Financial navigation services may also help to avoid, identify and/or address issues of elder abuse relating to finances.

A budget plan, drafted in conjunction with the identified supports in ACAT's assessment, assists an individual to understand clearly the cost and breaks down barriers to accessing and accepting a home care package.

– Hospital representative

However, external stakeholders and partner organisation representatives reported that private financial navigators may charge fees for their services that may not be affordable for many Australians, and may further compound financial barriers for those individuals. Others reported that the 'marketisation' of the aged care system may mean that consumers are not being provided impartial advice, and may further complicate financial decision making for people.

In the era of consumer choice and control, some service providers 'snatch and grab'. So older people are receiving biased advice.

– Partner organisation representative

Small brokerage consultancies have sprung up to fill the navigation need – these businesses are connected with a handful of providers and therefore not providing impartial advice.

– Partner organisation representative

Further information about the financial navigation provided through the FIS Officer trials is presented in Chapter 4.

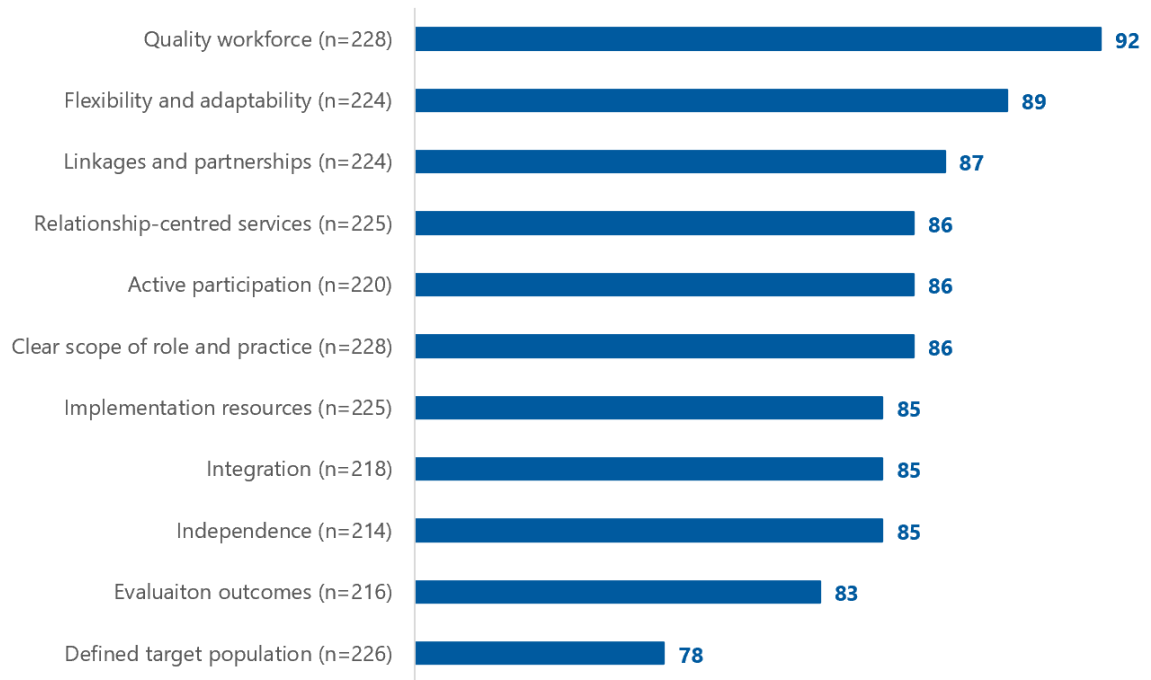
5.3.2 Design principles

The discussion paper identified 11 key design principles derived from the environmental scan and stakeholder consultations – these are outlined in Figure 5-1. Broadly speaking, all these principles were identified by stakeholders as being important in an aged care navigation model, with overall mean ratings of importance ranging from 78 to 92 (out of a maximum rating of 100).

Respondents highlighted the significant conceptual overlap between a number of design principles. For example, comments related to 'relationship-centred services' often included reference to 'flexibility and adaptability'. Similarly, comments regarding 'linkages and partnerships' often referred to 'integration'.

Across all discussion paper responses, the 3 design principles rated the highest were *quality workforce* (mean rating of 92/100), *flexibility and adaptability* (89/100) and *linkages and partnerships* (87/100). *Defined target population* was rated the lowest (78/100). However, it is important to note that there was some variability in the ratings of the design principles across different stakeholder groups that responded to the discussion paper. The mean ratings for each of the 11 design principles are shown in Table 5-3 by stakeholder group.

Figure 5-1: Rated importance of design principles for aged care navigator services



Note: a higher rating (out of a maximum of 100) denotes higher importance. Ratings have been rounded to the nearest whole number.

Table 5-3: Rated importance of suggested design principles for aged care system navigator services, categorised by stakeholder group

Respondent type	Quality workforce	Flexibility and adaptability	Linkages and partnerships	Relationship-centred services	Active participation	Clear scope of role and practice	Implementation resources	Integration	Independence	Evaluation outcomes	Defined target population
Government department/ agency	86 (n=19)	82 (n=20)	85 (n=20)	82 (n=20)	76 (n=19)	78 (n=20)	86 (n=19)	78 (n=19)	71 (n=18)	78 (n=19)	68 (n=20)
Aged care assessment workforce/ provider	95 (n=23)	86 (n=23)	88 (n=21)	91 (n=21)	79 (n=21)	92 (n=22)	87 (n=22)	89 (n=21)	83 (n=20)	85 (n=21)	83 (n=22)
Aged care service provider	93 (n=119)	90 (n=116)	86 (n=116)	86 (n=118)	87 (n=116)	85 (n=120)	83 (n=117)	83 (n=112)	80 (n=112)	82 (n=110)	77 (n=118)
Peak body	94 (n=21)	90 (n=20)	89 (n=21)	86 (n=21)	89 (n=20)	88 (n=21)	91 (n=21)	90 (n=20)	91 (n=19)	88 (n=20)	81 (n=20)
Other*	92 (n=44)	88 (n=42)	90 (n=44)	87 (n=43)	89 (n=42)	89 (n=44)	84 (n=43)	90 (n=44)	86 (n=43)	84 (n=44)	81 (n=44)

Note: The 3 highest mean ratings reported by each stakeholder group are shown with bold text and highlighted in blue, with the highest rating/s shown in dark blue, and the second and third highest ratings shown in increasingly lighter shades. The lowest ratings reported by each stakeholder group are shown with regular text highlighted in light grey.

*Respondents in the 'other' category included representatives of PHNs, local governments, community centres, hospital and health services, navigator services, aged care advocacy services, disability service providers and academic institutions/research bodies. For more information, see Appendix E.

Though the magnitude of ratings given to the design principles were generally similar across 4 of the 5 stakeholder groups that responded to the discussion paper, ratings from the government department/agency group tended to be somewhat lower.

That said, all 5 stakeholder groups gave their highest rating/s of importance to the design principle of *quality workforce*, with government representatives also rating *implementation resources* equally high. At the other end of the importance ratings, 4 of the 5 stakeholder groups gave their lowest rating to *defined target population*, while the fifth group – aged care assessment workforce/providers – gave their lowest rating to active participation.

Across all stakeholder groups, 9 of the 11 design principles were rated in the top 3 most important. Given this very broad spread, an arbitrary scoring system was applied in order to estimate the *relative* importance of these principles; that is, their importance in relation to each other. Each of the 11 design principles received a score based on the number of stakeholder groups that rated them as one of their top 3 most important principles:

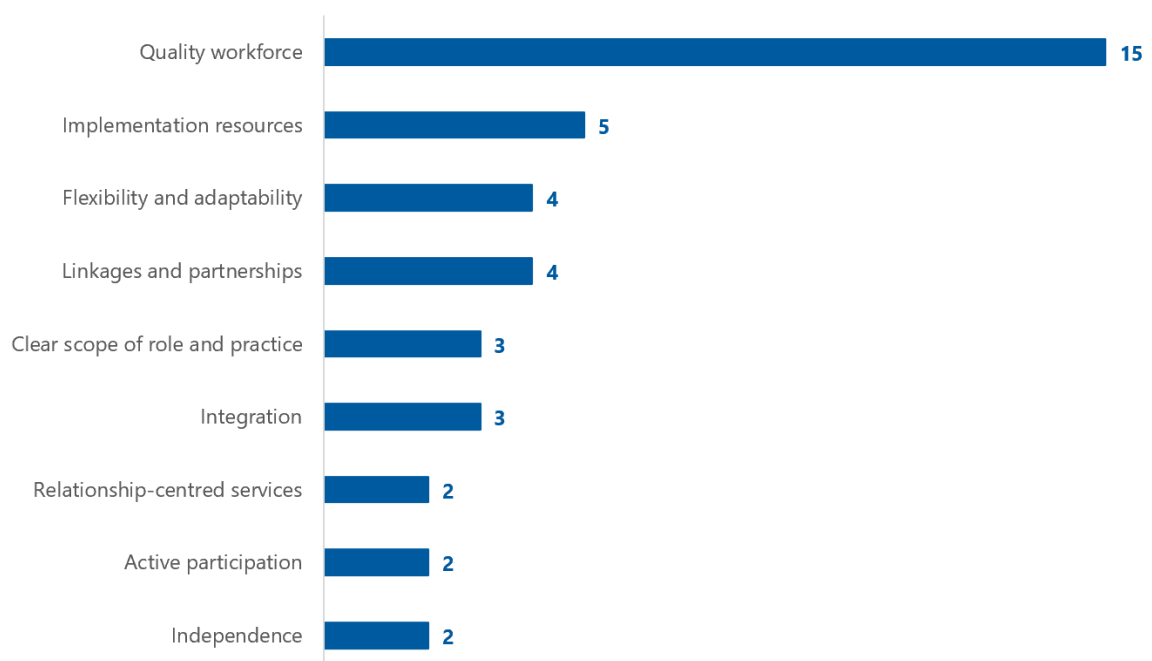
- Highest rating: 3 points (applied per instance of design principle ever having this rating from a stakeholder group)
- Second highest rating: 2 points
- Third highest rating: 1 point.

It is important to note that scores were applied based on relative ratings of importance (as set out in Table 5-3), and do not take into account the magnitude of ratings.

Based on this scoring system, the relative importance of the 9 design principles (that were rated among the 3 most important by one or more stakeholder group) was estimated (Figure 5-2).

As all 5 stakeholder groups gave their highest rating/s of importance to *quality workforce*, this design principle scored highest – by far – at 15 (see box on p. 187). The remaining 8 design principles were clustered between relative importance scores of 5 and 2. However, it is important to reiterate that the overall ratings indicate that stakeholders considered all 11 design principles to be important.

Figure 5-2: Relative importance of the highest rated design principles for aged care system navigator services



Quality workforce

Discussion paper respondents and external stakeholders reported that the aged care system navigator workforce should be suitably skilled and have relevant aged care expertise in order to provide the defined scope of services, and be adaptable to meet service user and community needs.

Staff must have in-depth knowledge of both the aged care sector and potential barriers experienced by those with diverse backgrounds, and how to best support them in a flexible and responsive manner.

– *Aged care service provider*

The use of 'aged care experts' as navigators – as distinct from health or social work experts – is essential. The aged care system in Australia is constantly changing and will continue to do so to accommodate increasing demand. It is essential that navigators are abreast of these changes and the detail of services available.

– *Aged care advocacy service*

Key attributes of navigators include having a clear knowledge of local services and service types (both formal and informal) as well as understanding of the needs of older individuals, their families and the community. Workforce diversity (e.g. to support diverse vulnerable populations) and recruiting navigators with relevant 'soft' skills (e.g. listening skills, problem-solving skills) were also deemed important. For Aboriginal Torres Strait Islander and CALD communities, bilingual navigators may be particularly helpful.

Training was reported to be an essential element of a *quality workforce*. The required components of such training were not often articulated, with many stakeholders referring to 'adequate', 'appropriate', 'suitable', 'quality', 'standardised' or 'accredited' training. Specific training elements that were mentioned include:

- Local aged care and other relevant services
- Person-centred care
- Dementia care
- Cultural competence
- Working with people from vulnerable groups
- Trauma-informed counselling and support
- Ongoing training and professional development

It is noted that at least one formal qualification for service navigation exists, designed for health and human services workers, although the course has been suspended for 2021 intake (The University of Melbourne 2020).

Discussion paper responses tended to assume 'workforce' referred to recruitment, training and ongoing development of professional navigators, with some noting concerns regarding the use of peer/lay volunteers (discussed in other sections of this report). However, the importance of appropriate and ongoing training of lay or peer volunteer (as well as professional) navigators, as well as mentoring and supervision requirements, were consistently raised.

Other workforce issues raised included staff support – for example, professional networks, career progression opportunities and 'a pay scale that says "professional"'.

A number of additional design principles were suggested by stakeholders and are summarised (in no particular order) below.

Accessibility: Navigators should provide support in a range of accessible modes including face-to-face, online and over the phone. Accessibility also considers financial barriers (e.g. provision of free or low-cost services) and language/communication barriers (e.g. plain English and well-translated resources; use of interpreters). A 'no wrong door' approach can support equity of access for diverse populations and particularly for vulnerable individuals. Increasing community awareness (e.g. through marketing activities) may also contribute to accessibility.

Inclusive design: Service design should be informed by respect for diversity, cultural competency and user and community co-design.

Innovation: Navigator services should consider innovative ways of delivering services to maximise their reach, especially to marginalised or disadvantaged people.

Responsiveness: Navigator services should minimise time between identification of need and delivery of services.

Sustainability: Financial investment in a sustainable workforce is required to support commitment to the local community.

Simplicity: Navigator models should not be complicated or add further red tape/bureaucracy to the system.

5.3.3 Navigator model components

The discussion paper presented navigator model components in 3 key domains:

- Providers of system navigation services (e.g. professional vs peer/lay navigators)
- Elements of system navigator services
- Modes of delivery

Stakeholders were invited to share their views on the statements proposed (presented in boxes below). These views are summarised in this section.

Navigator service providers

Professional aged care system navigators should hold qualifications in aged care and/or relevant health, behavioural and/or social sciences.

Peer or lay navigators should have lived experience relevant to the target population of the model/service.

As highlighted in Table 5-4, all 5 stakeholder groups indicated a strong preference for navigator models staffed by experienced and trained professionals rather than peer or lay individuals. Examples include health, allied health, and behavioural or social science professionals with experience in aged care.

Table 5-4: Rated importance of provider type for aged care system navigator services, by stakeholder group (mean/100)

Respondent type	Professional role	Peer/lay role
Government department/agency	82 (n=18)	54 (n=17)
Aged care assessment workforce/provider	94 (n=20)	60 (n=20)
Aged care service provider	88 (n=115)	69 (n=107)
Peak body	88 (n=20)	71 (n=19)
Other*	87 (n=41)	72 (n=39)
Overall	88 (n=214)	67 (n=202)

Stakeholders reported that the use of peer/lay navigators – even when appropriately trained – often raised issues relating to service quality and appropriateness, workforce stability and navigator burn-out.

It is unclear if peer models would be effective, particularly in the absence of significant prior experience or knowledge of the service system.

– Aged care service provider

A lot of issues related to boundaries, confidentiality, training would need to be considered, which would be expensive with no guarantee of an appropriate navigator as an outcome.

– Aged care assessment provider

*Respondents in the 'other' category included representatives of PHNs, local governments, community centres, hospital and health services, navigator services, aged care advocacy services, disability service providers and academic institutions/research bodies. For more information, see Appendix E.

5. Opportunities for the future of aged care navigation

Despite this, stakeholders noted there was some additional value in peer support services working alongside (rather than instead of) a professional navigator service. This might include peer/lay navigators working one-to-one with service users and/or within village and hub models to facilitate group education and support groups. Peer models may be particularly relevant in remote areas and among Aboriginal or Torres Strait Islander or CALD groups where translation of language and/or consideration of cultural preferences may be required. Peer navigator models may also help to avoid unnecessary/unhelpful levels of formality and professionalisation.

Peer and lay navigators are cost-effective and able to reach large numbers of the community through face-to-face interactions, social activities and local word-of-mouth.

– PHN representative

Professionals and peer/lay navigators are equally important and should collaborate on a basis of partnership.

– PHN representative

Peers can be professionals: we could have older people delivering paid, qualified navigator services. A navigator must be well-trained, well-supervised and deliver quality-assured outcomes.

– Peak body representative

Some stakeholders noted that peer support could be provided separately to (but integrated with) professional system navigation models.

Navigator service elements

Overall, stakeholders rated *identification and assessment* as the most important element of an aged care system navigator service, with 3 of the 5 stakeholder groups giving this element their highest rating (Table 5-5). At the same time, the remaining navigator service elements were also rated relatively highly, indicating that all elements were considered important.

Table 5-5: Rated importance of various elements of aged care system navigator services, by stakeholder group (mean/100)

Respondent type	Identification and assessment	Care planning	Level of service intensity	Financial navigation
Government department/agency	82 (n=18)	79 (n=18)	71 (n=18)	72 (n=18)
Aged care assessment workforce/provider	95 (n=19)	90 (n=19)	81 (n=18)	82 (n=20)
Aged care service provider	88 (n=115)	84 (n=113)	79 (n=114)	74 (110)
Peak body	79 (n=21)	68 (n=21)	86 (n=20)	81 (n=21)
Other*	85 (n=29)	81 (n=41)	87 (n=38)	85 (n=35)
Overall	87 (n=212)	82 (n=212)	81 (n=208)	77 (n=204)

Note: The 3 highest mean ratings reported by each stakeholder group are shown with bold text and highlighted in blue, with the

*Respondents in the 'other' category included representatives of PHNs, local governments, community centres, hospital and health services, navigator services, aged care advocacy services, disability service providers and academic institutions/research bodies. For more information, see Appendix E.

Identification and assessment

Navigator services should have clear referral, intake and holistic assessment processes to identify service user needs and goals.

Identification and assessment – and particularly the current need for these functions at multiple levels throughout the aged care intake system – was raised as a key issue by stakeholders. As highlighted in Table 5-5, 3 of the 5 stakeholder groups rated this element as the most important element of an aged care system navigator service.

The integration of a navigator service with a streamlined assessment system (either through close linkages or expansion and resourcing of the assessment providers' role) was suggested as an ideal situation, enabling vulnerable service users to be identified at first contact and subsequently assisted through the system. This, however, does not assist potential service users reach the point of intake through My Aged Care.

Identifying prospective consumers of a navigator's service pre-My Aged Care requires working in partnership with community and health organisations to publicise how such a service can support individuals who may experience barriers in accessing aged care. Identifying prospective consumers of a navigator service post-My Aged Care can be done in collaboration with RAS and ACAT teams who can identify potential consumers at the point of assessment who have been given approval for various supports but need assistance to engage with the market, understand how they best fit (e.g. within the 2 community aged care systems) and ultimately make choices within the resources made available to them.

– *Independent aged care consultancy*

Care planning

Aged care system navigator services should have a clear and consistent approach to developing service user care plans, in consultation with individuals and families (where appropriate).

While 3 of the 5 stakeholder groups rated care planning as the second most important element of an aged care system navigator service, it was viewed by 2 stakeholder groups as the least important element (see Table 5-5).

Stakeholder comments suggested some confusion about what care planning meant in the context of navigator services compared with the aged care service delivery context. These findings indicate the importance of defining a navigator's scope of practice and its 'fit' within the system-wide (and even cross-system) context.

Avoidance of duplication and the integration of care planning across other elements of the system (e.g. identification and assessment) was consistently raised by stakeholders.

Navigators don't do care planning or assessment – they interface with those that do.

– *Aged care advocacy service*

Level of service intensity

Aged care system navigator models should offer a range of service intensities that are appropriate and responsive to changing service user needs.

While 2 stakeholder groups rated level of service intensity as the most important element of an aged care system navigator service, it was viewed by 2 stakeholder groups as the least important element (Table 5-5).

Broadly speaking, stakeholder comments pointed towards the importance of being able to provide appropriate variation in the level of service intensity in contributing to flexible and person-centred care.

The future program should provide a combination of targeted navigator services for defined cohorts alongside universal, less intensive guidance and advice for the general population.

– Aged care assessment provider

Generally, variation in the required level of service intensity was linked to the relative needs of those from disadvantaged and vulnerable populations. However, stakeholders also noted the need for differing service intensity across the consumer journey – for example, from before accessing My Aged Care (e.g. online and in-person information and support, drop-in centres and community hubs) through to one-to-one navigation after contact with My Aged Care.

The level of service intensity and professional role need to be linked to the vulnerability and risk profile of the client.

– Aged care service provider

Financial navigation

Aged care system navigator models should, through the provision of information, support individuals to understand the financial implications of decisions related to accessing aged care.

Though 2 stakeholder groups rated financial navigation as the second most important element of an aged care system navigator service, it was viewed by one stakeholder group as the least important element (see Table 5-5).

This type of navigation was considered important to help consumers understand the financial implications of accessing supports in different service systems (e.g. CHSP versus HCP versus residential aged care) and make informed decisions. In particular, the potential financial impact of ill-informed decisions was considered a significant risk, especially for vulnerable and disadvantaged populations.

However, whether this function should be the role of an aged care system navigator was queried, with some suggesting either integrated or stand-alone aged care financial navigation services should be available.

Financial navigation is essential due to the complexity of the issue and potential impact on consumers.

– *Peak body representative*

The need exists, but who is best to do this? It is not the role of navigators to provide financial information, but navigation to financial planners, Centrelink etc.

– *Aged care service provider*

Mode(s) of delivery

- Face-to-face navigation services are useful to enhance user–navigator relationships and to build trust and rapport.
- Telephone navigation services can improve reach to some population groups as well as those who are geographically isolated.
- Virtual/online navigation services can provide a range of information about aged care services.
- Outreach enables face-to-face modes of service delivery to particularly marginalised people that may not otherwise have access to services.
- Hubs offer a physical or online location where a range of navigator services can be provided.

Four of the 5 modes of system navigator service delivery were generally rated as important by discussion paper respondents, with all stakeholder groups rating *face-to-face delivery* the highest (Table 5-6). The comments provided suggested that this was seen as especially important for vulnerable populations. *Online* modes of support were rated the lowest by far by all stakeholder groups.

Table 5-6: Rated importance of system navigator services' modes of delivery, by stakeholder group (mean/100)

Respondent type	Face-to-face	Outreach	Hubs	Telephone	Online
Government department/agency	91 (n=18)	81 (n=18)	60 (n=18)	62 (n=17)	35 (n=16)
Aged care assessment workforce/provider	94 (n=20)	92 (n=19)	73 (n=19)	55 (n=18)	44 (n=18)
Aged care service provider	91 (n=114)	82 (n=109)	66 (n=108)	67 (n=110)	50 (n=110)
Peak body	97 (n=21)	88 (n=21)	77 (n=20)	79 (n=21)	61 (n=20)
Other	92 (n=39)	86 (n=41)	70 (n=38)	73 (n=39)	58 (n=39)
Overall	92 (n=212)	84 (n=208)	68 (n=203)	68 (n=205)	51 (n=203)

Combination/hybrid

Through discussion paper comments and stakeholder interviews, it became apparent that there is strong support for a combination of all modes of service delivery provided by a single navigator service. This was suggested to be particularly relevant to enable flexibility within service delivery and the provision of supports of varying intensity to assist consumers with varying:

- Levels of vulnerability, capacity and confidence
- Needs and preferences
- Degrees of progress in accessing aged care services.

It was noted, for example, that while *face-to-face* contact was generally viewed as extremely important, subsequent follow-up via *telephone* may be entirely appropriate. Alternatively, service users may first make contact through a group meeting at a *hub*, with further access via other modes. This may be a general model that reduces the resource intensity of service delivery and may be of even greater relevance in rural/remote areas where a 'fly-in, fly-out' model could support initial *face-to-face* contact with *telephone/online* follow-up.

In addition, where *face-to-face* delivery is impractical, alternative modes of delivery should exist (e.g. in remote areas or for geographically dispersed populations).

Clients are best served through a diversity of communication and engagement modes which match their communication preferences and needs (e.g. mobility, regionality, technological access etc.).

– Aged care service provider

The modes of delivery are all simply tools to achieve the desired outcomes, with flexibility to address individual needs.

– Local government representative

As most [of the CALD community] have language and reading and IT challenges, it is important to offer information in as many forms as possible to enhance knowledge.

– Ethno-specific organisation representative

Face-to-face

Noting strong support for the provision of options regarding navigator service delivery mode, face-to-face delivery of aged care navigation was generally felt to be most important, and even essential, for many older Australian consumers. This is likely to be even more pertinent for those from vulnerable population groups. In discussion paper responses, all stakeholder groups rated face-to-face as the most important navigator service delivery mode (Table 5-6).

In this context, vulnerable people could include those from special needs populations as well as those with disabilities (e.g. hearing or vision loss, cognitive decline) or difficulties accessing or using technology. Beyond such practical considerations, building trust between navigator and service user was felt to be best facilitated through face-to-face contact.

The mode of delivery most needed is face-to-face: this is the component that is not available under the current system.

– Aged care service provider

Face-to-face delivery is central to building trust, providing a space for users to ask questions and, most importantly, time to consider the information being provided.

– Aged care assessment provider

Stakeholders noted that *face-to-face* service delivery could also support the *involvement of multiple family members* in discussions and decisions regarding aged care services.

However, the cost of one-to-one, *face-to-face* service delivery was noted, especially in the context of the burgeoning ageing population and ever-increasing need for this type of support. In addition, it was noted that these needs and preferences may change over time:

While the survey may have been biased towards face-to-face [service provision], it is not always practical or cost-effective, and will change over time as generations become more tech-savvy and connectivity in remote areas improves.

– Aged care service provider

Stakeholders felt that *face-to-face* contact would optimise consumer engagement, build trusting relationships and allow navigators to get relevant information about a consumer that may not be disclosed by a service user or picked up by a service provider through telephone or online contact. Such comments often implied that the *face-to-face* contact would occur in a service user's home, allowing the navigator to see first-hand that person's living conditions, mobility, mental health, aged care and other needs as well as potential challenges. Home visits may also allow the service user to feel more comfortable and in control, as well as reduce mobility and transport barriers.

So many people will not or cannot travel to metro centres for an appointment – we need to go to them.

– Peak body representative

Other stakeholder comments implied that ongoing contact with a navigator service would ideally mean ongoing contact with the same individual navigator to maximise the opportunities and efficiencies afforded by trust between navigator and service user.

While *face-to-face* service delivery was often taken to mean one-to-one services, the *face-to-face* nature of village/hub and outreach models was also noted by a number of stakeholders as a key benefit of these modes of delivery. These are discussed separately below.

Outreach

The importance of outreach was underlined in discussion paper responses, with all stakeholder groups rating this mode as the second most important after face-to-face (Table 5-6).

Outreach was frequently referred to by stakeholders as a necessary pairing with face-to-face service delivery to reach individuals who may otherwise 'fall through the gaps' left by other modes of navigator service delivery. Stakeholders' interpretation of 'outreach' included visiting service users in their own homes (or other relevant community settings) and engaging with communities more generally (e.g. through partnerships/engagement with community groups and/or other relevant service providers).

Responses indicated that outreach activities facilitate the development of new aged care system entry points for vulnerable and hard-to-reach populations.

Meeting [consumers] where they are, or at least in the local community, is preferable.

– *Aged care assessment provider*

Outreach mode is a useful tool to engage with communities, provide information, training and peer-to-peer support. It can also be a good tool to secure a 'mandate of recognition/approval from relevant community leaders.'

– *CALD organisation representative*

Telephone

While overall discussion paper responses indicated that telephone contact was considered to be an important mode of aged care navigator service delivery, it was rated behind face-to-face and outreach, and on par with hubs (Table 5-6).

Though its convenience was noted for more simple information exchanges, telephone contact was considered less appropriate for conveying and discussing complex information or serving people who may experience a range of barriers to this mode (e.g. language barriers, hearing impairment, cognitive decline). Overwhelmingly, telephone support was considered appropriate for more able/engaged service users and as an adjunct to other service delivery modes, most particularly face-to-face (e.g. as an initial contact to arrange a face-to-face meeting or as a follow-up once background information has been gathered and a baseline relationship established).

Many are either harassed by cold callers or have hearing issues, so the phone is not a good option unless the client chooses it.

– *Aged care service provider*

Consumers are in their 80s plus – face-to-face contact with telephone follow-up builds the relationship.

– *Aged care service provider*

Hubs

Overall, stakeholder groups rated hubs below face-to-face and outreach, and on par with telephone delivery. However, hubs were felt to have a potential role in improving visibility of navigator services and engaging the community (Table 5-6).

Many of the benefits of hubs related to the provision of face-to-face navigation services as well as representing outreach into communities. However, the challenges relating to these service delivery modes, especially in remote communities, were also noted to apply to hubs (see relevant sections above).

Stakeholders noted that hubs could support flexibility and integration of services – for example, by housing professional and peer navigators, financial navigators and aged care assessment services, and by providing access to written and online resources.

It was suggested that hubs could be strategically co-located with other services to improve reach into specific communities (e.g. with an Aboriginal Medical Service) or with other services frequently visited by older Australians in general (e.g. primary/community health centres). Others noted that local councils might be ideal settings for aged care navigator hubs.

Hubs seem a natural form of supporting identified people within their communities in trusted, safe and familiar settings.

– *CALD organisation representative*

However, stakeholders felt that some vulnerable populations may experience significant barriers to accessing hub-based services. Mobile hubs (and/or their staff) could potentially reduce this barrier and facilitate maximum reach.

The hub and worker need to be mobile: going to where people live, their communities. Not expecting older people to go to you.

– *Aged care advocacy service representative*

Online

In discussion paper responses, all stakeholder groups rated *online* supports as the least important mode of aged care navigator service delivery (Table 5-6).

Generally, a lower cost service channel such as online resourcing is preferred to manage costs for high volumes, but the extent to which this would meet the needs of older adults has not been determined.

– *Aged care assessment provider*

5. Opportunities for the future of aged care navigation

Most significantly, limited digital literacy among target populations and other barriers to *online* access were noted. Despite this, an *online* presence was considered to be important as a relatively low-cost adjunct to other delivery modes (rather than a primary mode of delivery) and may suit the needs of some (generally less disadvantaged) aged care consumers and their families. *Online* information could also be utilised by family members and other organisations supporting aged care consumers. Emails following other modes of initial contact could also provide a record of discussions and tailored information.

Stakeholders also noted that the digital literacy of older Australians is likely to increase considerably over time, meaning that *online* service delivery may become more and more important in future years. There may also be opportunities to integrate basic aged care navigation elements into existing, broader digital literacy programs for older people.

Navigation services could intersect with digital literacy capacity-building services (e.g. in library and local council settings) to empower people to navigate online resources and portals.

– *Local government representative*

The delivery mode needs to be able to change over time. Currently the majority of clients in the aged care system are unlikely to want [online service delivery]. However, their families may, and within 10-20 years this function will likely be in greater demand than telephone.

– *Aged care service provider*

Some stakeholders noted that videoconferencing in combination with *face-to-face* service user contact could allow remote family members to be included in information provision and decision making within a navigator model. It was also raised as a potential alternative to *face-to-face* service delivery for those in rural/remote areas.

Other components

Other components of an aged care navigator model deemed important by stakeholders included service user follow-up and feedback/evaluation, and carer support.

5.4 Promising models

Which system navigator models offer most promise for future investment/implementation in Australia?

This section presents relevant findings from the environmental scan, discussion paper responses, stakeholder consultations and trial data.

5.4.1 Relevance of navigator models to the Australian aged care system

Though commenting on the relative strengths and weaknesses of individual models of system navigation (as summarised in Section 5.3.1), stakeholder responses suggested that there is a potential role for *all* of the navigator models highlighted in the discussion paper in the Australian aged care setting.

Discussion paper respondents and external stakeholders strongly suggested that aged care system navigation should be provided through a holistic and flexible model. In particular, it was noted that flexibility may be best promoted through the use of a 'hybrid' navigator model (e.g. combination of professional and peer navigators, opportunities to include family members, access to financial navigation, multiple communication channels, hubs and outreach). This view is supported by the findings of the COTA Australia-led trials, which demonstrated the value of tailoring responses to the local context, and to the needs and preferences of different population groups.

They are all very good models, and definitely have a place. However, to truly have an impact there needs to be multiple models used to ensure that there are many avenues for people to access information to help them access the services they may require, along with targeted roles within the models for marginalised groups.

– Aged care service provider

Rather than focus on the respective merits of each model, we believe strongly that a hybrid model, reflecting the needs of the particular audience being served and the outcomes to be achieved, will be what is required.

– Peak body representative

In my opinion, it would be nice to have a navigator model where all strengths are present. This ideally should happen if patient, professional, family, peer and hub [models] work collaboratively in an interprofessional team.

– Aged care service provider

Although stakeholders noted a strong preference for professional navigation models, it was often mentioned that these could be supported by peer navigators for lower-intensity information/service provision. In this way, peer and professional navigators could have different roles within the system, and support a 'stepped care' approach. As discussed in Section 1.1.1, many partner organisations used this approach to good effect.

Peers are essential for identifying those who are isolated and in need in the community. Professionals are essential for identifying complex needs, or stepping in and doing a home visit when a client's needs are too complex for a non-professional.

– Partner organisation representative

In addition, it is possible that the development of an effective model of professional navigation might inform future opportunities for peers to have a more significant role.

As navigation establishes itself as a function, it may be advisable for this to be led by professionals in the first instance. Once the model is evaluated and training requirements for navigators are firmly established, peer navigators can be trained for maximum reach and effect.

– Aged care assessment provider

Many stakeholders noted that it is important not to 'reinvent the wheel', with good work currently being done across the country to help consumers access and navigate the aged care system. In particular, many discussion paper respondents made reference to the A&S program in Victoria.²⁸ Appendix E provides a summary of aged care navigation models identified through an environmental scan, consultation with external stakeholders, as well as partner organisations.

There may also be opportunities to learn from existing models in other relevant sectors, such as Local Area Coordinators funded through the National Disability Insurance Scheme and the Carers Gateway.

²⁸ Note that 35% of discussion paper respondents were Victorian.

5.5 Addressing implementation challenges

How can promising models of aged care navigation complement/build on existing supports and investments?

What other implementation considerations should be taken into account?

This section highlights some of the implementation challenges and considerations highlighted by the ACSN evaluation.

In the ACSN discussion paper, stakeholders were asked to comment on barriers and enablers to the implementation of an aged care navigator model with respect to the following categories:

- Capacity
- Reaching target populations
- Funding, independence and competition for services
- Integration
- Research/data collection

Stakeholders' views, obtained through responses to the discussion paper as well as individual consultations with external stakeholders, are discussed under their respective categories below. Some of these have been already discussed in the context of service design principles (see Section 5.3.2).

Capacity

Barriers identified by stakeholders regarding capacity most often included the *time-intensive* nature of providing *tailored navigator support* to disadvantaged and geographically distant consumers with complex needs, and a general lack of funding to do it. While it was noted that many organisations are currently fulfilling a navigator role (including service providers, advocacy services and community organisations), very few of them are funded to do so, and their capacity to undertake this role is often limited. For individual staff members involved in system navigation, workload and prioritisation of consumers is a key issue, along with managing consumers' expectation of the navigator services where the scope may be more limited than consumers would like. It was noted that professional navigators needed sufficient time to network and learn about relevant local agencies, and that the navigator role should be separate or quarantined from clinical roles and expectations.

The process of explaining and assisting older people with navigating the aged care system, funding options, service options and financial considerations is a time-consuming process. The need to work with families adds additional challenges in regard to timeliness of decision-making.

– Aged care service provider

For most organisations, capacity to support rural and remote communities is often particularly limited, as travel time detracts significantly from direct service provision. Evaluation data collection and reporting requirements also contribute to capacity challenges, if overly onerous.

Enablers relating to service capacity included defining/delineating the role of navigators and determining the end point of interactions to avoid 'scope creep' and allow what capacity exists to be focused strategically. Systematic prioritisation of waiting lists and managing service user and community expectations regarding the scope of the service may also be important implementation considerations. These activities may also help to minimise 'competition' between community

organisations for service users for similar or related services. Stakeholders expressed concerns about the effect of capacity issues on navigator staff.

A weakness of all models [of aged care system navigation] is the possibility of over-engagement and [navigator] burn-out.

– *Aged care service provider*

If staff are not paid well and are overworked – like what we have right now – these models are useless.

– *Aged care service provider*

A focus on empowerment and independence, rather than case management, may also help to address capacity issues in some cases, although stakeholders acknowledged that the most vulnerable consumers will likely need more intensive assistance. *Diversity within the navigator workforce* could improve a service's ability to reach, engage and provide appropriate support for individuals and population groups.

Better staffing allows for a greater spread of people to find more of the target population and expand service provision.

– *Dementia Advisory Service*

Particularly for larger and/or less vulnerable community groups, presentations and seminars provided for large numbers of community members may be a good way of reaching many people through a single activity, potentially leaving more time to offer more intensive services to disadvantaged service users in a stepped model of service. Such a model could include involvement of a number of variously-qualified navigators, allocated to individual consumers or roles depending on level of need.

Give consideration to tiers of professional and paid navigator staff (nurses, allied health professionals, allied health assistants, certificate-trained staff) linked to the complexity and risks of the client and situation. Perhaps a specialist qualification could be established to broaden the cohort of people able to provide a professional navigator service.

– *Aged care service provider*

In this vein, the use of peer/lay navigators in combination with (and supervised by) professional navigators may also help to bolster service capacity.

Networks and partnerships (e.g. between navigator services and community groups) may help to address capacity issues for both organisations and facilitate assertive outreach. Working with other community organisations to bring a consistent information offering to different target community groups, and support from quality resource materials and tools to support both navigators and service users will help maximise capacity. For navigator service providers, this might include development/involvement with networks, CoP, and professional development.

Given the importance of integration and networks and linkages as design principles, navigators should also be provided with dedicated time to develop and maintain key linkages (e.g. attending network meetings, orientation to funded agencies).

Building capacity within navigator services (e.g. resourcing, reach, training and professional development for navigators), other relevant services (e.g. primary care and other providers) and

communities (e.g. through improving health literacy) will likely help to maximise all sectors' capacity to support aged care navigation.

Other factors that may promote capacity include:

- Ongoing, quality training for navigators (e.g. to understand scope of practice, develop cross-sectoral networks).
- Clear referral pathways for other services.
- Video link capabilities (to reach geographically isolated communities).

Unsurprisingly, stakeholders noted that *appropriate funding levels* were needed to meet demand for navigator services and adequately resource the workforce.

[We need] secure block funding and career/salary progression for navigators to avoid high turnover and enable continuity of service provision.

– *Peak body representative*

Reaching target populations

Stakeholders noted that, while many older Australians would benefit from aged care navigator services, reaching target (vulnerable) populations to provide access to such services is difficult. Despite this, they confirmed the importance of providing a navigator service that is accessible to vulnerable populations, and the need for a proactive approach to facilitate this.

As noted in the discussion paper, engaging 'hidden' populations may be difficult due to:

- Mistrust of the aged care system or systems more broadly due to prior life experiences
- Social isolation
- Low levels of awareness of the aged care system, or health and social systems more broadly
- Language/communication barriers (including low levels of literacy).

Other factors include geographic barriers, complex family circumstances (e.g. elder abuse, family violence), and financial barriers.

Reaching our most vulnerable needs a model that is flexible and has the capacity (time) to build trust.

– *Sector support provider*

A trusted navigator entity with the right staff is needed.

– *Aged care service provider*

Identified *enablers* included positioning navigators in communities, where they are *most accessible* to older people. 'Housing' aged care navigators within neighbourhood/senior citizens centres, ethno-specific community organisations for CALD populations, homeless and other relevant services, or co-located with other services commonly used by even socially isolated members of target populations were all suggested as useful strategies. Many older people are connected with primary care services, particularly at the point of changes in health status or health crises, and this could be one setting through which individuals might access professional aged care navigation services.

The ACSN evaluation has found that there are benefits of having both a centralised and a local, community-based approach to the provision of navigation services.

5. Opportunities for the future of aged care navigation

Engaging with communities and peer support programs could also be useful for reaching those from specific populations. Again, networks and referral pathways could assist in identifying those in need of navigator services, and connecting them appropriately. This includes engaging relevant community leaders as well as organisations.

It was noted that *co-designing services with target populations* and those who support and advocate for them would promote reach and relevance of the service, and potentially avoid wasted efforts. Employment of a diverse range of navigators (e.g. Aboriginal or Torres Strait Islander people, those from CALD groups, veterans etc.) would also *improve the reach and appropriateness* of navigator services.

There needs to be different strategies for different target populations, co-designed with the group.

– Aged care service provider

Targeting not only individuals, but their *informal and formal support networks* may assist. For example, assertive, innovative outreach, based on local needs and characteristics, might represent an ideal strategy.

At a broader level, general community awareness of a navigator service can promote access. While generally stakeholders noted the need for aged care navigators to be high, this did not always translate to high demand, as many consumers did not know where to go for information (and often relied on individual providers).

I was part of a team that offered free aged care advice in conjunction with GPs and found it was very difficult to recruit clients to deliver the advice to. Marketing and hunting down people in need was challenging, which was a surprise as we all think people are out there desperate for help.

– Aged care service provider

Building and promoting *clear and consistent branding* that is recognisable and appropriate to the audience may help to raise awareness of a national aged care navigator service. Creative ways of reaching specific population groups could also be considered (e.g. community radio). A visible community 'presence' (discussed above) may also help (e.g. hubs in strategic locations to target older people in general and those from disadvantaged populations more particularly). Training and formal referral pathways for "gatekeepers" who work with vulnerable people already (e.g. through health and community sectors), could be another strategy, supporting a "no wrong door" approach.

Navigation services are like local bank branches in small country towns...they need to have a physical presence, even if that presence is part of another established organisation.

– Aged care service provider

At the local level, community scoping and assessment (mapping) can assist in developing an appropriate model and system that reaches the desired target(s). "Universal" strategies could also be utilised to promote access to aged care navigation for all older Australians. Such approaches might include, for example:

- Providing an aged care information pack (including information about navigation services) when someone accesses the aged pension or superannuation.

5. Opportunities for the future of aged care navigation

- Integrating an aged care navigator function (or screening for need) within aged care assessment
- Utilising the 75+ health assessment as an opportunity to educate people about maintaining independence, services that may assist with this, and the aged care system.

Funding, independence and competition for services

At a basic level, funding has already been discussed at it relates to service capacity and continuity and sustainability of a navigator model. It has also already been noted that providing navigator services for vulnerable population groups is likely to be more resource-intensive than providing such services to less disadvantaged groups. Despite this, offering services that are free of charge to disadvantaged people (if not all older Australians) was considered important.

Stakeholders highlighted the *importance of government commitment to stable ongoing funding* for any aged care navigator service model implemented. Funding of a navigator service needs to consider a number of activities beyond direct service provision, including adequate implementation resources, systems development (e.g. for tracking and referrals), transport and travel (in metro as well as rural and remote areas), translating and interpreting services, community liaison activities, partnership development activities, staff recruitment, training and development, evaluation and quality improvement activities and administration.

The [aged care] navigator trials in New South Wales are a great example of a well-planned model not having sufficient resources to be implemented to its full capacity.

– *Peak body representative*

Stakeholders noted the value in having a recognisable and independent service providing aged care navigation services, allowing both consumers and other relevant organisations (e.g. in the health and community sectors) to develop streamlined relationships and referral networks.

This may also allow differentiation between independent navigation services associated with My Aged Care and aged care service providers' own models which have the potential to be affected by conflicts of interest.

Clearly separating navigation services from aged care service provision could help to mitigate any "competition" for service users between the 2 and allow navigators to remain (and be perceived as) independent. However, as noted earlier in the discussion of independence as a design principle, this may not be as important – or even desirable – in the context of some specific population groups.

Some felt funding for navigator services should be directed to community organisations to eliminate potential conflicts of interest. Local governments and PHNs were frequently cited as appropriate choices in which to "house" navigator services.

Local governments are the ideal hosts, underpinned by a strong code of ethics, governance structures and conflict of interest policies.

– *Aged care service provider*

Aged care assessment services might also be ideally placed (noting that potential conflicts are not absent in all local government and assessment service settings).

It is imperative that service navigation is integrated into the streamlined assessment model being developed by the Australian Government.

– *Aged care assessment provider*

The navigator model should not be considered separately to the My Aged Care system and the streamlined aged care assessment model. If the system is well designed from the beginning to “flow”, then [aged care navigation] does not need to be considered and funded separately.

– *Local government representative*

It should be noted, however, that some aged care providers reported delivering navigation services that were independent in nature, and that this model worked well when appropriate governance was in place to avoid conflicts of interest having any bearing on navigator service delivery. In particular, this model was noted to be effective in smaller communities, where the number of providers is limited (perhaps even to one organisation) and/or where a provider is a “trusted expert” on aged care in the community.

Integration

As discussed in Section 5.3.2, many stakeholders felt that ‘integration’ should be interpreted broadly to maximise the utility and effectiveness of an aged care navigator service. Many stakeholders noted that an ideal navigator model would not be limited to government-funded aged care services, but have a broader focus on promoting physical, mental and social wellbeing.

We do not want navigators to be set up just for funded aged care systems but other areas as well: health, community support, libraries, senior citizens clubs.

– *Aged care service provider*

Relevant services/sectors might include:

- My Aged Care
- Aged care assessment providers (and the new streamlined assessment model)
- Aged care providers
- Primary care providers, PHNs, community health and allied health
- Hospitals (public and private)
- Community health services
- Disability sector service providers and Local Area Coordinators (NDIS-funded navigators housed within partner organisation)
- Senior citizens/neighbourhood centres
- Peak bodies/community organisations (condition specific organisations such as Parkinson’s Australia, Dementia Australia, as well as community-specific organisations)
- Carer supports and networks (e.g. Carer Gateway)

Information sharing within these integrated networks – for example, systems that allow for consent and release of consumer information to other providers – would support consumer outcomes. For example, allowing navigators to have controlled access to shared data (e.g. through My Aged Care service provider portal, My Health Record etc.) was supported by a number of stakeholders.

One of the best systems I have encountered has arisen from a cooperative group of providers in a local government area gathering under the PHN banner. They have been able to cooperatively address issues in their specific community and build strong links to services across the health and community sectors. The strength of these networks creates benefits that build stronger communities as well as deliver better collaborative responses to client needs.

– Aged care service provider

A key component of integration was *consistent and robust referral pathways* to facilitate the supports needed by individuals. Activities to support this might include mapping of consumers' care journey and current care, support and service options, and relevant partnerships with effective information sharing.

Meaningful coordination and integration can occur once the service landscape is clear and understood, and there is a sense of shared purpose among agencies and organisations.

– Peak body representative

System navigators need to be...very familiar with the community and have extensive professional connections.

– Peak body representative

In order to realise all the benefits of integration, the importance of resourcing navigators to *develop and maintain relevant linkages and partnerships* was raised by numerous stakeholders. Activities involved might include navigators' attendance at partnership meetings, seminars and conferences, promoting services through GP and other network meetings, community engagement and peer support networking. Such activities need to be recognised and rewarded in the model, including thorough research and evaluation activities (see below).

Linkages and partnerships don't happen when [you're] focused on output-based KPIs.

– Aged care service provider

Research and data collection

Beyond comments about the utility of data-sharing activities (discussed above), research and data collection activities were not raised as implementation challenges as much as other barriers discussed above. However, it was consistently acknowledged that data collection was vital to inform what works with particular population groups, justifying investment and demonstrating need for growth of that investment over time, and embedding a culture of continuous improvement within the service. Despite this, it was also noted that some valuable aspects of aged care navigation may be difficult to evaluate, and that outcome measures (including consumer experience/satisfaction) were of particular importance.

A lot of what an effective navigator will do will not be easily measured. There is a risk that it will not be acknowledged and resourced.

– Aged care assessment provider

Throughput pressure inevitably and significantly undermines almost all the desired design principles

– *Local government representative*

Stakeholders *warned against excessive administrative burden* (and burden on service users) associated with data collection, and noted that funding should be allocated for these activities. Standardised data collection tools and reporting guidelines could help ease administrative burden if well designed, but have the reverse effect if not.

Other implementation issues

A number of other implementation issues were raised by stakeholders through responses to the discussion paper and other consultations.

‘Fix the system’

Despite the perceived usefulness and need for aged care navigation services in the current Australian context, some stakeholders noted that the need for navigation (in any sector) was a reflection of unnecessary complexity within that sector, or disconnection between it and other relevant sectors. If this is the case, it was reported that efforts should focus on addressing these systemic issues, as opposed to helping consumers navigate them.

The explosion of scope [for navigators] occurs because there are so many gaps in the system, rather than a problem with the system navigation models.

– *Government representative*

Integrated planning across services could be trialled as a novel concept.

– *Aged care service provider*

In this context stakeholders raised a number of concerns about the lack of user-friendly, accessible information currently available through My Aged Care (both the website and telephone-based customer service centre). They suggested that low-level navigation assistance might be provided to consumers through the existing My Aged Care service.

Fix My Aged Care to be simplistic in design and contain clear and concise information.

– *Peak body representative*

The rationale for the My Aged Care website, phone number and portal was that it would be the ‘one stop shop’ of aged care. The Federal Government was to assume responsibility for the increasing ageing population.

– *Aged care service provider*

Apart from complexity/disconnection within and between sectors, the rate of change and reform in the aged care system presents implementation challenges for any aged care navigator model operating in this context. This is because it makes it difficult both to ensure navigator knowledge is up-to-date (e.g. through ongoing training and professional development) and to build accurate awareness within communities in general as well as important community ‘touchpoints’.

All models rely on the navigator having in-depth knowledge of a support network fraught with complexity and change.

– *Aged care service provider*

Engage all stakeholders in design, planning and implementation

To promote integration, it will likely be important to consider and engage a broad range of stakeholders in the design and implementation of an aged care navigator service.

Local government is part of the solution but the full strategy needs to be developed in full consultation with all stakeholders, including those not yet engaged.

– *Peak body representative*

A systemic, planned approach to the development of the model which incorporates responses to all the identified barriers and enablers. Those who have had recent experience 'in the field', including RAS and ACAT officers, should be involved in the planning process.

– *Government representative*

Avoid duplication

Many stakeholders reinforced that aged care navigation activities are already happening in a number of different settings, and felt strongly that the experience gained from these activities should not be wasted, and duplication of effort should be avoided.

A navigator model should harness existing systems or assets within communities.

– *Peak body representative*

5.6 Summary

The national coordination, support and branding of an aged care navigation service, and its potential integration with assessment services, addresses some of the challenges noted throughout the ACSN evaluation, including:

- Independence (from aged care providers)²⁹
- The need for suitably qualified and trained navigators
- Clear scope of practice and consistency of the service offering
- Avoiding duplication of effort.

Providing or managing navigator services through a distributed network of offices has the potential to simultaneously utilise local knowledge and networks.

However, there is likely to be a continued need for 'grassroots' local community supports, particularly for vulnerable and hard-to-reach populations who may be least likely to engage with unfamiliar individuals and organisations as a first point of contact, to understand and access the aged care system.

A broader agenda of increasing communities' awareness and understanding of healthy ageing and aged care in Australia (in line with the service offerings of ACSN Community and Information hubs) may also be best supported by individuals with established community links, who may be provide such support on a paid and/or voluntary basis.

Financial navigation (such as that provided by FIS Officers) is an important offering for people entering the aged care system, although it is noted that the skill set required to provide this service may be considerably different to that required for aged care system navigation more broadly).

²⁹ Although it is noted that in some cases it may be appropriate for service providers to act as navigations, e.g. in the case of specialist Aboriginal or Torres Strait Islander service providers, and those serving some remote or isolated communities.

6 Conclusions, options and policy considerations

The ACSN Measure provides an important means of supporting older people to better understand and engage with the aged care system. The COTA Australia-led trials and FIS Officer trials have been delivered by a committed, passionate workforce and have demonstrated a range of achievements including strong levels of engagement with local communities and positive feedback from navigator service users (where reported). Importantly, the ACSN Measure has provided opportunities to test and refine approaches to navigation and contribute to a growing evidence base for aged care system navigation in the Australian context.

A wide range of approaches to aged care system navigation have been described through this evaluation, including those delivered through the trials funded through the ACSN Measure and those uncovered in a review of other system models. However, there is no clear evidence of which model will work best for different population groups or in different settings. Rather, the evaluation has found that navigator services should be locally tailored, holistic, and flexible to meet the needs of diverse population groups and individuals.

Despite the recognised need for a tailored response, there is, benefit in some aspects of broader consistency, coordination and support. The following principles, service delivery elements and implementation considerations have been identified as important for future aged care navigation services for diverse and vulnerable population groups.

6.1 Principles

The review of system navigator models identified a range of principles that should underpin design of system navigator services (see Table 6-1).

Although these principles have largely been incorporated into the COTA Australia-led trials, the evaluation has highlighted the importance of the following:

- Aged care navigation services should be underpinned by a professional workforce (supported, where appropriate, by trained volunteers).
- Navigation services should, where possible, be independent of aged care service providers in order to provide impartial advice (exceptions may apply in 'thin' markets such as Aboriginal or Torres Strait Islander services).
- Aged care navigation services should be designed with the end user in mind, taking into account:
 - The need for flexible approaches to engage with individuals, while adhering to a clear scope of practice
 - The holistic needs of individuals (not limited to aged care services), including linkages and partnerships (if not integration) with other services and organisations
 - The importance of trusted relationships in engaging and supporting people from vulnerable and/or hard-to-reach populations.

Table 6-1: Important design principles for aged care navigation models

Design principle	Details
Quality workforce	Navigators should be appropriately experienced, with relevant qualifications* where required, trained and supported (e.g. with ongoing training and professional development)
Implementation resources	Navigator programs should include implementation resources/toolkits/guides to support consistent, high-quality delivery of navigation services
Flexibility and adaptability	Navigator models should be flexible, adaptable and responsive to meet the needs of the service user and the required level of service intensity
Linkages and partnerships	Navigators should dedicate time to developing their knowledge of local services, building partnerships with other organisations and sectors, and performing promotional/integration activities
Clear scope of role and practice	Navigators should have a defined scope of practice with roles and responsibilities that are transparent and commensurate with the skills and experience of the navigator delivering the service, including guidance on management of risk
Integration	Navigator models should aim to integrate fragmented and disconnected systems of care, and draw on existing local efforts/supports/infrastructure
Relationship-centred services	Navigator models should identify the context, needs and priorities of the service user, in order to provide a personalised navigation service. They should recognise the importance and influence of the relationships that exist between the service user and others, including service providers
Independence	Navigators should be independent from service providers, to foster the necessary trust and rapport required to reach people facing challenges when accessing and navigating aged care services**
Active participation	Navigation should enhance the capacity of service users (including individuals/carers/families) to be actively involved in navigating the aged care system
Evaluation outcomes	Implementation of aged care navigator programs should include an evaluation framework to monitor outcomes for service users and inform future policy decisions
Defined target population	Navigator models should focus on defined target populations and prioritise those who are vulnerable or are experiencing barriers to accessing information and care
Other	Accessibility, inclusive design, innovation, sustainability, responsiveness, simplicity.

Note: *professional aged care system navigators should hold qualifications in aged care and/or relevant health, behavioural and/or social sciences. **Exceptions to these design principles may apply in thin markets such as Aboriginal or Torres Strait Islander services, to ensure access to culturally appropriate navigation support and aged care services.



6.2 Service elements

Aged care navigation services should:

- Be informed by detailed, localised needs assessment, that considers population demographics, aged care service availability and mapping of other relevant services to support development of referral networks and avoid duplication.
- Provide a flexible mix of services, recognising that levels of need (and, therefore, intensity of required support) will vary between individuals, and may fluctuate over time.
- Where necessary, support people through the process of registration with My Aged Care, and assessment, to the point at which aged care service delivery is commenced.
- Use a range of modes of delivery, noting that for marginalised populations face-to-face interaction is generally preferable. However, partner organisations have indicated the value of telephone and online modalities through the COVID-19 pandemic. Though these cannot fully replace face-to-face delivery, they are valuable supports and warrant further exploration.
- Use targeted approaches, including assertive outreach, to engage with people who are particularly marginalised, socially isolated, or otherwise unlikely to engage with the aged care system.
- Refer clients where necessary to independent financial navigation services, such as the FIS. Although financial navigation is an important service, it requires specialist expertise, which may be outside the skill set of many navigators. The FIS should continue to be promoted as a high quality, independent source of aged care financial information.

Figure 6-2 provides an example of the range of services that should be considered as part of a flexible, multi-modal system navigator model that accommodates the different support needs of navigator service users across the aged care journey. Note that while individuals may need ongoing support and case management beyond the point of aged care service commencement, this is outside the scope of aged care system navigators as conceptualised in the ACSN trials and this evaluation.

Figure 6-1: Suggested range of navigator services across the aged care journey

Complex  Moderate  Low Intensity of need	Targeted approaches <ul style="list-style-type: none"> • May or may not be from diverse populations 	Individual support to register with My Aged Care and address other needs ----- Assertive outreach	Regular follow-up (face-to-face, if feasible): <ul style="list-style-type: none"> • Assistance with assessment process • Support to address other needs 	Regular follow-up (face-to-face, if feasible): <ul style="list-style-type: none"> • Assistance to select provider/s • Support to address other needs 	Ongoing case management if required (out of scope for navigators)
	<ul style="list-style-type: none"> • Diverse populations • Distrust of government • Social/financial disadvantage 	Individual support to register with My Aged Care ----- Information and education	Periodic follow-up: <ul style="list-style-type: none"> • Assistance with assessment process 	Periodic follow-up: <ul style="list-style-type: none"> • Assistance to select provider/s • Support to address other needs 	
	Universal approaches	Information and education: <ul style="list-style-type: none"> • Healthy ageing • Aged care system • How to register with My Aged Care 			
Aged care journey					
	Learning about aged care	Registration with My Aged Care	Assessment	Service commencement	

6.3 Implementation considerations

6.3.1 Service provider organisations

- The evaluation of the COTA Australia-led trials and the review of system navigator models have confirmed that navigation services can be delivered effectively by a range of organisations including local governments, PHNs, advocacy organisations and community organisations that support special needs groups.
- Navigation services should have a physical presence – for example, as a ‘hub’ – with an accessible space to facilitate face-to-face engagement (noting they may be co-located with other services).
- It is essential that organisations delivering navigation services have established trust with the groups they are working with. Further, given that distrust of government has been found to be a barrier to people from diverse and vulnerable populations engaging with the aged care system, we recommend that navigation services are delivered separately from government (noting that distrust is not necessarily applicable to all forms of government).
- Though navigation services may specialise in a particular population group, they should be accessible to all, and where required facilitate referrals to other population-specific navigation services.

6.3.2 Staffing

- Services should be staffed by experienced personnel, including qualified professionals where required, with expertise in the aged care system, and the specific populations with which they work.
- In addition, training in cultural awareness and trauma-informed practice should be provided to all staff.
- Volunteers can play a role in several areas, including:
 - Connecting to local/diverse communities and providing basic information.
 - Providing emotional or peer support, serving as an example of successful engagement with the aged care system.
 - Undertaking administrative tasks to support professional navigators.

The model of community champions described in Section 3.4.2, ‘What worked well when implementing each trial, and what was the positive impact?’ is worthy of further exploration. Through this approach, navigation services link with community champions, who have leadership roles (often in a voluntary capacity) within their communities. Another approach would be to *formalise* these connections, for example through a gatekeeper approach, where community champions (or indeed any member of a community) might have a more formal connection to the navigator service to promote it and enhance engagement.

6.3.3 Funding

- The funding model should reflect that meeting the needs of those who are hard to reach or have particularly complex needs will be resource-intensive.
- Sustainability of funding is important in order to grow services over time and build recognition.
- Funding should be sufficient to support innovation and service improvement.

6.3.4 Building national consistency

- A nationally networked, branded, program of aged care navigation services:
 - Increase awareness and visibility among the Australian public.
 - Enhance consistency in processes, including scope of practice, service delivery guidelines, data collection/reporting and processes for interaction with other services.
 - Facilitate communication, training, information sharing and referrals between organisations.
- Though national consistency in the objectives and scope of aged care navigation is important, services should be encouraged to tailor activities to best meet local needs. This may include considering different approaches to local promotion, networking and delivery of navigation support.
- A central coordination function could support national consistency and promotion of good practice. This role could be provided by a navigation service provider or an independent third party. The option of keeping the central coordination function separate from contract management – which may be more efficiently managed by the Department – could be considered.

6.3.5 Monitoring and evaluation

- Navigation services should be responsible for monitoring local population demographics and need, and modifying their approaches accordingly.
- Nationally consistent data collection will support ongoing monitoring and evaluation. Data collection requirements should aim to minimise burden on service providers and navigator service users, and reporting should be streamlined to maximise quality and quantity of collected data (for example, through an online portal).
- This evaluation has highlighted the benefits of qualitative reporting in addition to quantitative data.

Cited references

Australian Government Department of Health 2020, *Ensuring senior Australians can access the support they need*, viewed 11 November 2020, <<https://www.health.gov.au/ministers/senator-the-hon-richard-colbeck/media/ensuring-senior-australians-can-access-the-support-they-need>>.

Department of Health 2017, *Legislated review of aged care 2017*, Commonwealth of Australia, Canberra.

The University of Melbourne 2020, *Specialist certificate in service navigation*, viewed 16 November 2020, <<https://study.unimelb.edu.au/find/courses/graduate/specialist-certificate-in-service-navigation/>>.