The care finder's role in the client journey

Assertive outreach, engagement and rapport building

- Make **connections with local intermediaries e.g.** in health/community sectors
- **Make contact** with potential clients directly and via intermediaries
- **Build rapport** with clients
- Organise **interpreter/Auslan support** if needed
- **Encourage** clients to consider accessing support if they are resistant
- With client consent, **add information to** care finder organisation's **secure IT system**
- Provide clients who are not in the care finder target population with **relevant contacts for other supports**

Support through registration, screening and assessment

- **Continue to develop rapport** and reassure client about next steps
- **Explain types of support** and services available (in any relevant sector) and processes to access services
- With client consent **create My Aged Care client record** (if they don't have one) nominate self as their 'agent'
- With consent, **help clients contact My Aged Care** or use the website to **apply for an assessment** online or call other services/fill in forms
- Work with client to **arrange an assessment and attend** if the client wishes

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

- Support client **to follow up on referrals** made by the assessor **or find appropriate providers** e.g. on the My Aged Care website and help client review quality and costs information
- Help **complete income/means testing forms** and calls to Services Australia
- Set up appointments/**meet with providers**/visit aged care facilities with the client and **help them compare costs and quality**
- **Call other support services** with client e.g. housing services
- **Ensure they have understood** any agreements they need to sign

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

- **Call or visit** the client after the services are in place (regularity will be based on circumstances)
- **Talk through any concerns** or issues client has experienced with services to prevent escalation to the point of client unnecessarily refusing services or being unable to receive them
- **Proactively identify other services** that may support the client to maintain health and independence
- Note: aged care providers are responsible for meeting client's changing needs. Care finders' role is to confirm this is happening **not duplicating provider roles**

Follow up support if needs change or services have lapsed

- Help the client **take steps to resolve issues** e.g. call the provider (with the support of an advocate if required and if client consents and is comfortable or can refer to an advocate)
- Work with the client to **arrange re-assessment** (if not identified by provider) or **set up new services**
- Work with clients to **change services with existing provider(s)** if needed
- **Support clients to find alternative provider**(s) if they are not happy with their services

Care finding from the client perspective

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

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

Assertive outreach, engagement and rapport building

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

Support through registration, screening and assessment

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

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

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

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

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

Follow up support if needs change or services have lapsed

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

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

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

Assertive outreach, engagement and rapport building

- **John's friend calls the local council** and explains John's circumstances, without giving his name, and asks about how he can get more permanent housing. She is **given the number of a local care finder** organisation.
- She calls and describes the situation. A **care finder called Pete calls her back and offers to talk to John**, if he agrees.
- John agrees to talk on the phone and is reassured that Pete says **he doesn't need to give any personal information** if he's not comfortable.
- After many conversations, including at his friend's place, **John says what he wants most is help to visit his sister at her care home regularly**

Support to access aged care connect with relevant supports

- Pete says John can get transport through My Aged Care but, while they're arranging that, **a volunteer from his organisation can drive** him there.
- John is really happy about this and soon after agrees **to reconnect with his GP** for a medication review. A few weeks after seeking support from his GP, John is feeling well and is **interested in accepting more help**.
- Pete **helps him apply for financial support** through Services Australia and **social housing**. This takes some time as **John remains fearful** of providing information.
- Eventually John moves into a **social housing property**.

Support through registration, screening, assessment and setting up aged care services

- Pete suggests John might benefit from some further support, such as **help with cleaning and a social group**.
- **John is wary** of people coming into his space but acknowledges he would like the help and to have more company.
- They **apply for an assessment on the My Aged Care website** together and Pete promises he will be there when the assessor comes. Pete **ensures the assessor is aware of John's fears** before the meeting.
- After the assessment Pete helps John **contact local providers** and over a few months gets the services organised.

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

- After a couple more months **Pete calls John to see how he is going**.
- John is still living in the apartment but is **no longer getting cleaning or going to the social group**.
- Pete **offers to come round to talk about it**. When he gets there John says the cleaner stopped coming and he doesn't know why.
- Pete **calls the provider** and is told the apartment is too cluttered and dirty for the cleaner.
- John says he only went to the support group a couple of times because **had nothing in common** with the other people.

Follow up support if needs change or services have lapsed

- With John's consent **Pete arranges a deep clean of the apartment** through a hoarding and squalor specialist provider and they then **work with John on strategies** to avoid getting into the same situation.
- Pete also **talks to the cleaning provider about coming more frequently** and helping John to decide what to throw away at each visit.
- Pete **explores other options for community support** and puts John in touch with a local **Men's shed**. John thinks this will be a better fit for him.
- Pete **stays in regular touch** with John and helps adjust his support as needed.