Care Finder Program: Supplementary Needs Assessment

phn EASTERN MELBOURNE
An Australian Government Initiative

Background

Prior to the initial commissioning of care finder services, EMPHN was required by the Department of Health and Aged Care (DoHAC) to undertake additional activities, to supplement its existing Needs Assessment, to identify local needs in relation to care finder support.

These additional activities have provided the evidence base for EMPHN's commissioning approach to care finder services and will therefore determine the services that EMPHN will commission alongside the existing Assistance with Care and Housing (ACH) providers as care finders.

Purpose

This Once-off Report on Supplementary Needs Assessment Activities:

- Provides information on the additional activities undertaken by EMPHN to identify local needs in relation to care finder support
- Set out the evidence base for EMPHN's initial commissioning approach to care finder services
- Is a stand-alone update to EMPHN's existing Needs Assessment
- Inform development of EMPHN's Activity Work Plan.

Reporting period

This Once-off Report sets out the evidence base for EMPHN sets out the evidence base for EMPHN's initial commissioning approach to care finder services, and will therefore address the three-year period from 1 July 2022 to 30 June 2025

Outcomes

The table below provides a summary of the outcomes of the additional activities undertaken to identify local needs in relation to care finder support by triangulating findings from:

- data analysis to understand the profile and needs of the local population in relation to care finder support
- stakeholder and community consultations to identify local needs in relation to care finder support
- analysis undertaken to understand the local service landscape as relevant to care finder support.

Quantitative Analysis

The outcomes from the available data relating to the need and demand for services are set out in the table below. Where appropriate, outcomes from the stakeholder consultations have been embedded into this table.

Immediately after this table is a further table that sets out the outcomes of the stakeholder consultations.

Identified need	Key issue	Evidence
Need		
EMPHN **population** size of people aged 50 years and over	A higher proportion of older adults within a region is an indicator of service need as it can be assumed that service usage increases as the population increases.	In 2020 there were 540,376 people over the age of 50 living in the EMPHN catchment (see **Table 1**), representing 34% of the total population in the catchment. This is slightly higher than the state average of 33% (based on the 2020 ERP, there were 2,211,211 individuals aged > 50 years out of the 6,696,670 total population living in Victoria).

Identified need	Key issue	Evidence
Need		
EMPHN **population** size of people aged 50 years and over	**Whittlesea** and **Boroondara** have the highest number of residents aged over 50 years of age within the EMPHN catchment.	**Table 1.** Estimated Resident Population of the LGAs within the EMPHN catchment (PHIDU, 2020)

RANK	LGA	2020 ERP aged > 50 years	% aged > 50 years of overall ERP
1	Whittlesea (C)	64,923	27.4
2	Boroondara (C)	64,142	35.0
3	Monash (C)	62,730	31.9
4	Whitehorse (C)	60,522	33.5
5	Knox (C)	58,740	35.6
6	Yarra Ranges (S)	57,707	36.1
7	Manningham (C)	51,438	39.9
8	Banyule (C)	47,034	35.6
9	Maroondah (C)	40,867	34.2
10	Nillumbik (S)	24,146	37.0
11	Mitchell (S)	6,158	32.6
12	Murrindindi (S)	1,969	48.1
EMPHN CATCHMENT		**540,376**	**33.9**
VICTORIA		**2,211,211**	**33.0**

As shown in **Table 1** above, Whittlesea and Boroondara have the largest population of older adults at 64,923 and 64,142 respectively. The populations of Murrindindi (1,969) and Mitchell (6,158) that fall within the EMPHN catchment are significantly lower than the rest of the region. However, the proportion of older adults in Murrindindi was almost half the overall total population.

Note: All references to Murrindindi and Mitchell are related to the proportion of the area that falls within the EMPHN catchment.

Identified need	Key issue	Evidence
Need		
Projected growth in the proportion of people aged 50 years and over within the region	The proportion of older adults in the EMPHN catchment is projected to grow substantially in the next decade indicating an increased need for aged care services in the future.	Consistent with the trends in population ageing occurring across Australia, the older population within the EMPHN region is expected to increase significantly by 2036 (see **Table 2**). **Table 2**. 2036 Projected Resident Population of the LGAs aged >50 years (Victoria in Future, 2019 & PHIDU,2020)

RANK	LGA	Projected ERP 2036	% Change in ERP of residents aged >50 years (2020 vs. 2036)
1	Murrindindi (S)	8,997	357.0
2	Mitchell (S)	27,815	351.7
3	Whittlesea (C)	109,334	68.4
4	Maroondah (C)	53,334	30.5
5	Monash (C)	81,033	29.2
6	Knox (C)	74,453	26.8
7	Yarra Ranges (S)	72,324	25.3
8	Whitehorse (C)	73,966	22.2
9	Banyule (C)	57,414	22.1
10	Nillumbik (S)	29,116	20.6
11	Manningham (C)	61,420	19.4
12	Boroondara (C)	74,395	16.0
EMPHN CATCHMENT		**723,601**	**191.0**
VICTORIA		**3,039,673**	**37.5**

The greatest increases are expected in Murrindindi (357% increase) and Mitchell (351.7% increase); however, their total population will remain well below those in other LGAs. In comparison to the median projected population (72,324), Whittlesea is set to grow significantly with a projected population of 109,334.

Identified need	Key issue	Evidence
Need		
Under serviced/ priority community groups	Older adults with **low levels of literacy, including those from a culturally and linguistically diverse background,** experience significant barriers accessing services due to the challenges in accessing appropriate information. These barriers are manifold and can be individual, cultural, structural, or service-related and can include poorer literacy and numeracy, language barriers, and lower health literacy. This cohort also generally experiences poorer health outcomes due to lower rates of health literacy, which impedes their capacity to access, understand and make effective decisions about their health.	There were two key data indicators used to potentially assess low levels of health literacy. Across both indicators, older people residing within **Whittlesea** experience the highest levels of low literacy. This is further described below. **1. Low health literacy levels in culturally and linguistically diverse backgrounds** The proportion of older adults born overseas with poor English proficiency as a percentage of the resident population is highest in Whittlesea (20.6%), Monash (14.1%) and Manningham (11.8%). These figures are notably higher than the Victorian average (7.8%). As shown in **Table 3** below, these rates are also significantly higher than those reported for other LGAs within the EMPHN catchment. Notably, the lowest proportion of residents with poor English proficiency came from 0.6% of Murrindindi and Mitchell (1.0%). **Table 3.** The proportion of residents born overseas who report poor English proficiency (PHIDU, 2016)

RANK	LGA	% of ERP born overseas who report poor proficiency in English aged >65 (2016)	No. of people born overseas in non-English speaking countries aged > 65 years
1	Whittlesea (C)	20.6	55.5
2	Monash (C)	14.1	44.7
3	Manningham (C)	11.8	44.0
4	Whitehorse (C)	10.1	31.9
5	Boroondara (C)	6.3	26.7
6	Knox (C)	6.0	29.8
7	Banyule (C)	5.3	25.7
8	Maroondah (C)	3.4	17.6
9	Nillumbik (S)	1.5	17.4
10	Yarra Ranges (S)	1.4	15.8
11	Mitchell (S)	1.0	11.1
12	Murrindindi (S)	0.6	7.6
EMPHN CATCHMENT AVERAGE		**8.7**	**32.5**
VICTORIAN AVERAGE		**7.8**	**27.4**

The top five languages, other than English, spoken within the top five LGAs with the highest proportion of residents aged over 65 years with poor English proficiency are highlighted in **Table 4.** The most common language, with the exception of Whittlesea, spoken across the top five LGAs was Chinese.

Identified need	Key issue	Evidence
Need		
Under serviced/ priority community groups (cont)		**Table 4.** Top 5 languages spoken in EMPHN overall and the top 5 LGAs with the highest proportion of residents with poor English proficiency (ABS, 2019)

	EMPHN	Whittlesea	Monash	Manningham	Whitehorse	Boroondara
1	Chinese (35.4%)	Indo Aryan (35.2%)	Chinese (75.3%)	Chinese (35.4%)	Chinese (68.2%)	Chinese (42.7%)
2	Indo Aryan (12.5%)	Macedonian (23.7%)	Indo Aryan (25.6%)	Indo Aryan (12.5%)	Indo Aryan (13.3%)	Greek (10.4%)
3	Other (9.8%)	Arabic (23.2%)	Greek (20.8%)	Other (9.8%)	Greek (9.0%)	Indo Aryan (9.0%)
4	Greek (9.7%)	Italian (23.0%)	Other (13.5%)	Greek (9.7%)	Other (8.0%)	Other (6.1%)
5	Italian (8.0%)	Other (21.3%)	Italian (7.7%)	Italian (8.0%)	Italian (4.9%)	Italian (6.1%)

Qualitative data commentary:

All stakeholders consulted also reflected these findings. Stakeholders suggested that various CALD backgrounds are reflected in the community (including both newly arrived individuals and families, and those who have lived in Australia for some time but have reverted to solely using their first language once their adult children have left home) and their needs are seldom met by the current service providers.

For example, many stakeholders discussed the need for increased, enhanced interpretive services to meet various CALD backgrounds, and for community supports and services to improve their cultural safety generally.

2. Low health literacy levels in the broader population aged 50 years and over

The data indicator related to the rate per 100 people aged > 65 years who left school at Year 10 or below has been used as another proxy to measure the level of health literacy. Older adults with low literacy levels most commonly reside in Whittlesea (64.4 per 100 people), Mitchell (54.9 per 100 people), and Murrindindi (47.9 per 100 people). In Whittlesea and Mitchell, the rate is higher than the Victorian average (48.7 per 100 people).

Across the other LGAs within the EMPHN region, the rate is relatively consistent with the Victorian average, the only outlier is Boroondara which has a significantly lower rate of 25.5 per 100 people (see Table 5).

Identified need	Key issue	Evidence
Need		
Under serviced/ priority community groups (cont)		**Table 5.** Proportion of older adults who left school at Year 10 or below (PHIDU, 2016)

RANK	LGA	ASR per 100 people aged >65 who left school at Year 10 or below or did not go to school
1	Whittlesea (C)	64.4
2	Mitchell (S)	54.9
3	Murrindindi (S)	47.9
4	Knox (C)	47.3
5	Yarra Ranges (S)	47.2
6	Banyule (C)	46.7
7	Maroondah (C)	44.4
8	Monash (C)	44.0
9	Manningham (C)	43.9
10	Nillumbik (S)	41.6
11	Whitehorse (C)	40.8
12	Boroondara (C)	25.5
EMPHN CATCHMENT AVERAGE		**44.4**
VICTORIAN AVERAGE		**48.7**

Qualitative data commentary:

Stakeholders suggested that a significant barrier to engaging with services (and the My Aged Care system), is due to lack of understanding of what aged care services are, and subsequent ability to navigate the system more generally. For example, many stakeholders reflected on the need to educate both individuals and families on what constitutes aged care services, how to access services, and continue to support them through significant service wait times to ensure they do not fall between the cracks. Further, many stakeholders suggested individuals may not find technology accessible, and may therefore avoid telehealth consultations, or find it difficult to engage through this method.

Identified need	Key issue	Evidence
Need		
Under serviced/ priority community groups	**Aboriginal and Torres Strait Islander** individuals have a higher burden of disease rate than non-Indigenous Australians. This means there is a high demand for services within this community. They also experience barriers in accessing culturally appropriate services. This is often compounded by linguistic barriers and the challenges of accessing services in remote locations.	Approximately, 0.3% of EMPHN's population aged > 50 years (or 1,814 residents) identifies as being of Aboriginal and Torres Strait Islander descent. This is less than the state average of 2.3%. The total number of residents within the EMPHN catchment that identify as Aboriginal and Torres Strait Islander is 9,011. The estimated resident Aboriginal and Torres Strait Islander populations are largest in Yarra Ranges (356 residents), Whittlesea (351 residents), and Banyule (200 residents). The estimated population in the remaining nine LGAs is less than half of the top-ranking LGA (see **Table 6**). **Table 6.** Aboriginal and Torres Strait Islander Resident Population (PHIDU, 2020)

Rank	LGA	ERP2020 Estimated Residents Poulation who identify as Aboriginal and Torres Strait Island aged >50	Aboriginal and Torres Strait Island poulation aged >50 years of the total poulation aged >50
1	Mitchell (S)	125.8	0.9
2	Murrindindi (S)	58.0	0.8
3	Yarra Ranges (S)	356.3	0.6
4	Whittlesea (C)	351.2	0.6
5	Banyule (C)	200.3	0.4
6	Maroondah (C)	160.5	0.4
7	Knox (C)	170.5	0.3
8	Whitehorse (C)	136.7	0.2
9	Nillumbik (S)	51.4	0.2
10	Monash (C)	86.6	0.1
11	Boroondara (C)	70.7	0.1
12	Manningham (C)	46.3	0.1
	EMPHN CATCHMENT TOTAL/AVERAGE	1814.4	0.3

Qualitative data commentary:

Most stakeholders consulted also reflected these findings. Stakeholders suggested that many Aboriginal and Torres Strait Islander peoples are living in the community, and their needs are seldom met by the current service model.

Further, stakeholders suggested that some Aboriginal and Torres Strait Islander individuals have had negative experiences with services, which highlights the importance of trust and the provision of services that are culturally safe. Many Aboriginal and Torres Strait Islander individuals in this population will seek out services and community supports that are culturally safe and Indigenous-specific.

Identified need	Key issue	Evidence
Need		
Under serviced/ priority community groups	Members of the **LGBTI+ community** generally experience poorer mental and physical health than non-LGBTI+ Australians. They also face increased discrimination and social isolation, which has reinforced the invisibility of LGBTI+ individuals within aged care services. As such, they represent a key priority group for Care Finder services.	The proportion of LGBTI+ individuals living in the EMPHN catchment is relatively consistent with the Victorian average (5.7% of residents). Whittlesea (6.8%) and Whitehorse (6.3%) have the highest number of LGBTI+ identifying individuals (see **Table 7**). Manningham has a considerably lower proportion of LGBTI+ residents (1.5%) than the other LGAs with the next smallest being Maroondah (3.3%). **Table 7.** Proportion of the resident population in each LGA that identify as LGBTI+ ranked from highest to lowest (Victorian Population Health Survey, 2017) **Qualitative data commentary:** In consultation with an LGBTI+ specific organisation operating in the EMPHN catchment, it was suggested that individuals identifying as LGBTI+ may not engage with LGBTI+ services/organisations due to a general fear that the service may 'out' them, or they may feel unsafe. Many individuals may also perceive the service as being particularly suited to a younger person, rather than their age group.

RANK	LGA	% of ERP that identify as LGBTI+
1	Whittlesea (C)	6.8
2	Whitehorse (C)	6.3
3	Knox (C)	6.1
4	Banyule (C)	5.7
5	Mitchell (S)	5.7
6	Murrindindi (S)	5.7
7	Boroondara (C)	4.7
8	Monash (C)	4.7
9	Nillumbik (S)	4.6
10	Yarra Ranges (S)	4.2
11	Maroondah (C)	3.3
12	Manningham (C)	1.5
EMPHN CATCHMENT AVERAGE		**4.9**
VICTORIAN AVERAGE		**5.7**

Identified need	Key issue	Evidence
Need		
Under serviced/ priority community groups	**Individuals experiencing homelessness** face a higher risk of mental and physical health problems and often experience an earlier onset of health problems including chronic conditions. They are also often isolated from family members and others in the community. Older persons experiencing homelessness also encounter a number of unique challenges to accessing services including a lack of medical records and interaction with the health system along with a mistrust of healthcare professionals.	The proportion of individuals experiencing homelessness is relatively low across the EMPHN catchment, in comparison to the state average (0.2%). The Yarra Ranges (0.2%), Maroondah (0.1%), and Monash (0.1%) have the highest proportion of older adults experiencing homelessness (see **Table 8**). There are no notable outliers within the dataset. **Table 8**. Proportion of the population aged over 65 years experiencing homelessness ranked from highest to lowest (PHIDU, 2016) **Qualitative data commentary:** A number of stakeholders consulted who support people experiencing homelessness raised the issue of premature ageing for this population. They described people experiencing health issues that are consistent with the ageing process, much earlier in their lives, highlighting the need for aged care services to be available to this group of people aged under 65.

RANK	LGA	% of ERP aged >65 years who were homeless as a proportion of total persons aged >65 (2016)	No. of older adults experiencing homelessness
1	Yarra Ranges (S)	0.2	40
2	Maroondah (C)	0.1	24
3	Monash (C)	0.1	33
4	Whitehorse (C)	0.1	22
5	Boroondara (C)	0.1	26
6	Mitchell (S)	0.1	10
7	Murrindindi (S)	0.1	4
8	Whittlesea (C)	0.1	20
9	Knox (C)	0.1	19
10	Banyule (C)	0.1	15
11	Nillumbik (S)	0.1	5
12	Manningham (C)	0.1	10
EMPHN CATCHMENT AVERAGE/TOTAL		**0.1**	**228**
VICTORIAN AVERAGE/TOTAL		**0.2**	**1,489**

Identified need	Key issue	Evidence
Need		
Under serviced/ priority community groups	Older adults with **low socio-economic status** are faced with poorer health outcomes and a heavier burden of disease than other older adults. This is compounded by the many barriers that they face in accessing timely and appropriate care.	The Socio-Economic Indexes for Areas (SEIFA) ranks areas across Australia according to different Census variables, including income, education levels, employment, and housing conditions. The Index of Relative Socio-economic Disadvantage is a general socio-economic index that summarises a range of information about the economic and social conditions of people and households within an area. A low score indicates relatively greater disadvantage, and high scores indicate a relative lack of disadvantage. The results in **Table 9** highlight the variation of SEIFA IRSD across the LGAs in the catchment and suggests that the outer eastern suburbs of Whittlesea (991), Murrindindi (IRSD 996), and Mitchell (IRSD 997) experience greater levels of disadvantage. Nillumbik, with an IRSD score of 1,099 was found to have the least disadvantage, just below the Victorian average (1,010). **Table 9.** IRSD score for each LGA ranked from most to least disadvantaged (PHIDU, 2016)

RANK	LGA	SEIFA IRSD (2016)
1	Whittlesea (C)	991
2	Murrindindi (S)	996
3	Mitchell (S)	997
4	Yarra Ranges (S)	1,040
5	Monash (C)	1,044
6	Maroondah (C)	1,045
7	Knox (C)	1,048
8	Whitehorse (C)	1,049
9	Banyule (C)	1,055
10	Manningham (C)	1,066
11	Boroondara (C)	1,097
12	Nillumbik (S)	1,099
EMPHN CATCHMENT AVERAGE		**1,048**
VICTORIAN AVERAGE		**1,010**

Identified need	Key issue	Evidence
Need		
Under serviced/ priority community groups	Older adults who qualify as **renters, living alone with a disability, and low income** experience co-occurring risk factors that lead to poorer health outcomes. They also experience significant financial, social and physical barriers to accessing aged care services. The highest proportion of older adults experiencing co-occurring risk factors live in Banyule and Maroondah.	**Table 10** shows the proportion of older adults in each LGA that experience co-occurring risk factors (factors are renters, living alone with a disability, and low income). The top three LGAs are all located in the south of the catchment area at Banyule (0.5% of the population), Maroondah (0.5% of the population), and Whitehorse (0.4% of the population). Conversely, the lowest ranked LGAs are Yarra Ranges (0.2%), Manningham (0.2%), and Nillumbik (0.2%). All LGAs are under the state average of 0.6% who experience co-occurring risk factors (i.e., renters, living alone, with a disability, low income). **Table 10.** The proportion of each LGA whose population experience co-occurring risk factors (i.e., renters, living alone, with a disability, low income) (PHIDU, 2016)

RANK	LGA	% of ERP who experience co-occurring risk factors (renters, living alone, with a disability, low income) aged >65	No. of residents who experience co-occurring risk factors (renters, living alone, with a disability, low income) aged >65
1	Banyule (C)	0.5	105
2	Maroondah (C)	0.5	79
3	Whitehorse (C)	0.4	104
4	Knox (C)	0.4	84
5	Mitchell (S)	0.4	8
6	Monash (C)	0.3	91
7	Boroondara (C)	0.3	77
8	Whittlesea (C)	0.3	55
9	Murrindindi (S)	0.2	2
10	Nillumbik (S)	0.2	16
11	Manningham (C)	0.2	41
12	Yarra Ranges (S)	0.2	33
EMPHN CATCHMENT AVERAGE/TOTAL		**0.3**	**651**
VICTORIAN AVERAGE/TOTAL		**0.6**	**4,774**

Qualitative data commentary:

Most stakeholders suggested that many individuals live alone, reflecting these findings. As a result, individuals may be significantly isolated both socially, and by way of literal proximity of their property from neighbours/the community.

Some stakeholders also suggested that individuals who live alone may wish to continue to do so but require significant support from services to do this successfully. Some stakeholders also commented that some individuals who live alone, particularly in rural areas, are unlikely to reach out for support and are less likely to accept support when offered.

Identified need	Key issue	Evidence
Need		
Need based on the number of individuals in permanent residential aged care	**Maroondah** and **Monash** had the highest number of residential aged care places. We need to further our understanding of residential aged care availability across the catchment.	**Table 11** outlines the number of residential aged care places available per 1,000 population aged > 70 years. The highest number of places relevant to population size was found in Maroondah, with 94.9 places per 1,000 population, which was 22% higher than the state average. High rates were also found in Monash (92.1) and Manningham (91.7). In contrast, the least number of residential aged care places were found in Mitchell and Yarra Ranges with 50.3 and 50.7 places per 1,000 population aged > 70 years respectively. **Table 11.** The number of residential aged care places available per 1,000 population aged > 70 years ranked from highest to lowest (PHIDU, 2020)

RANK	LGA	No. of residential aged care places available per 1,000 population aged >70 years
1	Maroondah (C)	94.9
2	Monash (C)	92.1
3	Manningham (C)	91.7
4	Boroondara (C)	87.9
5	Knox (C)	85.8
6	Whitehorse (C)	84.2
7	Nillumbik (S)	83.7
8	Banyule (C)	82.3
9	Whittlesea (C)	76.4
10	Murrindindi (S)	52.4
11	Yarra Ranges (S)	50.7
12	Mitchell (S)	50.3
EMPHN CATCHMENT AVERAGE		**82.6**
VICTORIAN AVERAGE		**77.6**

Identified need	Key issue	Evidence
Need		
Potentially preventable hospitalisations for acute and chronic conditions	The rate of **potentially preventable hospitalisations** for acute and chronic conditions by older adults provides an indication of the extent to which the needs of older adults within these regions is not being met through primary and community health care services.	The top LGA rankings for the rates of potentially preventable hospitalisations for acute and chronic conditions is not consistent. The top three LGAs reporting the highest levels of potentially preventable chronic hospitalisations are Whittlesea (1,056 per 100,000 population), Mitchell (888 per 100,000 population), and Banyule (867 per 100,000 population). With the exception of Banyule (392 per 100,000 population), this does not align with the top three LGAs for acute conditions, which include Maroondah (380) and Knox (374). However, the bottom two LGAs with the lowest rates of hospitalisations of chronic and acute conditions was the same across both indicators. Boroondara had the lowest rate for both categories (332 chronic and 187 acute hospitalisations), followed by Nillumbik (509 chronic and 263 acute hospitalisations per 100,000 persons) (see **Tables 12 and 13**). **Tables 12 and 13.** Rate of potentially preventable hospitalisations for acute and chronic conditions within each LGA ranked from highest to lowest (VAED via POLAR, 2019 - 2020)

RANK	LGA	ASR per 100,000 population aged >50 years of potentially preventable hospitalisations for acute conditions
1	Banyule (C)	392
2	Maroondah (C)	380
3	Knox (C)	374
4	Whittlesea (C)	360
5	Murrindindi (S)	345
6	Yarra Ranges (S)	342
7	Manningham (C)	308
8	Whitehorse (C)	304
9	Monash (C)	280
10	Mitchell (S)	265
11	Nillumbik (S)	263
12	Boroondara (C)	187

RANK	LGA	ASR per 100,000 population aged >50 years of potentially preventable hospitalisations for chronic conditions
1	Whittlesea (C)	1056
2	Mitchell (S)	888
3	Banyule (C)	867
4	Maroondah (C)	822
5	Knox (C)	821
6	Yarra Ranges (S)	786
7	Murrindindi (S)	755
8	Whitehorse (C)	677
9	Manningham (C)	677
10	Monash (C)	674
11	Nillumbik (S)	509
12	Boroondara (C)	332

Identified need	Key issue	Evidence
Need		
ED presentations for chronic diseases	The rate of **ED presentations** for the most common principal diagnoses in older adults admitted to hospital is generally highest in **Banyule** and **Whittlesea**. This is evidence of need potentially not being met or managed within primary care or the community and an indication of where services may be required.	The rate of ED presentations by older adults is highest in Banyule (3,755 per 100,000 population), Whittlesea (3,534 per 100,000 population), and Knox (3,377 per 100,000 population). Across the five most common principle diagnoses (digestive disorders, respiratory disorders, cardiovascular disease, musculoskeletal disorders, and genitourinary disorders), Banyule and Whittlesea consistently rank as either the highest or second highest LGA indicating unmet demand for services in these two regions. The lowest ranked LGAs by ED presentations are Murrindindi and Mitchell with 450 and 947 per 100,000 population respectively (see **Table 14**). As with the top ranked LGAs, Murrindindi and Mitchell generally are rated either lowest or second lowest across all five principal diagnoses. **Table 14**. Rate of ED presentations within each LGA by persons aged over 50 years, ranked highest to lowest (VEMD via POLAR, 2021)

RANK	LGA	ASR per 100,000 population of ED presentations by persons aged > 50 years (2021)	ASR per 100,000 population of ED presentations by persons aged >50 years for cardiovascular disease (2019-2020)	ASR per 100,000 population of ED presentations by persons aged > 50 years for respiratory disorders (2019-2020)	ASR per 100,000 population of ED presentations by persons aged > 50 years for digestive disorders (2019-2020)	ASR per 100,000 population of ED presentations by persons aged > 50 years for musculoskeletal disorders (2019-2020)	ASR per 100,000 population of ED presentations by persons aged > 50 years for genitourinary disorders (2019-2020)
1	Banyule (C)	3755	67	266	422	531	169
2	Whittlesea (C)	3534	64	287	475	493	183
3	Knox (C)	3377	38	227	441	538	127
4	Yarra Ranges (S)	3271	43	226	390	539	124
5	Manningham (C)	3193	69	237	367	513	130
6	Maroondah (C)	2952	43	226	328	542	119
7	Whitehorse (C)	2866	45	198	331	432	100
8	Nillumbik (S)	2614	55	170	264	335	131
9	Boroondara (C)	1911	25	116	189	233	64
10	Monash (C)	1689	24	114	196	279	66
11	Mitchell (S)	947	4	100	168	104	32
12	Murrindindi (S)	450	15	33	44	58	7

Identified need	Key issue	Evidence
Need		
ED presentations for chronic diseases	The rate of **ED presentations** for the most common principal diagnoses in older adults admitted to hospital is generally highest in **Banyule** and **Whittlesea**. This is evidence of need potentially not being met or managed within primary care or the community and an indication of where services may be required.	Regarding the rate of ED presentations for mental and behavioural disorders (see **Table 15**), Banyule again ranks highest with 781.9 per 100,000 population, followed by Maroondah with 717.10 per 100,000 population. This is higher than the Victorian average of 679.3. In line with this, the lowest ranked LGAs were Nillumbik (521 per 100,000 population) and Boroondara (549.7 per 100,000 population). **Table 15.** Rate of ED presentations within each LGA by persons over 65 years, ranked highest to lowest (PHIDU)

RANK	LGA	ASR per 100,000 population of ED presentations by persons aged > 65 years for mental and behavioural disorders
1	Banyule (C)	781.9
2	Maroondah (C)	717.1
3	Manningham (C)	713.4
4	Whittlesea (C)	712.8
5	Yarra Ranges (S)	686.5
6	Knox (C)	669.8
7	Murrindindi (S)	655.6
8	Whitehorse (C)	638.1
9	Mitchell (S)	623.8
10	Monash (C)	597.7
11	Boroondara (C)	549.7
12	Nillumbik (S)	521.0
EMPHN CATCHMENT AVERAGE		**661.8**
VICTORIAN AVERAGE		**679.3**

Identified need	Key issue	Evidence
Need		
Unmet Need (representing the Composite Index Score)		
Overall **need** for aged care services across the EMPHN catchment based on demographic factors	Considering all demographic indicators and at-risk groups, **Whittlesea**, **Yarra Ranges**, and **Mitchell** rank as having the highest level of need for Care Finder Services within the EMPHN catchment.	As noted in Section 1, a Composite Index Score (CIS) was calculated to measure the potential unmet need for Care Finder Services across the EMPHN catchment and is composed of 12 demographic indicators). Whittlesea ranked significantly higher than all other LGAs with a score of 14.0% (representing the relative proportion of need when compared to the other LGAs in the EMPHN catchment). This is to be expected given this LGA has the highest proportion of Aboriginal and Torres Strait Islander, CALD, and LGBTI+ individuals along with the lowest IRSD score. It is also expected to have significant growth in the population aged > 50 years over the next 10 years and beyond. Yarra Ranges was the second highest ranked LGA with a score of 10.6%, as it ranked near the top on most indicators. The LGA with the lowest unmet demand score was Nillumbik (6.0%) as this region consistently ranked near the bottom (see **Table 16).** **Table 16.** Unmet Need CIS Index Scores for each LGA ranked from highest to lowest

RANK	LGA	% of Need
1	Whittlesea (C)	14.0
2	Yarra Ranges (S)	10.6
3	Mitchell (S)	9.6
4	Knox (C)	9.5
5	Banyule (C)	9.5
6	Monash (C)	9.5
7	Whitehorse (C)	9.4
8	Maroondah (C)	9.2
9	Murrindindi (S)	8.7
10	Boroondara (C)	7.6
11	Manningham (C)	7.0
12	Nillumbik (S)	6.0

Identified need	Key issue	Evidence
Need		
Overall **demand** for aged care services across the EMPHN catchment	Considering all unmet service demand-related indicators, the LGAs of **Whittlesea, Banyule, and Knox** rank as having the highest unmet demand for primary services within the EMPHN catchment.	The CIS for the overall demand for Care Finder Services consists of nine indicators relating to potentially preventable hospitalisations and ED presentations by people aged over 50 years. In line with the results noted above regarding the top and bottom-ranked LGAs for ED presentations, Whittlesea and Banyule are the top-ranked LGAs with scores of 12.0% and 11.5% respectively. This is higher than the next highest LGA, Knox (9.9%). This is demonstrated in **Table 17** Again, consistent with the results described above, Murrindindi ranked the lowest on the unmet demand index with a score of 4.7% (driven by the small population in this LGA) and Boroondara ranked second lowest with a score of 5.1% (driven by the high levels of services available in this LGA). **Table 17**. Demand CIS Index Scores for each LGA, ranked from highest to lowest

RANK	LGA	% of Demand
1	Whittlesea (C)	12.0
2	Banyule (C)	11.5
3	Knox (C)	9.9
4	Manningham (C)	9.7
5	Yarra Ranges (S)	9.5
6	Maroondah (C)	9.5
7	Whitehorse (C)	8.4
8	Nillumbik (S)	8.0
9	Monash (C)	6.3
10	Mitchell (S)	5.5
11	Boroondara (C)	5.1
12	Murrindindi (S)	4.7

Identified need	Key issue	Evidence
Need		
Combined index of overall **need and demand** for aged care services across the EMPHN catchment	Taking into account overall need and demand for services within the EMPHN catchment **Whittlesea** is rated as the region with the **greatest need** for Care Finder services followed by the **Yarra Ranges and Banyule.**	The CIS results for each LGA in the EMPHN catchment are outlined in **Table 18** below. The LGA that has been identified as having the highest need and demand is Whittlesea, representing 12.4% of the total CIS. This is due to it being ranked as having the highest need and demand of all LGAs within the EMPHN catchment. The next two LGAs with the highest CIS scores are the Yarra Ranges (9.6%) and Banyule (9.6%). Note that the raw index scores for need and demand have been included in Table 18 to demonstrate how this feed into the total composite score. **Table 18.** CIS for Care Finder Need and Demand in the EMPHN catchment

RANK	LGA	CF Need Index	CF Demand Index	Composite Score	% of Composite Score
1	Whittlesea (C)	0.1505	0.0733	0.224	12.4
2	Yarra Ranges (S)	0.1156	0.0582	0.174	9.6
3	Banyule (C)	0.1032	0.0704	0.174	9.6
4	Knox (C)	0.1056	0.0602	0.166	9.2
5	Maroondah (C)	0.0984	0.0581	0.156	8.7
6	Whitehorse (C)	0.1044	0.0511	0.155	8.6
7	Monash (C)	0.1061	0.0383	0.144	8.0
8	Manningham (C)	0.0795	0.0593	0.139	7.7
9	Mitchell (S)	0.0964	0.0334	0.130	7.2
10	Boroondara (C)	0.0873	0.0314	0.119	6.6
11	Murrindindi (S)	0.0867	0.0288	0.115	6.4
12	Nillumbik (S)	0.0640	0.0487	0.113	6.2

Stakeholder Consultations

Complementing the outcomes from the quantitative analysis noted above, the following table contains additional outcomes that emerged from the analysis of the stakeholder consultations.

Identified need	Key issue	Evidence
Engagement and rapport building with clients.	Older adults in the region have **needs left unaddressed** in circumstances where **investigation into the client's home life is unable to be completed in person.** This was noted as a particular issue arising from the COVID-19 pandemic, as well as the use of telehealth/phone consults with clients.	Many stakeholders noted that in many circumstances clients did not want to acknowledge their own needs (for example, stating 'I'm fine', and subsequently avoiding further interaction), or the home showing significant areas of unmet needs. These individuals may want to maintain their independence but require services to assist them to navigate this process successfully. Where these situations arise, most stakeholders noted the importance that investigation of a person's circumstances are completed in-person (see 'Need' set out in the next row) and include a carer, advocate, or family member (where available). This is because observing a person's individual circumstances, and hearing from a trusted person who may observe things about the person's needs, can inform a broader view of the person's circumstances and needs. Stakeholders also identified that in-person engagement will also provide further evidence on the role that a carer might play in supporting an individual, as well as any unique needs that the carer may have that require a response and/or intervention. Stakeholders supporting people who are at risk of, or experiencing homelessness, particularly noted that it can take significant time over multiple occasions of service, to effectively engage and build rapport. This was also highlighted in co-design workshops with COTA Australia, in presentations from a range of providers delivering navigation support. With respect to face-to-face outreach, one stakeholder comprehensively described their initial engagement by phone, which was significantly extended during the pandemic, and how they achieved effective engagement with older people at risk. This highlighted the potential for using both in-person and telehealth engagement methods, given staff receive an appropriate level of training and guidance in how to do this effectively.

Identified need	Key issue	Evidence
Engagement and rapport building with clients.	**Face-to-face assertive outreach** is required in the home or other familiar environments.	In general, many older adults are hesitant to engage in telehealth/phone consultations regarding their health/mental health needs. This may be due to: • Reluctance to, or difficulty with using new technology • Reluctance to share information over the phone/telehealth • Older adults from CALD backgrounds experiencing barriers impacting their ability to advocate for themselves, or speak to their own health/mental health concerns or living situation. For many providers consulted, telehealth/phone consults do not paint a holistic picture of the individual, leading to overlooked/ 'hidden' health/mental health issues. An example that several stakeholders noted was that remote assessments do not allow for evidence to be gathered at the home, particularly where individuals live alone. Further evidence shared via the stakeholder consultations regarding the need for face to face assertive outreach in the home or other familiar environments shows: • Many older adults reported by stakeholders as living in squalor, and showing evidence of hoarding • Many older adults wish to be 'left alone' (either to live independently or reluctant to accept services) despite needing assistance • Individuals require visits during significant wait times for services, to avoid falling between the cracks in this period • Telehealth/phone consults to conduct mental health assessments may be inadequate to address complex needs • In circumstances where individuals need assistance outside of the home (e.g., socialisation/social events or to be assessed), face to face options comfortable for the client (e.g., park/public place/allowing a carer or family member to attend) may allow them greater opportunity to engage • Individuals are reluctant to use technology (or have difficulty using technology) to learn about, or engage with, services • Due to COVID-19, many individuals in the region have not been visited by either services or family in (up to) years, leading to degradation of the home and swift health deterioration (e.g., personal care visits provided by a service provider have decreased from typically 3 times per week to 1 time per week). In contrast to reports from a number of providers, as previously noted, one particular provider noted their ability to engage with people using remote methods, which indicates the potential for other providers to explore these opportunities.

Identified need	Key issue	Evidence
Engagement and rapport building with clients.	**Issues relating to transport** prevent older adults from accessing services.	It was reported by the majority of stakeholders that transport issues for individuals prevent them from accessing or engaging with services on a regular basis, and put them at risk of falling off the radar. Further evidence regarding transport concerns shows: • Services may not be in close proximity to those living remotely, particularly those living in the bush/semi-rural areas. Individuals without familial/carer assistance are further isolated. • Transport to access services may be prohibitively costly. • Specific areas without a physical presence of health services may lead to a lack of engagement.
Limited ability to access services.	**Long wait times to access services** were reported by the majority of stakeholders, and it was reflected that these circumstances lead to many clients falling between the cracks and/or not receiving the care they need.	Evidence regarding **service wait times** shows: • Individuals from the Target Cohort may not regularly engage with a general practitioner, putting them at risk whilst waiting for services. • Individuals may choose not to seek help for non-acute medical situations (which can lead to a crisis point) • Individuals without an existing medical record are at risk of 'falling off the radar' whilst waiting for services • Many services do not provide for advanced bookings (and are not incentivised to do so) • Where a GP is involved in the process, service providers reported that they may experience difficulty interacting with My Aged Care, which may impact their active follow up with this system, on behalf of the individual needing support • Quality of referrals may differ significantly, affecting the service process for an individual, and increased wait times
Limited ability to access services.	**Contacting service providers** on behalf of clients was identified as a key enabler to ensure client engagement with the aged care system.	Most stakeholders reported that clients may be apprehensive about engaging in services, potentially due to prior negative experiences. In most circumstances, **contacting service providers on behalf of clients** is necessary to ensure needs are being met. Most stakeholders reported that clients may have a) had varied experiences with services; b) experience confusion on how to engage/follow up services; c) no prior engagement with services and are fearful of what aged care services mean for changes in their lives, for example, entering a nursing home when that's not the outcome a person wants. Further evidence regarding **contacting service providers on behalf of clients:** • Individuals may not have a strong advocate, families/children acting for them. • Fear that service will 'out' them, or that they may feel unsafe. • Reluctance to engage with LGBTI+ specific services, as many individuals perceive them as being suited for a 'younger' person. • Individuals may be unresponsive to services where they perceive a lack of empathy regarding their trauma • Individuals may feel that they will not be validated or believed when engaging in services • Individuals may be disenfranchised from the community generally • Individuals may be distrustful of government and services generally • Cultural/language barriers may lead to misunderstandings and difficulties in engaging.

Identified need	Key issue	Evidence
Support and **guide clients through assessment,** and support to **help people find and stay connected with aged care services.**	Support to **find aged care services, navigate the system,** and **remain connected with aged care services**	Stakeholders reported that individuals (and services) require considerable help to navigate the system and engage (and remain connected to) services, due primarily to language/cultural barriers and system complexity (including My Aged Care). Stakeholders supporting people at risk, particularly those at risk or experiencing homelessness, also noted that it can take significant time to build trust and rapport, in order to effectively connect the person to services, and sustain that connection. Many stakeholders noted that most individuals (and services) do not know how to navigate My Aged Care. It was suggested that information in plain language, improved interpretation services and educating clients, families, and services on navigating the system would be highly beneficial, given most referrals go through the My Aged Care system. Further, most stakeholders referred to the need for connections within the community at the local level as being essential to successfully address needs amongst the target population. Further evidence regarding **support to find aged care services and navigate the system:** • CALD communities may have a lower health literacy/limited understanding of the system, and a high reliance on family to provide support. • Many referrals go through the My Aged Care system. • Clients are from a diverse range of CALD backgrounds (Vietnamese; Greek; Italian; Turkish; Iraqi; Arabic); are newly individuals/families; or do not have extended family to help them navigate the system). • Men may be more resistant to engage with services and may present with poorer health/greater needs. • Clients may have cognitive impairment. • Clients may not have advocacy support from families. • Clients may not have any form of 'connection' within the community to guide them to services • Clients may feel disengaged from services that do not communicate in a way that is easily understood or with staff who are unable to communicate in a person-centered way. • Particular services may not 'fit' with people's traditional ways of operating (e.g., family/community assistance, and 'village wisdom') • Clients may fear being 'locked away' or institutionalised if they engage with services on their own behalf • Clients may have a sense of pride preventing them from engaging with services • Aboriginal and Torres Strait Islander individuals are under-serviced at present, and more likely to engage with First Nations-specific and culturally safe services • Aboriginal and Torres Strait Islander individuals may not trust services, or fear what they mean in relation to changing their lives and have difficulty engaging with a service plan.

Identified need	Key issue	Evidence
Support and **guide clients through assessment,** and support to **help people find and stay connected with aged care services.**	Many clients may require **warm handover to relevant supports within the community**	Most stakeholders noted that members of the community; families; local councils; and some general practitioners, currently provide referrals for services. Stakeholders noted that when individuals move between services it is critical that service providers work collaboratively to ensure a warm handover. Stakeholders noted that such warm handovers offer numerous benefits, including: • Ensuring individuals move effectively between services (and do not fall between cracks) • Building effective engagement, trust, and rapport between the individual and the new service provider
Integration of Care Finders into the **local community**	Care Finders need to be engaged with **aged care, health, non-health, and community services** to be able to respond to the holistic needs of individuals from the Target Cohort.	Stakeholders reported that individuals from the Target Cohort often present with a variety of needs that span beyond the aged care sector and can include needs related to **health, non-health, and community services.** Stakeholders reported that these needs may include: • Accessing health services • Accessing rent-related or income support • Using transport Further, some stakeholders highlighted the importance of Care Finders understanding non-health related community services, that have a particularly local awareness of the needs of older people in their communities, including the people who live alone in isolated locations. Additionally, stakeholders noted that services that are trusted and valued by members of the community, or which provide social connection, were discussed as essential components of effective engagement. Examples of these services included the local pharmacy, post office, CFA, or social groups in the community.

Service Landscape

As a preliminary measure, EMPHN has developed a foundational service map that outlines the key services (segmented by sector) that deliver aged care and aged care-related services in the EMPHN region.

EMPHN will use this foundational service map to inform future Care Finders to understand the depth and breadth of relevant services that they will need to engage in delivering the service. Further, this foundational service map will be used as the basis for a more comprehensive analysis of the supply of relevant services that EMPHN will conduct in the future.

The foundational service map is set out in the table below.

Sector	Service Type	Service Provider
Primary Care	General Practice	Approx. 435 general practices in EMPHN catchment
	Mental health services	• Acute Mental Health Inpatient services • Adult Mental Health services • Clinical Psychology services • Mental Health services • Mental Health Advocacy • Mental Health Case Management • Mental Health Crisis Assessment and Treatment • Mental Health Information and Referral • Mental Health Non-Residential Rehabilitation • Mental Health Residential Rehabilitation • Neuropsychology • Psychiatry • Psychology
Aged Care	Aged Care Assessment Services	• Eastern Metropolitan ACAS - Outer East • Eastern Metropolitan Regional Aged Care Assessment Service - Central Eastern • North Eastern Metropolitan AVAS - St Vincent's - Kew • Northern Metropolitan Regional Aged Care Assessment Service - Heidelberg
	Regional Assessment Services	• Eastern Metro Regional Assessment Service *(Victoria's Department of Health is responsible for providing Regional Assessment Services across Victoria)*

Sector	Service Type	Service Provider
Aged Care	Access & Support Services	• Chinese Community Social Services Centre • EACH • Eastern Health • Migrant Information Centre (Eastern Melb) • Mullum Mullum Indigenous Gathering Place Ltd • St Vincent's Hospital (Melb) Ltd • Carrington Health • MiCare • COTA Vic
Social care	Housing - Assistance with Care & Housing	• The Salvation Army Property Trust • Housing for the Aged Action Group Inc (HAAG) • Villa Maria Catholic Homes Ltd • Wintringham • Merri Outreach Support Service Ltd
	Social connection	• Neighbourhood Houses • Social groups delivered via Victorian Community Health Centres • Friendline - telephone service
	Elders Rights & Advocacy	• Seniors Rights Victoria • Domestic and Family Violence Support Services • Elder Rights Advocacy (OPAN partner in Vic)'
	Carer support	• Carer Gateway
	Emergency Relief / Material Aid	• Eastern Emergency Relief Network • Anglicare Victoria • Hope City Mission • Local Councils - Support, Financial Hardship and Emergency Relief services
	Legal Issues	• Consumer Affairs • Women's Legal Service Advice Line • Victoria Legal Aid • Mental Health Legal Centre • Disability Discrimination Legal Service

Sector	Service Type	Service Provider
Social care	Aboriginal & Torres Strait Islander	• Mullum Mullum Indigenous Gathering Place • Victorian Aboriginal Community Controlled Health Organisation (VACCHO) • Healesville Indigenous Community Services Association
	LGBTI+	• Val's LGBTI Ageing and Aged Care
Secondary and Tertiary care	General Medicine	• Department of General Medicine, Austin Health • General Medicine Unit, Angliss Hospital • General Medicine Unit, Box Hill Hospital • General Medicine Unit, Maroondah Hospital • General Medicine, Monash Centre Clayton
	Health Independence Program	• Health & Rehabilitation Centre • Heidelberg Repatriation Hospital • Peter James Centre
	Cognitive Dementia and Memory Service (CDAMS)	• Monash Health • Wantirna Health • Heidelberg Repatriation Hospital • Bundoora Centre
	Geriatric Medicine Referrals (or Geriatric Evaluation and Management (GEM))	• Peter James Centre • Wantirna Health • Angliss Hospital • Maroondah Hospital • Box Hill Hospital • Heidelberg Repatriation Hospital • Bundoora Centre

Sector	Service Type	Service Provider
Secondary and Tertiary care	Older Adults Mental Health Referrals	• In-Patient Unit South Ward Peter James Centre • Bundoora Aged Persons Mental Health Unit (APMHU) • Canterbury Road CCU • Adult Mental Health Inpatient Unit • Brain Disorders Unit (Mary Guthrie House) • Clayton PARC • Community Recovery Program • Heidelberg PARC • Linwood PARC • Maroondah CCU • Maroondah Hospital HOPE Program • Maroondah PARC • Ngarra Jarra Aboriginal Health Program • P Block, Monash Medical Centre • Secure Extended Care • The Way Back to HOPE
	Falls and Balance Services	• Eastern Health: Falls and Balance Clinic • healthAbility • Top to Toe Health • OsteoStrong Hawthorn • Access Health and Community
	Emergency Services	• Northern Health - Northern Hospital • Austin Health - Austin Hospital • Mercy Hospital for Women • Eastern Health - Box Hill Hospital • Maroondah Hospital • Knox Private Hospital
Specific health services and systems	Condition specific needs	• Vision Australia • Dementia Victoria • Hearing Australia
	Other services	• National Disability Insurance Scheme