Dear Inspector-General of Aged Care,

I am a Geriatrician and have been in private practice for 25 years, as well as providing a Geriatric Medicine Liaison Service in my local public hospital. I run a single practitioner practice. Because of the concerns re cybersecurity and maintaining my patients' privacy, my practice's main computer is deliberately not linked to the internet. Financially it would be prohibitive to have and maintain the necessary software to ensure my patients' data were never accessible by someone with ill intent. This is the reason why I still post or fax letters, referrals, etc.

Many of the patients referred to me in my private practice have cognitive dysfunction, most commonly due to one of the dementias, alongside multiple other medical co-morbidities. Hence, I also have long term experience assisting my patients and their families to access services and supports from an ever-changing array of organizations.

My experience with My Aged Care (MAC) has not been positive. I list here, in no particular order, the difficulties I have encountered.

1. I had always completed referrals of my patients to the Aged Care Assessment Services (ACAS), when medical practitioners could refer directly and later via MAC. I would provide the relevant information about the patient's medical problems, medication and social situation. I would also clearly articulate the reason(s) why and what supports were being sought. I would dictate the referral, which my secretary would type, I would correct and then she would fax the referral to MAC. Unfortunately, MAC is no longer receiving faxes. This means my secretary either types up the referral for me to correct and then retypes it into the online referral portal on a separate computer or I have to complete the online form. Hence, after 20+ years of completing these referrals for my patients, I am no longer providing this service, as it is too time consuming and hence too expensive. I suspect MAC, by refusing to accept faxed referrals from medical practitioners like myself, aims to decrease its workload in a subtle manner.

2. MAC in the last few years has decided (at least in my local area), if a person has not been seen by the Regional Assessment Service (RAS), then they must be seen by this service first, even if the person requires an ACAS assessment. MAC will not let there be both a referral for a RAS and ACAS simultaneously. A person can only have 1 assessment in the system at a time.
   For example, a physically robust female patient with moderate dementia lived with her husband. He was her carer. Neither received any supports or services. He had progressive metastatic prostate cancer. When I met the patient and asked the husband what the back-up plan was, for when he became ill and /or died, he had none. My patient would not have been able to manage at home when her husband became terminally ill or died, yet she was forced to have a RAS assessment first, before she could access an ACAS assessment, for both residential respite and permanent care, which were the priority for her.
   Such examples are common place in my practice. Had I made the referral for my patient, I would have stressed the precariousness of her home situation. As long as

her husband was at home, she managed well. Thus, as his life span was limited to months, the ACAS assessment was needed soon. When the husband referred the patient to MAC, because she was physically robust and MAC was unaware of how ill he was, as it didn't occur to him to stress this, the ACAS assessment was not prioritized. When he died a little while later, my patient was unable to manage at home and at a very stressful time for the remaining members of their family, they had to manage his funeral arrangements and their grief at his death, while struggling to care for and support his wife, who became distressed and more confused in his sudden absence. They also did not know what options there were to accommodate my patient, as it was clear she could not live at home alone. This was an entirely predictable situation.

3. Currently, in my local area it takes up to 6 months to obtain an ACAS assessment. If an assessment is requested, as the patient's function is beginning to deteriorate, frequently if services are not needed immediately, MAC asks the patient to ring back when services are actually required. When services are required because of a sudden worsening of the patient's health and associated increased disabilities, being told they need to wait first for a RAS assessment for basic services, and only then can an ACAS assessment be completed for a Home Care Package (HCP), often results in the patient needing to access permanent residential aged care (RAC) rather than getting supports at home in a timely manner.
   For example: I provide a Geriatric Medicine Liaison Service at my local public hospital. Approx 30% of the inpatients I see are now so disabled their care needs have significantly increased. Frequently, these patients have either no or minimal services/supports at home. Unfortunately, trying to access any or increased services/supports in a timely manner to allow the patient to return home is impossible. Assessments for services/supports at home are not completed in hospital by either RAS or ACAS. Currently the wait between when a HCP is approved and when it is funded may be weeks to months, and many of the patients I see are not in a position where they can fund these services/supports themselves in the interim. This time frame also applies if the patient is on an HCP but now needs a higher level of care, both in getting the reassessment for the increased HCP level and then waiting for the funding to become available. Thus, these patients need to access permanent RAC directly from hospital.

4. Many of my patients are older and are accompanied by their spouse to my consultations. Frequently, as the spouse is also older, they have their own medical problems. Thus, the spouse may not be in a position to advocate for my patient with MAC when they contact MAC themselves. Where possible, I encourage the patient's child or children to accompany them to my consultations, but this is often not possible. MAC, because of protocol/policy, assumes each older person is able to advocate for themselves. Many of my patients cannot do this, either because of their cognitive dysfunction and/or because they are from a NESB. MAC makes is very difficult for anyone else (spouse, child, etc) to be a spokesperson for the patient.

5. On one occasion approx. 3-4 years ago, I referred one of my patients via MAC to the Community Rehabilitation Service. Before my referral was accepted, a RAS assessor

had to see the patient to decide if my referral was warranted. I thought this was the height of absurdity, given my job, which was listed on the referral.

6. If MAC deems an ACAS assessment is appropriate, currently it does not provide the person with a time frame of when they are likely to be seen. Rather, the person is informed, they will be contacted beforehand to make an appointment. Not surprisingly, many of my patients and their families don't remember when they were by contacted by MAC or ACAS, so have no idea of where they are up to in the assessment process.

7. People and their families do not understand the differences between a RAS and ACAS assessment, nor what has been approved for the person in terms of services/supports.

8. Recently, the daughter of my patient (her mother, who had already been through the MAC process and had an assessment at home) wanted to arrange an assessment of her father, who also had health issues and disabilities associated with these, through MAC. MAC (through another agency) wanted to arrange a 2 hour assessment of the father and his home. As the daughter needs to be present at the assessment to advocate for her father and she didn't have time to take off work for such a long assessment, she cancelled the assessment. The daughter couldn't understand why another assessment of her parents' home had to be conducted, if one had been done not so long ago.

What I want to see from MAC is:

1. A realization many of the people contacting them for support may have a degree of cognitive dysfunction, even if their English is perfect. All people should be encouraged to have a nominated spokesperson, who can talk to MAC on the person's behalf. Those who do not feel they need to have a spokesperson do not need to nominate one.
   This is even more important if the person's English is limited or non-existent.

2. Accepting referrals through a variety of means and not only online.

3. Clear communication back to the referrer regarding the outcome of an assessment. At my health service we can see if a referral has been made to MAC, but we cannot see the outcome, as there is never any feedback. Having this information would be useful when planning the discharge of a patient with complex needs, as many of the patients I see have been admitted to our health service on more than 1 occasion. Knowing what approvals, if any, they have and when these were provided would be of benefit to us in assisting our patients and their families in the discharge process.

4. Look at who the referrer is when deciding what assessment is needed, rather than going through a set procedure, irrespective of the information provided by the referrer.

5. Where people share a home as family, irrespective of their relationship, MAC fosters the sharing of the assessment of the home between the various people's files, rather than if the people are only house sharing. The set up and safety aspects of the home will be the same irrespective of which person living in the home was assessed.

Yours sincerely,
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