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AMA Submission to the My Aged Care Evaluation

The AMA was invited to participate in qualitative market research to provide insights to help the Department of Health assess the ongoing implementation and effectiveness of the My Aged Care Gateway.

1. To assist our understanding of your organisation's involvement in the aged care system, could you provide a brief overview of the role of your organisation and its membership in the sector?

The Australian Medical Association (AMA) is the peak membership organisation for medical practitioners and students in Australia. The AMA promotes and protects the professional interests of doctors and the health care needs of patients and communities.

Medical practitioners are an integral part of the aged care workforce as they provide quality care for older people. As a result, medical practitioners can provide first-hand experience of the quality of the current aged care system.

2. Since the implementation of the My Aged Care Gateway in July 2015, to what extent has yours, or your member organisations', experience with the aged care system changed overall? Have you seen any improvements or decline in performance in that time?

The My Aged Care Gateway was supposed to streamline access to needed services for patients. Instead it has complicated access by requiring all patients to undergo either a Regional Assessment Service (RAS) or Aged Care Assessment Team (ACAT) assessment in order to access support services. An assessment bottleneck has been created and is causing delay in elderly patients' access to support and medical care. In addition, direct referrals to service providers for required services are being blocked by the bureaucratic requirement for an assessment.

3. What impact have the changes to the system had on your organisation or on the organisations you represent? Has your workload changed? To what extent?

The My Aged Care website is easy to navigate for most patients. However, the number of complaints from AMA members and patients about the administrative process of the My Aged Care System is extremely high. Complaints include:

- Over a week to inform a patient they were ineligible for home support required to redress their infected wound and that their application required further processing. This process was a stream of back and forth phone calls between the patient, the referring doctor, and the My Aged Care call centre.
- The lack of communication in the new My Aged Care HACC application process and increased administrative burden on doctors and practice staff.

- Waiting times on the My Aged Care contact centre of 90 minutes for a referral.
- Several website malfunctions.
- The My Aged Care contact centre not following up with a patient's doctor when an attempted call to the patient has had no response.
- The contact centre failed to act on information supplied on the application form about a hearing-impaired patient unable to answer phone calls.
- The non-integration of referall forms into general practices' clinical software continues to add an administrative burden to GP practice staff.

4. How have the changes impacted on the delivery of information, assessment and referral to services?

For the My Aged Care system to work properly, it must be simple and efficient. Reports from our members indicate this is not the case (see member complaints under question 3), and previously simple processes have become complex and time consuming, leaving patients in need of urgent care left at home waiting.

5. Have you received any feedback from organisations involved in service delivery to particular cohorts, for example, rural and remote providers, CALD or Indigenous providers about particular barriers or challenges they have experienced in using My Aged Care?

The main issues are the lack of communication and cultural awareness of both Indigenous Australians, and cultures from other countries. There needs to be more awareness of services and training available to contact centre staff if CALD residents are to receive equitable aged care. For example, our members have reported that when a CALD patient receives a call, the contact centre has not respected requests to call a delegated person (e.g. son/daughter/carer) other than the CALD patient, who may have a limited understanding of English. The delegated person would receive notice that the CALD patient received a call but there would be no more information provided.

6. In your view, what are the main challenges faced by your membership in using My Aged Care? How could these areas be improved?

Our members have reported that the main issues using My Aged Care is the burden of administrative processes creating delays in access to much needed care. As mentioned in question 3, there is an absence of efficiency and attention to detail when dealing with My Aged Care staff, in addition to a lack of consultation with the patients' referring doctor.

The My Aged Care Gateway should be interoperable with clinical software. The My Aged Care Gateway referral form needs to be integrated into general practice clinical software so that the form can be auto-populated, attached to the patient record, and securely sent.

There is also an apparent lack of communication from ACAT/ACAS to doctors, staff, and service providers about the processes in place when a patient requires urgent attention. There is a lack of information on ACAT page on the My Aged Care website about this (noting there is further information on the Department of Health website that states if the service is urgent, it is possible to directly contact the service provider and complete the ACAT assessment as soon as practical). If the My Aged Care website is to be a "one stop shop", this information needs to be available on the website so it can be easily accessible by medical practitioners. Currently, General Practitioners are generally unaware they can still directly refer in the case of an urgent ACAT.

A streamlined process is required to improve access to respite care for people who have not yet been assessed by an ACAT or who have not yet entered the aged care system. GPs need to be more involved in the assessment process and need clear guidelines on what to do when a patient requires urgent care.

ACAT approval waiting times are also an issue. Although there are 'first clinical contact' timeframe guidelines (High urgency: 2 calendar days, medium: 3–4 calendar days, and low: 15–36 calendar days (Source: Department of Social Services (2015) My Aged Care Guidance for Assessors), our members are reporting delays longer than these outlined periods. While 47.8% of respondents in the 2015 AMA Member Aged Care Survey reported a wait for initial assessment by ACAT was less than one month, 38.8% had to wait 1-3 months. States who had the longest ACAT waiting times were New South Wales, South Australia and Queensland. The current aged care assessment arrangements fall short on efficiency and responsiveness to the care needs of older people.

The effectiveness of the aged care assessment process can be improved by including the patient's usual medical practitioner in the assessment arrangements. Our members tell us aged care assessment currently makes little use of the information doctors can provide about their patients. Medical practitioners form long-term relationships with their patients. An older person's usual doctor, be they a GP or geriatrician can bring his or her background knowledge of the whole person and their current circumstances to the assessment process. This information would ensure the person's assessment results reflect them receiving the care that is most appropriate for them, be it in the community or RACF. It would also reduce the assessment time, which would allow people to access services more quickly.

7. How have the challenges we have discussed changed/improved over the period My Aged Care has been in operation?

In January 2016, the AMA Council of General Practice provided feedback to the Department of Health regarding interoperability of the My Aged Care website, as follows:

> "The main concerns with the form itself are that the online form requires the completion of information that could be automatically populated from the GPs clinical records if the form was integrated with practice software. As the form is external to practice software, it requires manual completion of information that is already contained within the patient record. This is an inefficient use of GPs time, subject to transcription error, and unacceptable to them. In addition, the referral cannot be saved directly to the patient record, instead it must be saved as an external document and attached, making the information contained on the patient record digitally fragmented as well as digitally heavy (i.e. requiring more storage then for an integrated referral).
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> The online form also fails to account for practice workflows. There is no capacity with the current form to backtrack to previous pages without losing entered information and no capacity for the form to be saved when only partially completed. Nor is there facility for the referral and the information contained within it to be automatically re-utilised as the basis for a further referral when additional services are required. All users of this form would benefit from the capacity to return to a previous page to amend an entry.
>
> Furthermore, GP referrals for services for their patients should not be confined to the My Aged Care website. As the draft form itself indicates, services that are urgently required

should be addressed by direct GP referrals made directly to the local service provider. This capacity must be operationalised. GPs must be able to make direct referrals, not simply referred back to the online form. GPs are frustrated with the additional bureaucracy involved in patients accessing the care they need.

The form must be integrated with practice software to enable auto-population of patient and doctor details, and to better align with practice workflows when completing the form. This form fails to meet a number of the AMA's 10 Minimum Standards for Medical Forms."

The Department of Health reported that the interoperability described above was "part their forward workplan to enhance the capability of My Aged Care". The AMA are yet to see any implementation of these suggestions and as such would like to request a timeframe for interoperability.

8. Are there any other aspects of the implementation or performance of My Aged Care you would like to raise?

AMA's General Practitioner (GP) members request a higher level of involvement in the assessment process in order to provide a higher quality service to their patients. To do this, our members request as a matter of urgency a referral form that can sit within practice software that will:

- auto populate, and
- highlight early in the form any request or issues that would require communicating with a person or persons other than the client/patient, such as Dementia, special sense impairment such as deafness or blindness, language difficulties or psychiatric issues such as anxiety/panic disorder or cultural sensitivities or mobility problems that would make answering the phone slow or difficult.

Our GP members (and Geriatricians) also request greater transparency for GPs and patients/clients to be able view the progress of assessments. This will provide GPs with confidence that their patients are being provided with the necessary care in a reasonable timeframe, and will be able to take action if this is not occurring.

Our GP members also request greater input in recommending services they see patients need (rather than services clients want – which is not always reflective of their substantive needs to enable greater independence, safety and improved health outcomes).

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