Australian Government

General Practice in Aged Care Incentive GP and practice information kit

Effective – August 2024

my medicare

Australian Government

Contents

my medicare

About this resource

This information kit provides a range of resources for business owners and principals, clinical directors, GPs, practice managers and nurses, managers, administrators, and other team members to help you understand and participate in the General Practice in Aged Care Incentive.

This information kit has seven parts:

- Part 1: Understand the General Practice in Aged Care Incentive
- Part 2: Eligibility to participate
- Part 3: Choosing to participate
- Part 4: Meeting the service requirements
- Part 5: Information for practice managers and nurses
- Part 6: From good to excellent: Quality primary care in aged care homes
- Part 7: Nothing about us without us: Engaging with people in aged care homes.

This information kit should be used with the General Practice in Aged Care Incentive Program Guidelines and other supporting resources available at health.gov.au/our-work/gpaci.

Disclaimer

These resources and tools are for information purposes to support the introduction of the General Practice in Aged Care Incentive.

The Australian Government may alter arrangements for the General Practice in Aged Care Incentive at any time and without notice. The Australian Government does not accept any legal liability or responsibility for any injury, loss or damage incurred by the use of, reliance on, or interpretation of the information provided in these guidance or associated tools.

Background

Health care for all people matters

People living in residential aged care homes have higher rates of multiple complex conditions, including frailty and cognitive impairment and higher rates of emergency department presentations. They experience hospital visits and hospital acquired complications.

These complex needs require a proactive response that involves various people across both the health and aged care systems. While some GPs do attend residential aged care homes and provide exceptional care, overall, this is a need that has been inadequately met by the current health system.

Supporting better care

The General Practice in Aged Care Incentive is a new incentive payment for GPs and their practice, which commenced on 1 July 2024. It is directly linked to MyMedicare.

From 1 July 2024, eligible providers and practices registered in MyMedicare can receive incentive payments for providing their registered patients living in a residential aged care home with care planning and regular visits, at their home.

The incentive supports GPs and practices to deliver more proactive, planned, and continuous care for people living in aged care homes. The incentive is an important part of the Australian Government's response to the Royal Commission into Aged Care Quality and Safety and Strengthening Medicare.

More information about the incentive, including eligibility and service requirements, is available at health.gov.au/our-work/gpaci.

MyMedicare

People living in an aged care home, their preferred GP, and the practice they work in must register in MyMedicare to participate in the General Practice in Aged Care Incentive.

More detailed information about MyMedicare, what it is, its benefits, eligibility requirements and how to participate are available at health.gov.au/our-work/mymedicare/about.

General Practice in Aged Care Incentive Resources

Program Guidelines

The General Practice in Aged Care Incentive Program Guidelines outline the eligibility and servicing requirements that need to be met for GPs and practices to receive the incentive. The program guidelines are available at health.gov.au/our-work/gpaci.

Fact sheets

The following fact sheets have been developed to help stakeholders understand everything they need to know about the incentive:

- General Practice in Aged Care Incentive fact sheet
- Facts and benefits fact sheet
- Roles and contributions fact sheet
- Person-centred care fact sheet.

These are available on the Department of Health and Aged Care website at health.gov.au/our-work/gpaci.

Circulate these amongst business owners, principals, clinical directors, practice managers, nurse, and practice staff to ensure they understand the incentive.

Patient journeys

Mavis and Bernie's stories illustrate how the incentive can be applied to deliver high quality primary health care. They demonstrate how, across the course of a year, proactive, planned, and continuous team-based care makes a difference.

When familiarising GPs and practice staff on the incentive, practitioners should use these patient stories as discussion starters and case studies with staff.

These are available on the Department of Health and Aged Care website at health.gov.au/our-work/gpaci.

Quality standards

The General Practice in Aged Care Incentive Program Guidelines and fact sheets, and this information kit complement the:

- RACGP Aged Care Clinical Guide (Silver Book) Fifth Edition
- RACGP Standards for General Practice Residential Aged Care
- RACGP Standards for general practices 5th edition
- Department of Health and Aged Care National Aged Care Mandatory Quality Indicator Program (QI Program)
- Aged Care Quality and Safety Commission's Aged Care Quality Standards.

Business owners and principals, clinical directors, practice managers, nurses, administrators, and other practice staff are encouraged to familiarise themselves with these standards.

Part 1: Understand the General Practice in Aged Care Incentive

This section provides information to help you understand the General Practice in Aged Care Incentive, eligibility, service requirements and responsibilities, to help you better understand implications for your practice, GP, and care team.

More information about the incentive, including eligibility and service requirements, is available at health.gov.au/our-work/gpaci.

The General Practice in Aged Care Incentive

The General Practice in Aged Care Incentive is an important part of the Australian Government's response to the Royal Commission into Aged Care Quality and Safety and Strengthening Medicare.

The General Practice in Aged Care Incentive aims to improve access to quality primary care services defined as proactive, planned, and continuous primary care for people in residential aged care homes.

Benefits

The General Practice in Aged Care Incentive aims to benefit:

- people living in residential aged care homes, their families, friends and carers
- GPs, practices, and care teams
- aged care homes.

Information on benefits for different stakeholder groups is provided in the General Practice in Aged Care Incentive facts and benefits fact sheet at health.gov.au/our-work/gpaci.

These benefits will be evaluated by the Department of Health and Aged Care, through a national evaluation to ensure the incentive's design and supporting activities are achieving their policy objectives.

Benefits for GPs and practices

GPs and practices may benefit from:

- payments for reviewing their patients in their residential aged care home, rather than at their practice
- funding to manage the care for registered patients living in a residential aged care home
- establishment of formal relationships between patient, GP, practice, and other members of a patients care team.
- opportunities for other members of the practice team to deliver care to residents of aged care homes.

Other personal and professional benefits

Participation in the incentive may attract additional personal and professional benefits for GPs and care team members, for example:

- Enhancing patient care - By participating, GPs may access additional resources and supports that enhance their ability to manage complex health issues more effectively. This may lead to improved patient outcomes, higher patient satisfaction and, potentially, a more rewarding practice experience. It may allow GPs (and other care team members) to expand their scope of practice and depth of care and personal satisfaction.
- Continuing professional development (CPD) - Participation offers an opportunity to develop and evolve a skill set focused on older people e.g. care of people with dementia, deprescribing or palliative care. Additional training in this area may help you fulfil your educational CPD requirements. In addition, adopting a system leadership and quality improvement approach to implementing the General Practice in Aged Care Incentive may help you fulfil reviewing performance and measuring outcomes CPD requirements.

General Practitioner Aged Care Access Incentive (ACAI)

The General Practice in Aged Care Incentive is distinct and different to the former ACAI which ceased on 31 July 2024. Practices and providers who participated in the ACAI will need to follow the standard registration process to participate in the General Practice in Aged Care Incentive.

The two incentives target different outcomes and are not comparable in terms of outcomes sought, eligibility, service requirements and payment structure.

The General Practice in Aged Care Incentive:

- is underpinned by MyMedicare which enables relational, informational and managerial continuity between patient, GP and practice
- has no cap. The former ACAI had a $10,000 per year cap
- shifts the emphasis from GP activity and volume of care to a GP coordinated team-based care model whereby practice care team members can deliver a portion of eligible services under the direction of the responsible provider
- incentivises proactive, planned, and continuous care.

Part 2: Eligibility to participate

Eligibility to participate is detailed in the General Practice in Aged Care Incentive Program Guidelines available at health.gov.au/our-work/gpaci.

The program guidelines detail:

- practice eligibility and registration requirements
- 'responsible provider' eligibility and registration requirements
- 'alternative provider' and care team eligibility and registration requirements including, another GP or GP registrar, nurse practitioner, practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker eligibility
- patient eligibility.

Accreditation status

A core requirement of the General Practice in Aged Care Incentive is for practices, responsible providers, and patients to be registered in MyMedicare and linked in the General Practice in Aged Care Incentive program.

To be eligible for MyMedicare, general practices must be accredited against the National General Practice Accreditation Scheme.

Details on the National General Practice Accreditation (NGPA) Scheme are available at https://www.safetyandquality.gov.au/our-work/accreditation/national-general-practice-accreditation-scheme.

An exemption is in place until 30 June 2025 to enable non-accredited practices to participate in MyMedicare.

Details of approved accrediting agencies under the NGPA Scheme are available at

https://www.safetyandquality.gov.au/our-work/accreditation/national-general-practice-accreditation-scheme/approved-accrediting-agencies-under-ngpa-scheme.

Changes to the definition of 'general practice' made by the Royal Australian College of General Practitioners in April 2024 now encompass sole providers and those providing aged care services via an outreach model of care.

Guidance for the accreditation of general practices under the new definitions of a general practice for purposes of accreditation are available at Interpretive-guide-for-the-accreditation-of-general-practices-under-the-new-definition-of-a-gene.pdf (racgp.org.au).

Top tip

Information on accreditation support for unaccredited practices is available from your PHN. To contact your local PHN visit: health.gov.au/resources/apps-and-tools/primary-health-network-locator.

Registration requirements

Participating practice, responsible provider and patient registration requirements are detailed in the General Practice in Aged Care Incentive Program Guidelines: health.gov.au/our-work/gpaci.

The following provides an overview of registration requirements.

Practice	Responsible provider	Patient
Must be registered in: • Organisation Register • MyMedicare program • General Practice in Aged Care Incentive sub-program.	Must be: • an eligible provider, outlined at Appendix 2 • linked to their eligible practice in the Organisation Register • declared as the responsible provider of eligible services to the registered patient, including coordinating services provided by the care team.	Must: • permanently live in a Residential Aged Care Home • be registered in MyMedicare with the eligible registered practice • have the General Practice in Aged Care Incentive indicator selected on their MyMedicare profile by their practice • have a responsible provider identified by the practice when a General Practice in Aged Care Incentive indicator has been selected.

To participate in the General Practice in Aged Care Incentive, patients, GPs, and practices are required to register for MyMedicare. Practices are then required to register their participation in the General Practice in Aged Care Incentive for each eligible patient.

Guidance on how to register for the General Practice in Aged Care Incentive is available on the Services Australia website at servicesaustralia.gov.au/general-practice-aged-care-incentive.

Top tip

Your regional PHN may be able to provide further guidance and support on registration for the incentive if necessary.

Guidance on practice opt-out and patient withdrawal are included in the General Practice in Aged Care Program Guidelines: health.gov.au/our-work/gpaci.

Service requirements

Detailed service requirements and eligible services are provided in the General Practice in Aged Care Program Guidelines: health.gov.au/our-work/gpaci. These will help inform your decision to participate.

In summary, GPs as responsible providers, care teams and practices must deliver at least 10 eligible services, from eligible Medicare Benefits Schedule (MBS) and Department of Veterans Affairs (DVA) funded services, over a 12-month period including:

- 2 eligible care planning services delivered by the responsible provider
- 8 eligible regular services comprising of at least 2 per quarter, each in a separate calendar month.

Care planning services	Regular quarterly visits
Over a 12-month period a minimum of 2 eligible care planning services must be delivered by the responsible provider. Eligible care planning services include: • comprehensive medical assessment • contribution to, or review of, multidisciplinary care plan • residential medicine management review • coordinating or participating in a multidisciplinary case conference.	Within each quarter, the GP and care team must deliver 2 eligible regular services per quarter, each in a separate calendar month. • at least one of the regular visits must be provided face-to-face by the responsible provider • a second face-to-face visit may be provided by the responsible provider or an alternative provider i.e., another member of the patient's care team who acts on the direction of the responsible provider. • In Modified Monash Model (MMM) areas 4–7, practices will be able to provide up to 4 regular visits per 12-month period by eligible telehealth MBS items where they are unable to provide face-to-face services.

The General Practice in Aged Care Incentive Program Guidelines available at https://www.health.gov.au/our-work/gpaci outline:

- MBS and DVA eligible care planning service
- MBS eligible regular services
- MBS eligible regular telehealth services for practices located in MMM4-MMM7.

An illustration on meeting both 12-month service requirements and quarterly service requirements is provided in Part 4: Meeting the service requirements.

Incentive payments, rural loadings, and assessments

The General Practice in Aged Care Incentive offers incentive payments paid to the responsible provider and practice when service requirements are met:

Responsible Provider	Practice
$ 300 per patient per annum for the responsible provider	$130 per patient per annum for the practice

These payments will be paid on a quarterly basis across a 12-month period, in equal parts, on top of existing MBS and DVA funded services. Practices and GPs will need to meet the requirements of each quarter to receive the payment.

Rural loadings will apply to provider and practice incentive payments for Modified Monash Model (MMM) regions MMM 3 to MMM 7. The MMM region applied to the incentive payment will be determined by the location of the practice registered in MyMedicare. Details on MMM rural loadings are provided in the General Practice in Aged Care Program Guidelines: health.gov.au/our-work/gpaci.

Top tip

If modelling anticipated incentive payments or keeping a track of services provided and anticipated income, ensure you include applicable MMM loading.

The quarter 4 payment is contingent on accomplishment of the 12-month servicing requirements inclusive of 8 eligible regular visits (i.e., 2 per quarter) **and** 2 eligible care planning services completed in the 12 -month assessment period.

Fees and Disbursements

The practice and responsible provider have the discretion to determine:

- fees and charges for patients
- whether the incentive payments are to be distributed to alternative providers or provide a contribution to the funding of other positions within the care team.

Top tip

Consider and agree the practice service delivery model for Residential Aged Care, including fees and charges policy and internal disbursement arrangements as appropriate.

Part 3: Choosing to participate

The General Practice in Aged Care Incentive purposefully incentivises both the responsible provider and practice care team to deliver quality primary care.

This approach may assist in:

- increasing workforce capacity and capabilities
- improving the model of care through enhancing team collaboration
- reducing waste and inefficiencies in workflows
- improving practice infrastructure.

In addition, it may enhance practice and provider sustainability through provision of more efficient and effective ways of providing quality primary care services to people in aged care homes.

Considerations

Before deciding to participate, it is important to assess your context (your internal and external operating environment) and strategic alignment with the incentive.

Included tool

Assessment criteria you may wish to consider are summarised at Appendix 1 – Suggested assessment criteria to inform your decision to participate.

Choosing to participate

When considering participation in the incentive, practices, responsible providers, and care team members may consider:

- the specific requirements of the incentive and commitments involved
- practice strengths
- predicted revenue
- opportunities for capacity and capability development
- opportunities to strengthen joint working relationship with aged care homes.

For example, is there a need for additional training in new operating protocols on how the incentive will work in practice, changes to practice workflow, and new capabilities needed to enhance team-based care and collaboration? Part 6: From good to excellent: Quality primary care in aged care homes provides details on how to operationalise quality primary care in an aged care home setting.

By carefully considering these factors, business owners and principals, clinical directors, GPs, practice managers, nurses, administrative staff, and other team members can make an informed decision about participation in this incentive program that not only enhances professional practice but also significantly improves the care experience for their patients. Participation is an opportunity to lead in healthcare innovation, fostering a more dynamic and

responsive healthcare environment while enhancing personal and professional collaboration and satisfaction.

Part 4: Meeting the service requirements

The General Practice in Aged Care Incentive Program Guidelines outline service requirement that need to be met to be eligible for the incentive payment. They can be found at health.gov.au/our-work/gpaci.

This section illustrates how you could meet service requirements and outlines the steps required to track and claim the incentive payments.

Incentive structure

Figure 1 at the end of this part below shows the General Practice in Aged Care Incentive structure.

Quarterly service requirements and payments

Quarterly service requirements are assessed at the end of fixed quarters – the quarterly assessment period. The dates of these fixed quarters are:

- 1 July – 30 September
- 1 October – 31 December
- 1 January – 31 March
- 1 April – 30 June.

At the end of each quarter, an assessment will be made to confirm whether a minimum of 2 eligible quarterly visits in separate calendar months were made.

If these 2 visits were undertaken, then the following payments will be made:

Responsible Provider	Practice
$75 for the responsible provider	$32.50 to the eligible practice

A rural loading will be automatically applied to the incentive payments where appropriate:

MMM Region	Rural Loading
MMM3	20%
MMM4	30%
MMM5	30%
MMM6	50%
MMM7	50%

This process will be repeated every quarter if servicing requirements are met. Providers may also be eligible to receive the triple bulk billing incentive introduced in November 2023.

12-month service requirements and payments

At the end of the fourth quarter, an annual assessment will be made which will determine whether:

- the responsible provider or eligible care team members delivered at least 8 eligible regular services under the incentive, and
- the responsible provider delivered at least 2 eligible care planning services.

If these visits occurred, the fourth quarterly payment will be made.

When a patient does not receive both the required care planning items in the 12-month period, then no payment will be made for the final quarter.

Responsible providers will be required to deliver at least one eligible care planning service in the first quarter of the next 12-month care period.

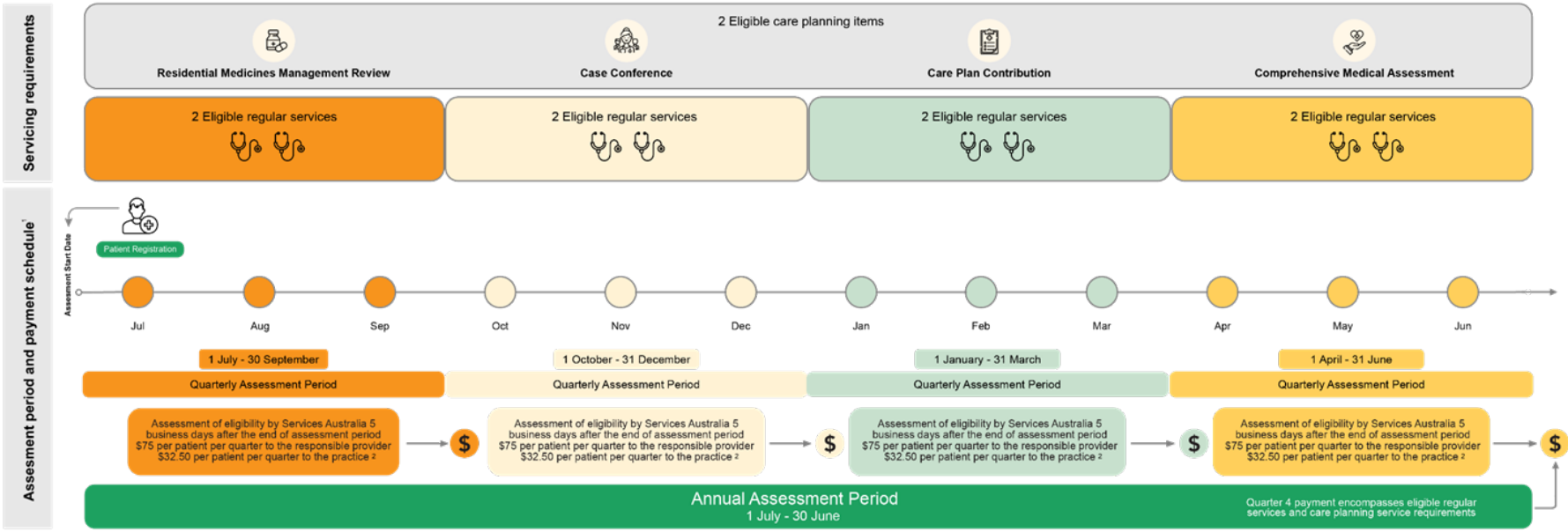
Failure to provide that care planning service in the first quarter of the next 12-month period will mean the practice and provider will be ineligible for General Practice in Aged Care Incentive payments for the remainder of the 12-month care period for that patient.

The 12-month assessment period starts in the quarter in which the patient was registered in the General Practice in Aged Care Incentive.

For example, if a patient was first registered for the incentive by the practice between 1 July and 30 September, the first quarterly assessment period, and the 12-month assessment period, would commence from 1 July. The 12-month assessment period would then end on 30 June of the following year.

Included tool

A summary checklist is provided at Appendix 2 – Checklist: Responsible provider.



1 The 12-month assessment periods are dependent on each patient's quarterly assessment start date
2 Rural loading to be applied where appropriate

Figure 1: General Practice in Aged Care Incentive Structure

Alt text: Figure 1 summaries the structure of the General Practice in Aged Care Incentive. A centre timeline goes from Jul to Jun horizontally, with each month represented by a circle. Above the timeline the servicing requirements are represented. A box extends across all 12 months summarising 2 eligible care planning items, including the text 'residential medicines management review', 'case conference', 'care plan contribution' and 'comprehensive medical assessment'. Beneath that every three months are grouped together with the text '2 eligible regular services'. Beneath the centre timeline the assessment period and payment schedule is represented. Every three months are grouped together as a Quarterly Assessment Period. Beneath each Quarterly Assessment Period is the text 'Assessment of eligibility by Services Australia 5 business days after the end of the assessment period. $75 per patient per quarter to the responsible provider. $32.50 per patient per quarter to the practice'. The four Quarterly Assessment Periods are combined into the Annual Assessment Period containing the text 'Quarter 4 payment encompasses eligible regular services and care planning service requirements.

Case Studies

The following case study provides an example of the General Practice in Aged Care Incentive servicing requirements in practice.

Case study 1 - Mavis

Mavis is an 89-year-old long-term resident of an aged care home in a regional area of NSW. She is widowed and has two adult children, one of whom lives nearby. Both children are busy with their careers and family commitments. Mavis does not socialise much with other residents. She is well educated and had a career in school administration before she retired. She has a long-standing GP who has regularly visited her in the aged care home over the past three years.

Mavis has chronic obstructive pulmonary disease (COPD), is oxygen-dependent and lives with other conditions including sleep apnoea, congestive heart failure, and arthritis – a source of chronic pain. She experiences recurrent urinary tract infections. Mavis is on seven different medications including medication for chronic pain. Her mobility is good across short distances, and she has no history of falls. She becomes very breathless and often requires a wheelchair.

Mavis understands how her condition impacts on her ability to conduct day to day functions and is keen to stay well. She has some confidence in her own ability to manage her condition with the support of staff at her aged care home but recently has experienced frequent trips to hospital. She is seeing a physiotherapist to assist with her lung health and mobility. While she is keen to avoid any further trips to hospital, she is resistant to the physio's suggested exercises. What matters to Mavis at this stage of her life is quality time with her family. She has lost some capacity to do the reading she used to enjoy but she still gets to it when she can. While not diagnosed, Mavis is likely to be depressed.

Dr Lee is Mavis's general practitioner. Dr. Lee's practice manager and Dr. Lee have been considering and reviewing the guidance for the General Practice in Aged Care Incentive Payment. They meet with staff at the aged care home where Mavis lives in July and discuss an approach to offer voluntary patient registration under MyMedicare for Dr Lee's patients and agree a process for raising awareness and assisting Dr Lee's patients sign up for MyMedicare.

The facility presents on the General Practice in Aged Care Incentive at the next weekly resident's meeting and circulates copies of the booklet for people living in residential aged care homes, their family, and carers. Dr Lee also mentions it to Mavis during their consultation in July, responds to her queries, advises her where she can find additional information on both MyMedicare and the incentive and leaves her with a MyMedicare registration form.

In August, Mavis consents to register with Dr Lee's practice under MyMedicare and nominates Dr. Lee as her preferred GP.

Commentary:

Mavis registered with MyMedicare in August. The assessment period therefore started at the beginning of that quarter i.e. 1st July.

Dr. Lee reviewed Mavis in July and again in August. These two face-to-face eligible services are included in the quarterly assessment period 1 July – 30 September.

Dr Lee and the practice are eligible to receive the first quarter's incentive payment comprising both the GP payment and practice payment.

Dr Lee reflects on this and discusses it with the practice manager and practice nurse. They discuss and plan Mavis's care for the forthcoming year and align her care plan to the incentive requirements. They introduce a mechanism for tracking and monitoring Mavis's care which ensures Mavis receives the proactive, planned, and continuous care she needs. This process will also help ensure the practice and Dr Lee as the responsible provider receive the incentive payments

Part 5: Information for practice managers and nurses

The General Practice in Aged Care Incentive enables GPs and practices to enhance and sustain the level of care they provide to people living permanently in aged care homes. This incentive is designed to enhance access to quality primary care and other health services. It recognises the additional time and complexity involved in managing the health care of people who live in aged care homes.

It is essential that those in a position to influence successful implementation and delivery of the incentive, including practice managers and practice nurses, understand the significance of this incentive and actively support GPs in their roles as responsible providers.

Case study 1 – Mavis

The practice manager informed Dr Lee that Mavis was eligible for a comprehensive medical assessment (CMA). Dr. Lee sought the support of the practice nurse to liaise with the aged care home and Mavis to organise a time for the nurse to attend and gather the information for a CMA. The nurse attended on the day Dr Lee was doing his rounds at the aged care home and completed the CMA, which Dr Lee reviewed. A copy was provided to Mavis and the aged care home.

The information gathering during the CMA identified a need to update vaccinations. The falls risk was also identified. The nurse asked aged care staff if there were provisions for falls management in the care plan prepared by the facility. The facility asked Dr Lee to review the care plan. An opportunity was identified for additional physiotherapy input and dietary support and a care plan completed.

The practice nurse prepared the referrals to the physiotherapist and dietitian. The care plan also listed the need for vaccinations to be completed and to encourage Mavis to act on the advice of the physiotherapist. The practice nurse scheduled three visits to see Mavis to complete the immunisations and then focus on motivation to follow and implement the physiotherapist's recommendations

Practice managers can streamline administrative processes to support the claim and reporting requirements. This would include maintaining accurate records of GP visits to aged care homes, efficiently managing schedules to allow GPs adequate time for these visits, and ensuring all documentation is timely and compliant with Medicare requirements. A data-driven approach will be useful and is described below.

Practice nurses also have a pivotal role in supporting GPs. They can arrange GP visits with aged care homes, prepare medical histories and other documentation before GP visits, and follow up on care plans the GPs set. Practice nurses can act as a bridge between the GP, the aged care home, and the patient, to ensure continuity of care through regular communication and updates. Practice nurses can also provide education and guidance to aged care home staff on best practices in patient care, based on the GP's recommendations.

A collaborative approach optimises healthcare delivery and maximises the incentive's benefits for practices and GPs, ultimately contributing to better health outcomes for people in aged care homes.

Roles and responsibilities

Delivering care outside of the general practice physical infrastructure requires careful planning and coordination.

A fact sheet on Implementation Partner Roles and Contributions is available on the Department of Health and Aged Care website at health.gov.au/our-work/gpaci.

Top tip

Role clarity is important – it forms the basis of trust within care teams and helps clarify who does what in the process of team care.

Included tool

A summary of possible roles and responsibilities that practice managers and practice nurses may take when operationalising the incentive checklist is provided at Appendix 3 – Potential roles and responsibilities of practice managers and practice nurses.

A data-driven approach

It will be important for practice managers or nurses to provide the GP as responsible provider with information and data to support them in providing proactive, planned, and continuous care to those patients living in aged care homes.
The approach to data collection and monitoring will depend on a number of factors including:

- number of patients the practice looks after in the aged care home setting
- the clinical information software system the practice uses
- the reporting software and any data extraction tools the practice uses.

Included tool

A summary of indicators that may be helpful to collect and monitor to meet program requirements are at Appendix 4 – Suggested indicators to support a data-driven approach.

Services Australia Professionals Online Services portal

Service Australia services can be accessed by logging into HPOS via PRODA.

Practices who are already registered for MyMedicare, and who have MyMedicare banking details recorded, can register for GPACI by clicking on the Organisation Register tile.

Once registered for General Practice in Aged Care Incentive, practices can add the GPACI incentive indicator for patients by going to the MyMedicare tile then the Patient List tile.

Once registered for GPACI, both practices and providers will have the option of another tile via MyMedicare labelled ‘View Payment Eligibility’.

The View Payment Eligibility tile will allow practices or responsible providers to:

- Request a forecast of incentive eligibility for the current quarter, including details of relevant services for each registered patient.
- View eligibility assessment outcomes (used for payment) after the end of the quarter.

From October 2024 an additional tile ‘View Payment Information’ will be available, which will allow practices or responsible providers to access a detailed breakdown of their payments following each quarterly assessment.

Notifications and correspondence relating to GPACI will also be sent to practices and providers via their HPOS mailbox.

Support materials are available on the Health Professional Education Resources site under the MyMedicare tile.

Further details are available from the Services Australia website available at: servicesaustralia.gov.au/general-practice-aged-care-incentive.

Included tool

A summary checklist regarding practice participation in the General Practice in Aged Care Incentive is provided at Appendix 5 – Checklist: General practice.

Part 6: From good to excellent: Quality primary care in aged care homes

The General Practice in Aged Care Incentive is structured to drive improvement in access to quality primary care services for people in aged care homes.

This section focuses on strategies practices can adopt to drive that improvement and builds on the basic steps and compliance requirements described in previous parts. It contains tips, advice, and clinical scenarios to help providers and care team members understand and meet the requirements of the General Practice in Aged Care Incentive. It signposts to other resources such as the RACGP Silver Book and existing tools and templates that can be used to strengthen service provision and your improvement activities.

This guidance does not provide detailed information on the MBS requirements for each of the items on the MBS Schedule. Readers should ensure their use of items numbers on the MBS and DVA schedule is consistent with the requirements of those programs.

Detailed information is available at: mbsonline.gov.au.

Practice population health approach

Practice-based population health is an approach to healthcare that focuses on improving the health outcomes for a defined group of people, typically a practice's patient population. This approach requires a shift from solely treating individual patients to also considering the health needs of the defined population. The defined population usually has similar healthcare needs: in this case, people who permanently live in an aged care home.

Key steps for implementing practice-based population health include:

1. population definition
2. data collection
3. risk stratification
4. care planning and coordination
5. patient engagement
6. preventive practices implementation
7. quality improvement
8. community partnerships
9. technology use.

Advice on implementing each of these key steps are outlined in more detail below.

Step 1. Population definition

The first step in practicing population health is to identify the population with similar care needs. For the General Practice in Aged Care Incentive this population is those who are permanent residents in a residential aged care home irrespective of age. Creating and maintaining a register of this population is an initial step in managing the care of this population.

There are various methods for identifying this population. The method you use will depend on the number of patients you have who live in aged care homes, how many homes you cover, the clinical record system you use and other factors. You will need to maintain a register of all your patients who permanently live in an aged care home and are registered with MyMedicare.

Here are some options:

- Maintain a manual register - If the number of residents is small you may want to maintain a manual list.
- Add coded data in the electronic medical record - You may add coded data in the electronic medical record (EMR). If you use this option, you can then search for codes using the EMR's search function. Your practice manager or practice nurse might help you with this.

Included tool

A General Practice in Aged Care Incentive patient monitoring and tracking tool is available for download.

An example

Figure 2 below is an example screenshot showing two codes: 'Lives in nursing home' and 'Patient registered'. These codes are from an accepted data dictionary known as SNOWMED.

Medical Conditions (6)

History | Active Only | All

Name	Diagnosed by	Diagnosed date	Status	Last Modified
Atrial fibrillation	Paresh Dawda	09 May 2024	Active	09 May 2024
COPD	Paresh Dawda	09 May 2024	Active	09 May 2024
Hypertension	Paresh Dawda	09 May 2024	Active	09 May 2024
Ischaemic heart disease	Paresh Dawda	09 May 2024	Active	09 May 2024
Lives in nursing home	Paresh Dawda	22 May 2024	Active	22 May 2024
Patient registered	Paresh Dawda	22 May 2024	Active	22 May 2024

Figure 2: Example screenshot showing use of SNOWMED codes.

Alt text: Figure 2 summaries the output of two codes in a patient's electronic medical record. There are six rows of data containing the following fields – medical condition name, diagnosed by, diagnosed date, status and date last modified.

Search demographics and place of residence

Your EMR may have fields in the demographics area to indicate whether a patient is registered with MyMedicare. It may also have a field to identify the patient's place of residence.

An example

Figure 3 below is an example screenshot showing accommodation.

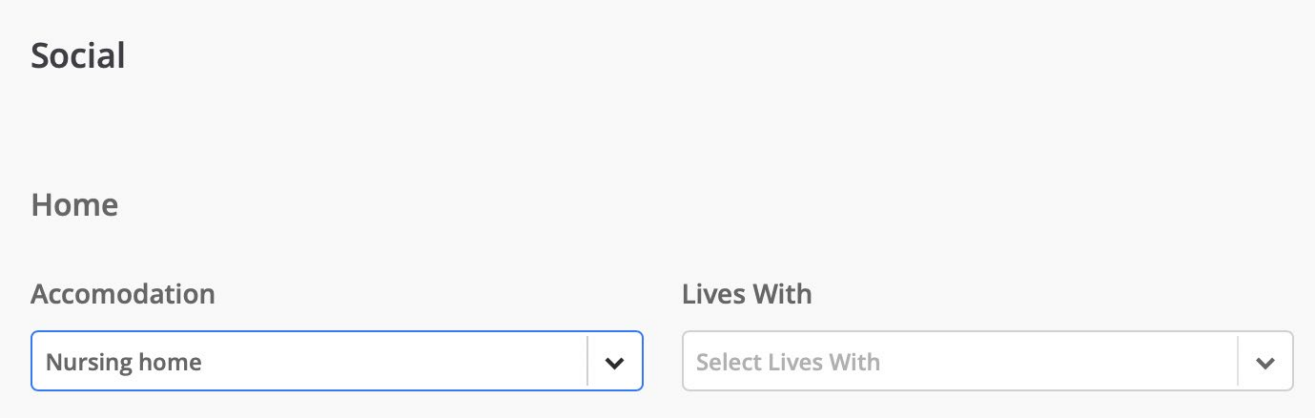


Figure 3: Screenshot showing accommodation.

Alt text: Figure 3 summaries the output of a patient's medical record showing an 'accommodation' data field, and 'nursing home' selected from a drop-down menu.

Search for billing item numbers

You may be able to search your EMR or billing software to identify patients with previous billing item numbers that can only be used for those people who receive services and live in an aged care home.

Use a data extraction and reporting tool

Your practice may use a data extraction and reporting tool which may be able to identify this population for you.

Reach out to local aged care homes

The aged care home may be able to provide a list of your patients for you.

Step 2. Data collection

Your register of patients who live in an aged care home and are registered with MyMedicare will help to monitor and track delivery of the General Practice in Aged Care Incentive service requirements. Over time the EMR and associated dataset may be expanded to support the delivery of proactive, planned, and continuous care.

A suggested key minimum data set that will help achieve the incentives service requirements includes:

- patient name
- MyMedicare registration status
- Date of MyMedicare registration (and name of GP)
- Assessment start date. The is the start date for the assessment period for the General Practice in Aged Care Incentive
- Care planning services:
  - Residential Medication Management Review (RMMR)
    - Date last RMMR
    - Date next RMMR due
  - Comprehensive Medical Assessment (CMA)
    - Date last CMA
    - Date next CMA
  - Case conference
    - Date last case conference
    - Number of case conferences in the qualifying year
  - Care plan contribution
    - Date of last care plan contribution
    - Date next care plan contribution due
- Quarterly service
  - Services provided this month
  - Additional services to be provided this month.

The minimum data set can be recorded in many ways, three examples are outlined below.

1. A front sheet for each patient on the register

Included tool

A patient front sheet template is available for download. This can be uploaded to your clinical records, saved in a folder in the aged care home or added to the persons clinical file in the aged care home records.

2. A spreadsheet tool

Included tool

A General Practice in Aged Care Incentive patient monitoring and tracking tool is available at Inclusion 3 for download.

3. A dynamic part of the EMR

You can use EMR system functionality including:

- Record keeping using coded data to help with monitoring and tracking. Relevant SNOWMED codes are summarised in the table below:

Code	How can this code help
Patient registration	This code, when recorded with the date, will identify: (1) the patient is registered (2) the date the patient was registered (3) the patient's usual GP (if entered in a free text box) (4) the patient's registration status. EMRs are introducing fields to identify patient registration and may in future receive this data from My Health Record.
Residential care medicine review	This will identify when the RMMR was undertaken.
Health assessment	This will identify when the last CMA was undertaken.
Review of care plan	This will identify when the last care plan contribution was undertaken (and at a glance show all the care plan reviews).
Case conference	This will identify when the last case conference was undertaken (and also at a glance show all the case conferences undertaken by date).
Seen in nursing home	This will identify and list those patients who are permanent residents in an aged care home.

- Using the EMR's recall, reminder and prompt functionality as you would for preventive care guidance. Most EMR systems allow you to enter reminders or recalls. Additionally, some software may also provide a prompt system:
  - Reminders are used to initiate prevention, before or during the patient visit. They exist to provide patients with systematic preventive care.
  - Recalls are a proactive follow-up to a preventive or clinical activity. These occur when it is crucial for a patient to be reviewed by the responsible provider or other team member.
  - Prompts (or flags) are usually computer-generated and designed to opportunistically draw attention during the consultation to a prevention or clinical activity the patient needs.

- Creating recurring appointments in the EMR's appointment book.

Top tip

Practice managers or practice nurses may be able to assist responsible and alternative providers make best use of the EMR system to ensure the provision of proactive, planned, and continuous care and accomplishment of the General Practice in Aged Care Incentive service requirements. Training may be needed to ensure that everyone in the team can use EMR functions consistently and confidently – so it becomes 'business as usual'.

If further support is needed, your regional PHN may be able to help upskill practice staff in the use of EMR systems and data extraction tools.

Step 3. Risk stratification

Risk stratification means segmenting the population into risk categories to identify which groups require more intensive health management. Examples of common stratification criteria for residents in aged care are those with active palliative care needs, a high likelihood of hospitalisation, or those on psychotropic medications. This step may help practices and eligible providers prioritise activities.

Step 4. Care planning and coordination

Care coordination involves deliberately organising patient care activities and sharing information among all participants in a patient's care to achieve safer and more effective care. It helps to provide safe, appropriate, and effective care by ensuring the patient's needs and preferences are known ahead of time and communicated at the right time to the right people. Care coordination is particularly important for permanent residents in residential aged care, who are likely to have complex health needs.

All four care planning services included in the incentive support care coordination. It is the provider's responsibility to make sure all legislative requirements for delivering eligible MBS and DVA Item services are met, and their service delivery complies with any other applicable programs or legislation. Each care planning service is discussed below.

Comprehensive medical assessment

A comprehensive medical assessment (CMA) is effective in reducing mortality and complex interventions in people with frailty and may reduce the risk of hospital admission and readmission. A CMA's role in a proactive cycle of care is summarised in Figure 4 below.

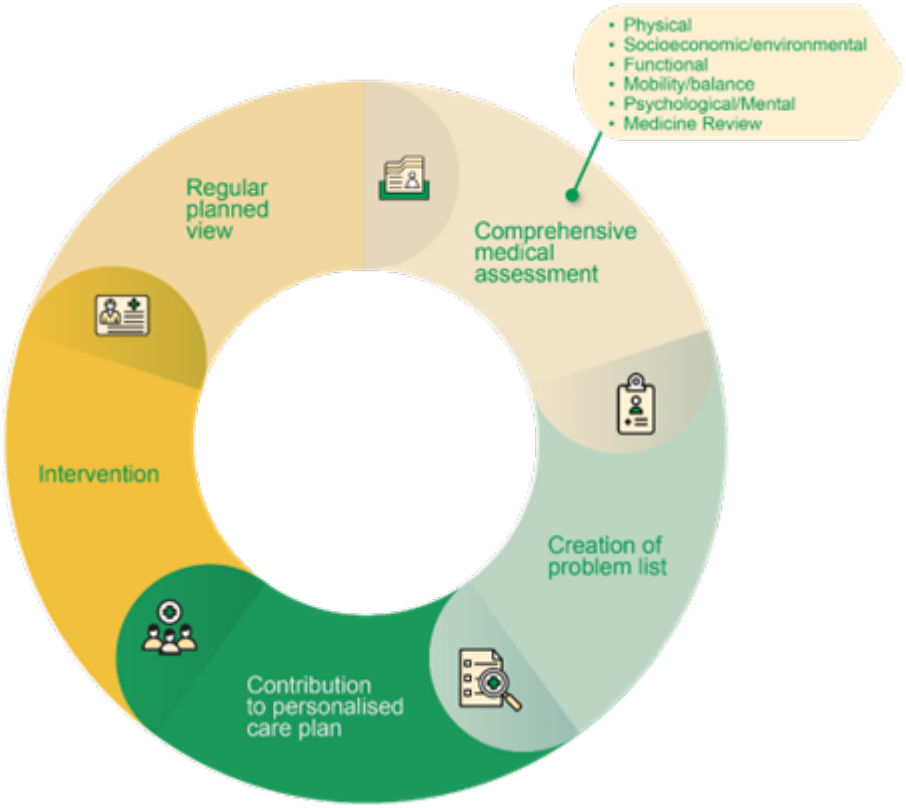


Figure 4: Proactive care cycle for people living in aged care.[2]

Alt text: Figure 4 summarises a proactive cycle of care, with a circle made up of five equal segments. The top right segment is labelled ‘comprehensive medical assessment’. To the right of this segment a call out summarises the components ‘physical, socioeconomic/environmental, functional, mobility/balance, psychological/mental and medicine review’. Continuing around the circle clockwise the next segment is labelled ‘creation of problem list’, then ‘contribution to personalised care plan’, ‘intervention’ and finally ‘regular planned view’.

A practice nurse may help to complete a CMA over one or more visits. The RACGP’s Aged Care Clinical Guide (Silver Book) outlines how to complete a CMA.

The Department of Health and Aged Care offers a downloadable CMA proforma available at https://www1.health.gov.au/internet/main/publishing.nsf/Content/AA19024A21F2A7EACA257BF0001DAB97/

Included tool

A CMA checklist is provided at Appendix 6 – Comprehensive Medical Assessment checklist.

Contribution to, or review of a multidisciplinary care plan

Care planning is a vehicle for helping shift from a reactive, disease-focused, and fragmented approach of care to a more proactive, holistic, and preventive focus. For residents in an aged care home, the aged care provider is responsible for developing the care plan and can invite a GP to review or contribute to that care plan. About one in three people living in aged care have a GP contribution to their care plan.

The elements typically included in a care plan for an older person are summarised in Figure 5 below.

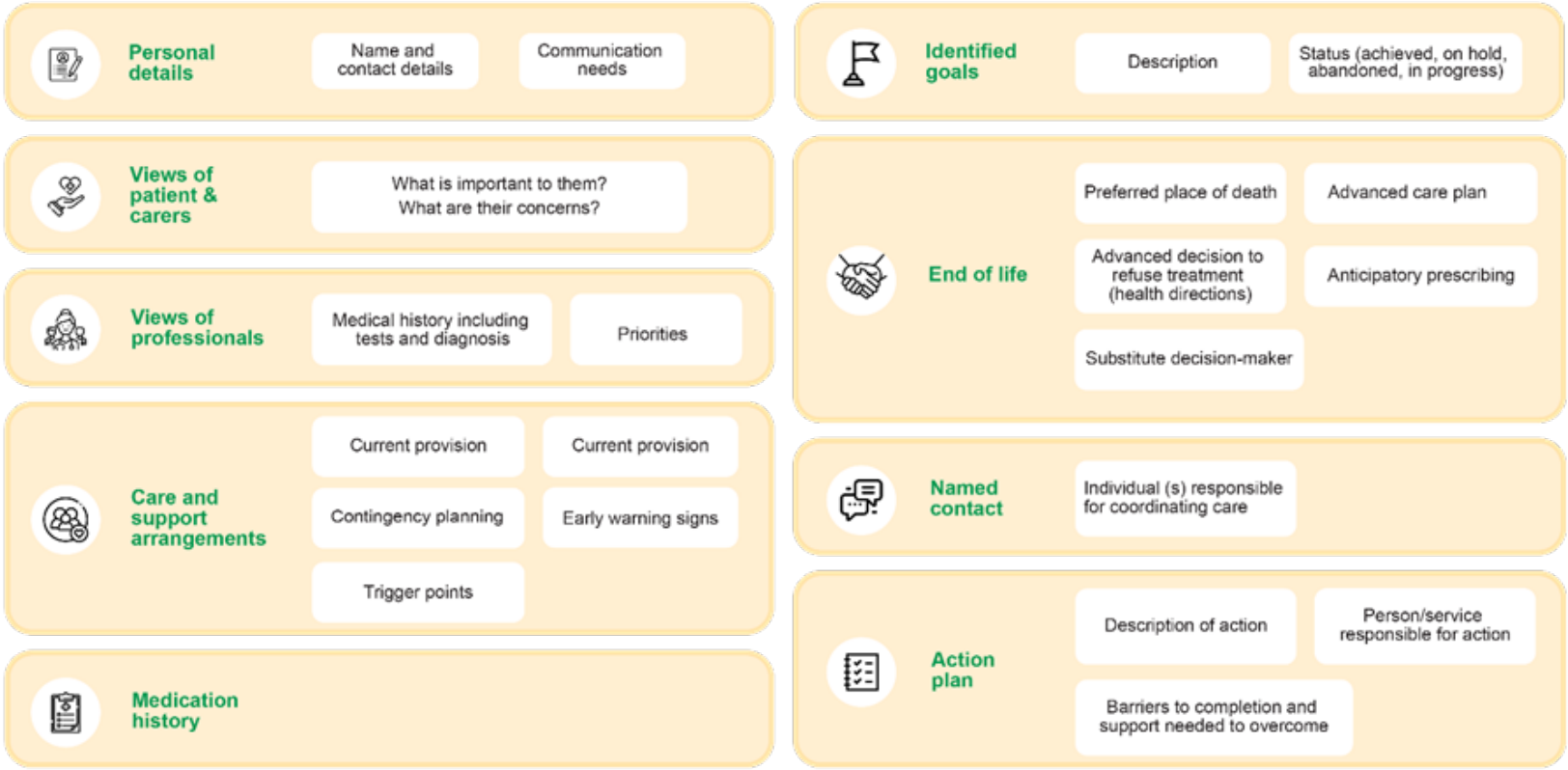


Figure 5: Care plan elements

Alt text: Figure 5 contains nine yellow boxes in two columns summarising the elements of a care plan. The first column contains 1. Personal details, including 'name and contract details' and 'communication needs'. 2. Views of patient and carers, including 'what is important to them? What are their concerns?'. 3. Views of professionals, including 'medical history including tests and diagnosis' and 'priorities'. 4. Care and support arrangements, including 'current provision', 'contingency planning', 'trigger points' and 'early warning signs' and 5. Medication history. The second column contains 6. Identified goals, including 'description' and 'status'. 7. End of life, including 'preferred place of death', 'advanced decision to refuse treatment (health directions)', 'substitute decision-maker', 'advanced care plan', and 'anticipatory prescribing'. 8. Named contact, including 'individual (s) responsible for coordinating care' and 9. Action plan, including 'description of action', 'barriers to completion and support needed to overcome' and 'person/service responsible for action'.

When reviewing a care plan or contributing to the care plan, you may wish to consider these elements. For example, contingency planning may include providing ranges of biomedical parameters (such as blood pressure ranges), sick day action plans, monitoring requirements for medications or cycle-of-care elements for long-term conditions. In keeping with the principles of person-centred care, individualised goals of care and an action plan to achieve them through an individualised management plan are critically important.

Included tool

A General Practice in Aged Care Incentive care plan contribution template is available for download.

Included tool

A multidisciplinary care plan checklist is provided Appendix 6 – Comprehensive Medical Assessment checklist.

Residential medicine management review

Older people are more susceptible to medication-related adverse events. An in-depth review of their medication, their indications, benefits, side effects and interactions contextualised to individualised goals of care may be enormously useful and inform a medicines management plan.

A residential medicine management review (RMMR) refers to a collaborative process between GPs and accredited pharmacists. Data from the Australian Institute of Health and Welfare suggests only about one in four people who permanently live in an aged care home receive an RMMR. GPs play a pivotal role, acting as primary facilitators of these reviews in collaboration with pharmacists.

GPs should consider initiating a RMMR whenever there are concerns about a patient's medication regimen, such as potential drug interactions, adverse effects, or lack of therapeutic efficacy. It is also advisable to conduct RMMRs when there is a significant change in the patient's health status, such as post-hospitalisation or following a new diagnosis that might affect medication management. The GP's role involves identifying eligible patients, obtaining consent, and providing relevant medical information to the pharmacist who will conduct the review. Tools that identify people who may benefit from an RMMR can be helpful.

After the pharmacist completes their assessment and recommendations, GPs should review these suggestions carefully, discussing any proposed changes with the pharmacist to be clear and in agreement about the best course of action. Implementing changes should be a shared decision with the patient or their primary substitute decision-maker, considering the patient's overall health plan and goals. Follow-ups to monitor the effects of any medication changes are essential. They help to assess the efficacy of the adjustments and maintain the patient's health stability. RMMRs are a proactive approach to medication management that

can significantly improve patient outcomes and reduce the risk of medication-related complications.

Included tool

A RMMR checklist is provided at Appendix 8 – Residential Medication Management Review checklist.

Coordinating or participating in a multidisciplinary case conference

A case conference is a meeting between healthcare professionals who provide care for a patient and should ideally include the patient or their primary substitute decision-maker. A case conference is useful when creating a person-centred shared care plan based on the individual's preferences and goals of care.

Case conferences are useful for improving medication appropriateness and management, and staff attitude, competence, and development.

The GP might organise and coordinate a case conference or participate in one that another care team member convenes. The case conference involves:

- discussing the patient's history
- identifying the multidisciplinary care needs
- identifying the outcomes that each team member is to achieve
- identifying and assigning tasks to help achieve the outcomes
- identifying whether previously identified outcomes were achieved.

Case conferences are useful in various scenarios when effective communication and collaboration among the multidisciplinary team may be necessary to enhance patient outcomes through comprehensive and coordinated care efforts.

Included tool

Appendix 9 – The Case Conference process outlines the steps to consider when coordinating a case conference.

A case conference checklist is provided at Appendix 10 – Case Conference Checklist.

Case study 2 – Bernie

Bernie is an 86-year-old man. He is a retired civil engineer. Since retiring he has lived in the same house for the past 25 years with his wife, Alice. Bernie and Alice have been married for over 60 years. They have little family support with two children residing overseas and only one, their son Paul, living closer to them. Paul has enduring power of attorney. They have had domestic and gardening assistance through a Commonwealth home care package. Carers assist Bernie with washing and dressing, and they also help with medication. They are a social couple and have a wide network of friends. Despite being speech impaired, Bernie is social and enjoys company, good food and wine.

Bernie experienced a major stroke some years ago. In the intervening time Bernie has become more immobile, increasingly frail and at risk of a fall. He is speech impaired and lives with diabetes, chronic heart failure and prostate cancer. He is under the care of a GP who has seen him for over 15 years and an oncologist, and he was recently referred to a geriatrician.

Bernie's health and speech impairment have rapidly declined. His capacity to live independently and Alice's incapacity to confidently and safely care for him has led to the decision for Bernie to transition to an aged care home following an Aged Care Assessment Team assessment. The aged care home is some distance from his local practice. His GP has indicated that, reluctantly, they will not visit him in his new home, and he will need to find a new GP. Alice will continue to live independently in the family home.

The aged care home that Bernie will be moving to provided Bernie with a list of GPs that attend the facility and information on MyMedicare and explained that there is an incentive to support GPs to visit people in residential aged care. Alice and Bernie looked through the list and spoke to Dr. Singh's clinic. They arranged an extended initial appointment at the aged care home to meet with Dr. Singh.

At the appointment Dr Singh went through Bernie's medical history and medications and Shared Health Summary on My Health Record. Dr. Singh explained how primary care service in aged care homes operate. Together they discussed the importance of a comprehensive medical assessment and agreed to proceed with this. Dr Singh advised that the practice nurse will assist with this and organised an appointment the following week for the practice nurse to visit Bernie.

The practice nurse attended and assisted with gathering information including the most recent reports from the oncologist and geriatrician. Following this information a care plan was constructed. Visual timelines for Bernie's care can be found at Appendix 11.

Step 5. Patient engagement

The Royal Commission into Aged Care Quality and Safety highlights the critical importance of including patients and consumers in planning and delivering care services. Doing so not only enables safe, compassionate, and competent care but also helps tailor care to each patient's individual needs and preferences.

Many strategies are available for engaging people who live in aged care homes in their own care. For example, after a care plan review or contribution is completed by the responsible provider, a practice nurse or Aboriginal health worker may follow up. Their services contribute to the quarterly service requirement for the General Practice in Aged Care Incentive.

Examples for engaging people who live in aged care homes in their own care include:

- Improve health literacy - Provide tailored information and health education sessions that are understandable and relevant to people who live in aged cares home and include their

family, friends and carers where appropriate. Use simple language and visual aids to explain health conditions, medications, and treatments.

- Support shared decision-making - Involve older adults or their substitute decision-makers in every step of their care planning. Make sure they understand all options so they can make informed decisions that reflect their personal preferences and values. Use shared decision-making tools where available to guide and facilitate the conversation.
- Support goal setting - Encourage people in aged care homes to set their own health goals, however small, which motivate them to engage more actively in their health management. Help them align their goals with their care plans. An illustration is provided in the Case Study below.
- Educate in technology - Train people who live in aged care homes in new technology, to enhance their independence.
- Support peer support groups. Facilitate access to peer support groups where older adults can share experiences, challenges, and strategies. These groups provide emotional support and practical advice from peers who understand their circumstances.
- Support advocacy training - Offer sessions on how to advocate for oneself in healthcare settings. Teach older adults how to express their needs and concerns effectively to healthcare providers.
- Implement physical activity programs - Implement accessible physical activity programs tailored to the abilities and interests of older adults to keep them physically active and socially engaged.
- Provide access to information - Make sure older adults have easy access to their own medical records and health information, including medication charts. Teach them how to use this information to better manage their health.
- Create regular feedback mechanisms - Develop systems in which older adults can regularly give feedback on their care experience. Use this feedback to make continuous improvements in services.
- Strengthen cultural competence - Make care and communication strategies culturally appropriate and sensitive so older adults from diverse backgrounds feel respected and understood.

Case study 1 – Mavis

Dr Lee and the practice nurse supported Mavis to consider and decide how her goals of care could be more person-centred to provide her with motivation she needs to better manage her health.

In doing so these goals of care shifted:

	From	To
Need	To breathe better	I need to feel less short of breath so I can get around more and have conversations with others

Goal	To prevent going to emergency	I will increase my daily activity level to manage my COPD more effectively. I plan to achieve this by walking for at least 10 minutes each day. This will help me improve my lung function and overall stamina, allowing me to participate more in activities that I enjoy
Action	Take puffers as prescribed	

Step 6 Preventive practices implementation

The suite of care planning services under the General Practice in Aged Care Incentive offers an opportunity to identify preventive and proactive care services and incorporate them in care planning.

The Royal Australian College of General Practitioners' Guidelines for preventative activities in general practice cover preventive activities for older people relating to immunisations, falls, physical activity, visual and hearing impairment, and dementia.

The Royal Australian College of General Practitioners' Guidelines are available here: https://www.racgp.org.au/clinical-resources/clinical-guidelines/key-racgp-guidelines/view-all-racgp-guidelines/guidelines-for-preventive-activities-in-general-pr/preventive-activities-in-older-age/introduction.

Your clinical information system recalls and reminders functions can help in planning and delivering those preventive services.

Step 7. Quality improvement

Quality improvement is a fundamental component of the General Practice in Aged Care Incentive. You will need to use a continuous quality approach to developing and delivering services under the incentive. Responsible providers and practice team members (practice manager, practice nurse and administrators) and the aged care home team members should come together to:

- co-design joint working relationships and agree roles and contributions
- put in place agreed workflows and joint working protocols
- plan and coordinate care
- regularly review and refine healthcare practices and joint working arrangements
- assess the population's evolving needs.

Top tip

Practices and aged care homes may benefit from formalising relationships through developing a simple Memorandum of Understanding which consolidates agreements on joint working relationships.

Using a systematic approach to quality improvement that involves reviewing data and performance and making changes to improve may contribute to professional CPD requirements.

Aligning quality improvement efforts with change activities required to implement the General Practice in Aged Care Incentive and voluntary or compulsory standards will strengthen collaboration between responsible providers, practice care teams and aged care homes to achieve better patient outcomes.

Relevant standards include:

- RACGP Aged Care Clinical Guide (Silver Book) Fifth Edition
- RACGP Standards for General Practice Residential Aged Care
- RACGP Standards for general practices 5th edition
- Department of Health and Aged Care National Aged Care Mandatory Quality Indicator Program (QI Program)
- Aged Care Quality and Safety Commission's Aged Care Quality Standards.

To inform continuous quality improvement consider surveying (once or twice a year) residents who have participated in the incentive about their experience and satisfaction with services being provided under the incentive.

Top tip

Liaise with your local PHN on the quality improvement capability building and facilitation services it may provide to strengthen implementation of the General Practice in Aged Care improvement and continuous quality improvement activities.

Step 8. Community partnerships

You may like to collaborate with community organisations and other stakeholders in your care of people who live in aged care homes to address broader social determinants of health.

An example of community participation in residential aged care is partnering with local schools to create intergenerational programs that benefit both residents and students. In this setup, students regularly visit the aged care home to engage with the residents by reading, playing games, doing arts and crafts, and sharing in storytelling sessions. This interaction not only provides people living in aged care homes with valuable social stimulation which may improve their mental health and overall wellbeing, but also gives the students the opportunity to learn from the older generation and develop empathy and social responsibility.

These visits can include educational components in which people share their historical knowledge or life skills, such as knitting or woodworking, with the younger generation. Conversely, students can help residents with technology, explain how to use smartphones and tablets, and connect them with distant family members on social media or video calls. This mutual exchange enriches the lives of both residents and young people and creates a vibrant community connection that breaks down age barriers and enhances quality of life.

Aged care homes usually organise this type of community partnership, but GPs may identify instances when a social prescription may help.

Step 9. Technology use

Technology can be enormously valuable when adopting a practice-based population health approach to the proactive, planned, and continuous care of people who live in aged care homes.

For those responsible providers and practices that operate in MMM areas 4–7, telehealth will help you meet 50% of the quarterly service requirements under the incentive.

All responsible providers and practices will benefit from the use of data extraction and reporting tools. These will help you monitor and track progress towards meeting the needs of your registered aged care home population.

Part 7: Nothing about us without us: Engaging with people in aged care homes

The principle of 'Nothing about me without me' emphasises the importance of involving patients in decisions about their own care. This approach is especially crucial in aged care homes where patients can often feel overlooked or disempowered. The Royal Commission into Aged Care Quality and Safety highlighted significant gaps in the delivery of person-centred care in aged care homes, underscoring the need to better engage aged care residents in their care planning and decision-making.

Findings from the Royal Commission revealed that many residents felt they had little to no say in the care they received, which directly impacted their wellbeing and satisfaction. The Commission's report stressed the importance of respecting peoples' autonomy and hearing their voices. This involves listening to their preferences and actively involving them in discussions about their healthcare plans, treatments, and daily activities. The report recommended that aged care homes adopt policies that promote shared decision-making and foster a culture of respect and inclusion.

The Aged Care Quality Standards support this approach by outlining requirements for consumer dignity and choice. Standard 1 specifically calls for care that is inclusive, respects individual identity, and ensures that residents are treated with dignity and respect.[8] These standards highlight the need for GPs and other healthcare providers to work collaboratively with residents, considering their preferences and involving them in all aspects of their care. This collaboration can lead to more tailored and effective care plans that align with the residents' values and needs.

For GPs working in aged care homes, applying the 'Nothing about me without me' principle means taking the time to understand each person's personal history, preferences, and health goals. It requires effective communication skills and a commitment to patient-centred care. This might involve regular meetings with residents and their families, using plain language to explain medical conditions and treatment options, and making sure people feel comfortable voicing their opinions and concerns.

Ultimately, embracing this principle not only enhances quality of care but also improves the overall experience for people in aged care homes. It fosters a sense of autonomy and respect, which is fundamental to their dignity and quality of life. By making people active participants in their care, GPs can help create a more responsive and compassionate aged care system.

Glossary

Glossary of term	Description
Accreditation	A formal process by which a recognised body assesses and recognises that a healthcare organisation meets applicable predetermined standards.
Advance Care Plan	A document that outlines a patient's wishes regarding future healthcare and treatments, especially end-of-life care, if they become unable to communicate these decisions themselves.
After Hours Attendance	Medical consultations provided outside of regular working hours to cater to urgent healthcare needs of patients. Urgent after-hours periods are from 11:00 pm to 07:00 am. Non-urgent after-hours periods in a Residential Aged Care Facility are defined as: Before 8:00 am and after 6:00 pm Monday to Friday Before 8:00 am and after 12 noon on Saturday 24 hours on Sunday and/or public holidays.
Alternative Provider	An alternative provider, within the same practice, who contributes to the delivery of eligibles services within the General Practice in Aged Care Incentive, at the direction of the 'responsible provider' including another GP or GP registrar, a nurse practitioner, a practice nurse, Aboriginal and Torres Strait Islander health practitioner or Aboriginal health worker.
Best Practice Resources and Tools	Recommendations developed based on evidence to guide healthcare professionals in providing the best possible care in specific clinical scenarios.
Care Planning	The process of organising and managing the health and wellness of a patient, particularly focusing on chronic disease management, preventive care, and coordination of care among multiple providers.

Glossary of term	Description
CIS (Clinical Information System)	A health information system used primarily in clinical settings to store and manage patients' electronic health records.
Comprehensive Medical Assessment (CMA)	A detailed evaluation of a patient's health status, typically including medical history, physical examination, and recommendations for treatment and care planning.
Department of Veterans' Affairs (DVA)	A government department responsible for delivering government programs for war veterans, including health care and support services.
Electronic Health Record (EHR)	A digital version of a patient's paper chart, EHRs are real-time, patient-centred records that make information available instantly and securely to authorised users.
General Practice in Aged Care Incentive	An incentive program aimed at enhancing the provision of primary care services in residential aged care facilities by paying eligible GPs, practices, and Aboriginal health services to provide more regular visits and care planning services to patients permanently living in aged care homes.
Medicare Benefits Schedule (MBS)	A listing of the medical services subsidised by the Australian government, providing information on the amount Medicare will rebate for each service.
Modified Monash Model (MMM)	A classification system that categorises locations in Australia based on geographical remoteness and population size, used to allocate healthcare resources and incentives.
MyMedicare	A voluntary patient registration model aiming to formalize the relationship between patients, their general practice, general practitioner, and primary care teams.
Person-Centred Care	An approach to healthcare that respects and responds to the preferences, needs, and values of patients, ensuring that patient values guide all clinical decisions.

Glossary of term	Description
Residential Aged Care Home (RACH)	Facilities providing accommodation and care for older people who can no longer live independently, offering assistance with daily activities, healthcare, and social support.
Residential Medication Management Review (RMMR)	A collaborative review process between a GP and an accredited pharmacist to optimise a resident's medication regimen, ensuring efficacy and reducing the risk of adverse effects.
Responsible Provider	A provider who takes responsibility for delivering eligible services, including services provided by other health professionals at the practice, to an eligible patient as part of the General Practice in Aged Care Incentive.
Royal Commission into Aged Care Quality and Safety	An investigation established to examine the quality of aged care services and the safety and wellbeing of recipients, resulting in recommendations for system-wide improvements.
SNOMED	A comprehensive, multilingual healthcare terminology that provides codes, terms, synonyms, and definitions used in clinical documentation and reporting.
Substitute Decision-Maker	A person legally authorised to make healthcare decisions on behalf of a patient who is unable to make decisions for themselves.
Telehealth	The delivery of health-related services and information via telecommunications technologies, allowing long-distance patient and clinician contact, care, advice, reminders, education, intervention, monitoring.

Useful resources

Resource	Description
Guidelines for preventive activities in general practice The Royal Australian College of General Practitioners (RACGP)	A guideline that provides the general practice team with guidance on preventive care, including a comprehensive and concise set of recommendations.
Health professional education resources Services Australia	This is the Services Australia portal for health professional education resources and covers: • HPOS • incentives programs • Medicare Benefit Schedule including multidisciplinary case conferences • Organisation Register • MyMedicare. Resources for the General Practice in Aged Care Incentive will be on this portal
Interpretive Guide RACGP	This guide offers guidance for the accreditation of general practices under the new definition of a general practice for the purpose of accreditation.
MyMedicare The Department of Health and Aged Care	This website provides more information on MyMedicare for patients and healthcare professionals.
Accessing the MyMedicare program for health professionals Services Australia	This page describes the requirements for general practices, healthcare providers and patients to participate in MyMedicare.
Primary Health Networks The Department of Health and Aged Care	This page offers information on all current PHNs, including a PHN finder.
Standards for general practice residential aged care. 1st edn. RACGP	Standards developed to support delivery of high-quality and safe GP care to people living in aged care homes. They are voluntary and may be helpful for practice managers to support conversations with aged care homes.
Standards for General Practice (5th edition) RACGP	This website offers information on the Standards for General Practice (5th edition) including a link to download a PDF.

Resource	Description
RACGP Aged care clinical guide (Silver Book) – 5th edition Part B. Medicare Benefits Schedule item numbers RACGP	This PDF offers advice and practice guidance on the requirements of the care planning services.
Consumer enablement – a clinician's guide NSW Agency for Clinical Innovation	Contains guidance on how clinicians can think differently about health care. It has information, tools, and resources to help consumers, carers and communities manage their own health and wellbeing.
Comprehensive geriatric assessment toolkit for primary care practitioners British Geriatrics Society	This toolkit explains the comprehensive geriatric assessment and how to undertake one. It includes a range of conditions and situations and a specific section on care planning.
Comprehensive medical assessment proforma Department of Health and Aged Care	This downloadable PDF is a proforma for a comprehensive medical assessment.
MBS Online Department of Health and Aged Care	MBS Online has a listing of the Medicare services the Australian Government subsidises and details about MBS item descriptors and explanatory notes.
MBS Comprehensive medical assessment for residents of residential aged care facilities fact sheet Department of Health and Aged Care	This fact sheet covers the components of a comprehensive medical assessment, restrictions on providing a comprehensive medical assessment, and other requirements.
Medicines management in residential aged care facilities – guiding principles Department of Health and Aged Care	These guiding principles for medication management in residential aged care promote the quality use of medicines and medication safety.
Medicines management review – information for medical practitioners NPS MedicineWise	This short information leaflet developed by NPS MedicineWise outlines the steps in a medication management review.
Multidisciplinary case conferences Services Australia	This educational resource from Services Australia has education on multidisciplinary case conferencing.

Resource	Description
Referral form for allied health services Department of Health and Aged Care	This referral form may accompany a care plan contribution so the patient can receive a rebate for allied health services.
Work together toolkit from end-of-life directions for aged care End of Life Directions for Aged Care	This toolkit has information, forms, and templates for case conferencing with a focus on palliative care case conferences.

Appendix 1 – Suggested assessment criteria to inform your decision to participate

From Part 3: Choosing to participate

Demographic:

- Population and predicted population growth.
- Demographics of people in aged care homes.

Ethical and philosophical:

- Alignment with personal and practice purpose, shared values, and principles.
- Level of commitment to greater access to quality primary care for people in aged care homes.
- Level of confidence in ability to successfully implement and realise the benefits of the incentive.

Economic/financial:

- An additional funding stream/income source.
- Opportunity to review fee structure.
- Opportunity to review disbursements.
- Opportunity to fund infrastructure, workforce, care team skills and capability building etc., via the practice incentive.

Policy/strategy:

- Alignment with strategic direction
- Alignment with practice sustainability or growth strategy.

External Environment

- Predicted aged care provider capacity growth.
- Opportunity to improve access to primary care and other health services through greater collaboration with aged care homes.
- Level of service provision/capacity amongst neighbouring practices.
- Emergent new providers.

Internal Systems, Workforce Capacity and Capability:

- Level of capacity
- Level of collaboration within the practice care team.

- Opportunity to enhance service capacity and capability through strengthening team-based care arrangements.
- Opportunity to streamline workflows to enhance service effectiveness and efficiencies.
- Opportunity for service alignment, development, or growth.

Telehealth and technology:

- Ability to provide eligible telehealth services under the incentive as an alternative to eligible face-to-face services.
- Ability to utilise practice incentive payment to sponsor technological growth.

Appendix 2 – Checklist: Responsible provider

From Part 4: Meeting the service requirements

The following provides a suggested checklist for responsible providers:

☐	Confirm you are an eligible provider.
☐	Check you are linked to your eligible practice on the Organisation Register.
☐	Confirm the patient's eligibility for the incentive.
☐	Confirm you are identified as the responsible provider of eligible services to the registered patient, including coordinating services provided by the care team.
☐	Speak with your practice colleagues to plan optimal care for your patient and others like them who are permanent residents in aged care homes and how to align this with the incentive.
☐	Discuss the incentive with the staff at the aged care home.
☐	Create a plan for informing your patients and, where they do not have capacity, their substitute decision-makers.
☐	Confirm the patient's consent to participate in the incentive.
☐	Deliver eligible service requirements to your registered patients.

Appendix 3 – Potential roles and responsibilities of practice managers and practice nurses

From Part 5: Information for practice managers and nurses

Below are some possible roles and responsibilities that practice managers and practice nurses may be able to take when operationalising the incentive. It is important that these are discussed and agreed with responsible providers within your practice to ensure agreement on team arrangements:

Administrative support

Appointment scheduling

- Efficiently manage the GP's schedule to optimise patient flow while ensuring sufficient time is allotted for each consultation. Informing the RACH, patient, and their carer/family of changes to schedules.

Billing and coding

- Handle all aspects of billing and coding accurately to ensure that the practice and provider receives appropriate compensation for the services the GP renders.

Compliance management

- Ensure that the practice adheres to all relevant health regulations and laws, including privacy laws and practice standards.

Patient eligibility

It is the practice's and provider's responsibility to ensure a patient is eligible. They must declare their patient meets eligibility criteria for the General Practice in Aged Care Incentive as part of the patient registration process. Practices will need to:

- link providers and their MyMedicare-registered patients to their practice.
- select the General Practice in Aged Care Incentive indicator on their patient's MyMedicare profiles.
- link patients to the responsible provider at the practice.

Patient records management

- Provide infrastructure to maintain secure and accurate patient records, ensuring they are updated promptly and are easily accessible to the GP.
- Collaborate with the RACH to ensure access for providers and practice team members to the RACH clinical software and electronic prescribing software (where appropriate).

Clinical support

Equipment and supplies

- Ensure that all necessary clinical supplies and equipment are stocked and maintained so the GP has the necessary tools to provide care.
- Ensure cold chain processes are in line with accreditation requirement for offsite vaccinations.

Infection control

- Implement and maintain high standards of cleanliness and infection control necessary for offsite visits.

Clinical assistance

- Provide assistance during examinations and procedures as needed, including preparation and follow-up care.

Communication and coordination

Patient communication

- Manage communication with patients, including appointment reminders, follow-ups, and education as directed by the GP.

Referral coordination

- Coordinate with other healthcare providers for referrals, ensuring seamless care transitions and sharing of necessary patient information.

Team collaboration

- Foster a collaborative environment within the practice to facilitate effective teamwork and communication among all staff members.
- Provide support with co-ordination of case conferences.

Communication with aged care homes

- Collaborate with aged care homes to agree and document ways of working. These may be informal or formalised through a Memorandum of Understanding (MoU). The Standards for general practice residential aged care may assist.

Staff management

Professional development

- Facilitate continuous professional development (CPD) opportunities for all staff to keep up-to-date with the latest medical practices and technologies.

Staff scheduling

- Manage staff schedules to ensure that the practice is adequately staffed to support the GP and patient needs during practice operational hours.

Conflict resolution

- Promptly address and resolve any conflicts within the practice to maintain a positive working environment.

Quality improvement

Feedback and reviews

- Implement systems to gather feedback from patients, RACH staff and practice team members to identify areas for improvement in the services provided.

Performance monitoring

- Regularly review the performance of the practice in terms of patient care and operational efficiency, making adjustments as necessary.

Appendix 4 – Suggested indicators to support a data-driven approach

From Part 5: Information for practice managers and nurses

To meet the program requirements, indicators such as those listed below may be helpful. The indicators should be both forward-looking and backward-looking. Reports may be accessible from data-extraction tools and/or practice clinical information software tools. Most of these indicators are process indicators:

Indicator
Number of patients who are permanent residents in aged care homes
Number of patients who are permanent residents in aged care homes and who are registered with MyMedicare (GPACI Register)
Number of patients who are permanent residents in aged care homes and who are registered with MyMedicare segmented by responsible provider
Number of patients on the GPACI Register who have had a CMA in last 12 months (with option to segment by provider) Number of patients on the GPACI Register who will be eligible for a CMA in the next 12 months (with option to segment by responsible provider)
Number of patients on the GPACI Register who have had a Care Plan Contribution in the last 12 months (with option to segment by provider) Number of patients on the GPACI Register who will be eligible for a Care Plan Contribution in the next 12 months (with option to segment by provider) Number of patients on the GPACI Register who have had a Care Plan Contribution in the last 13 weeks (with option to segment by provider) Number of patients on the GPACI Register who will be eligible for a Care Plan Contribution in the next 13 weeks (with option to segment by provider)
Number of patients on the GPACI Register who have had a RMMR in last 12 months (with option to segment by provider) Number of patients on the GPACI Register who will be eligible for a RMMR in the next 12 months (with option to segment by provider)
Number of patients on the GPACI Register who have had a Case Conference in last 12 months (with option to segment by provider) Number of patients on the GPACI Register who will be eligible for a Case Conference in the next 12 months (with option to segment by provider)

Indicator
Number of patients on the GPACI Register who have had two or more care planning services since the Assessment Start Date (with option to segment by provider)
Number of patients on the GPACI Register who have NOT had a minimum of two care planning services since the Assessment Start Care and require these to be conducted in the next quarter to retain registration (with option to segment by provider)
Number of patients on the GPACI Register who have had two or more visits in the current quarter in separate calendar months (with option to segment by provider)
Number of patients on the GPACI Register who have NOT had two or more visits in the current quarter in separate calendar months (with option to segment by provider)

Appendix 5 – Checklist: General practice

From Part 5: Information for practice managers and nurses

The following provides a useful suggested checklist for implementing the General Practice in Aged Care Incentive for practice managers and nurses:

☐	Confirm the practice is registered in the Organisation Register.
☐	Confirm the practice is registered with the MyMedicare program (with banking details added).
☐	Register the practice in the General Practice in Aged Care Incentive.
☐	Confirm the incentive indicator has been added to the patient's MyMedicare profile.
☐	Agree on a data-driven system for monitoring performance against the requirements in the practice.
☐	Meet with responsible providers who provide services to people in aged care homes and agree the supports the practice can offer them in providing care.
☐	Consider patients who have had care plan contributions and where follow up from a practice nurse may be appropriate.
☐	Liaise with aged care home and agree ways of working for mutual benefit.

Appendix 6 – Comprehensive Medical Assessment checklist

From Part 6: From good to excellent: Quality primary care in aged care homes

When conducting comprehensive medical assessments (CMAs) it is suggested you confirm you have:

☐	a checklist for identifying those who are eligible for a CMA
☐	a monitoring system for monitoring CMA completion (and CMAs due) for people residing in residential aged care
☐	a proforma for CMA (ideally embedded in the EMR)
☐	a consenting process for CMA from the patient where they have capacity or from their substitute decision-maker (CMAs are voluntary and require informed consent)
☐	a process for sharing the findings of the CMA with the patient.

Appendix 7 – Multidisciplinary Care Plan checklist

From Part 6: From good to excellent: Quality primary care in aged care homes

This checklist of care plan elements may help when reviewing a care plan. Any omissions may be supported with a care plan contribution.

☐	Communication-related concerns
☐	View of patients/family Individualised goals of care
☐	Views of professionals • Problem list • Psychological concerns • Functional and social concerns • Medication-related concerns • Mobility and balance issues • Bone health • Risk of falls and fractures • Emotional wellbeing • Confusion, cognition, and delirium-related concerns • Mental capacity concerns • Continence-related concerns • Nutritional concerns • Dental and oral hygiene concerns
☐	End of life-related matters and concerns • Preferred place of death • Advanced care plan • Substitute decision-maker
☐	Action plan • Details of responsible people
☐	Follow-up details

Appendix 8 – Residential Medication Management Review checklist

From Part 6: From good to excellent: Quality primary care in aged care homes

When conducting Residential Medication Management Reviews (RMMRs) it is suggested you:

☐	Obtain a list of eligible RMMR service providers with whom the RACH has agreements.
☐	Refer new residents for an RMMR as soon as possible after admission.
☐	Use a tool such as the NO TEARS9 tool to help identify medication-related issues and patients who may benefit from an RMMR.

Appendix 9 – The Case Conference process

From Part 6: From good to excellent: Quality primary care in aged care home

Pre-Conference Preparation:

- **Identify the Need for a Conference**:
  - Assess if the patient's condition involves multiple health disciplines or complex care needs.
  - Determine if recent changes in the patient's health status require a reassessment of the care plan.
- **Set Clear Objectives**:
  - Define what you aim to achieve through the conference (e.g., update care plan, resolve specific issues).
- **Gather Relevant Information**:
  - Compile medical records, recent test results, and any other relevant patient information.
  - Review medications, current treatment regimens, and recent health changes.
- **Invite Appropriate Team Members**:
  - Identify all healthcare professionals and support staff whose input is crucial for the patient's care.
  - Ensure invitations include clear details on the conference's objective, date, time, and venue or online platform details.
- **Consent and Communication**:
  - Obtain consent from the patient or their legal guardian/carer for the conference and the sharing of their medical information.
  - Communicate the purpose and expected outcomes of the conference to the patient or their carer.

During the Conference:

- **Facilitate Discussion**:
  - Lead the meeting effectively, ensuring all participants can contribute their views and expertise.
  - Encourage a collaborative atmosphere and mediate any conflicts or discrepancies in opinions.
- **Focus on Patient-Centered Care**:
  - Ensure that all decisions and care plans focus on the patient's preferences, needs, and overall well-being.
- **Document Key Points and Decisions**:
  - Take detailed notes on discussions, care decisions, and assigned responsibilities.

Post-Conference Actions:

- **Communicate the Care Plan**:
  - Clearly communicate any changes or updates in the care plan to the patient and their carer.
  - Distribute a summarized report of the conference to all participants and other relevant parties.
- **Implement Agreements**:
  - Initiate any changes or interventions agreed upon during the conference.
  - Coordinate with other team members to ensure smooth implementation of the plan.
- **Schedule Follow-Ups**:
  - Set dates for follow-up meetings or assessments to monitor the patient's progress and effectiveness of the new care plan.
- **Update Records**:
  - Update the patient's medical records with the outcomes of the conference and any subsequent treatment changes.

Review and Reflect:

- **Evaluate the Conference Process**:
  - Reflect on the process and outcome of the case conference.
  - Consider feedback from participants and areas for improvement in future conferences.

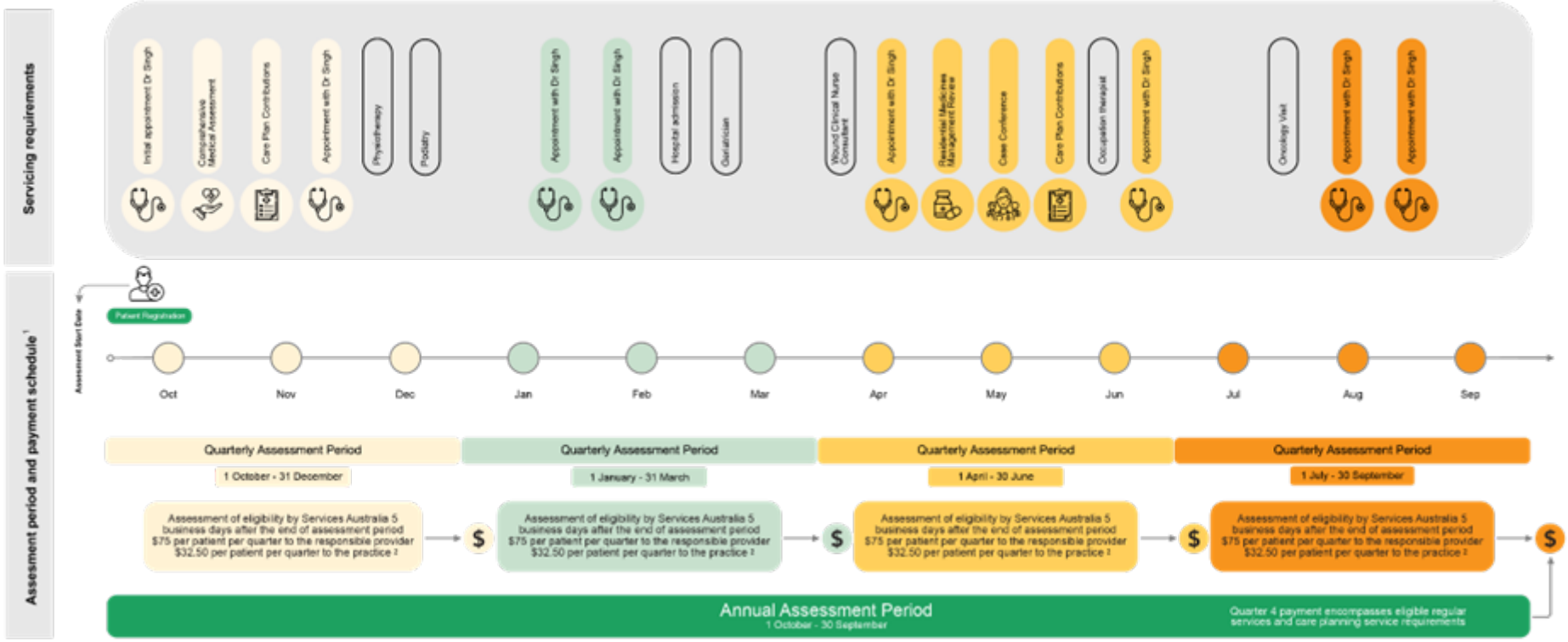
Appendix 10 – Case Conference Checklist

From Part 6: From good to excellent: Quality primary care in aged care homes

When conducting case conferences, it is suggested that you:

☐	Establish a process for documenting your patients' care team members.
☐	Identify opportunities when case conferencing may help a patient's care.
☐	Identify a template for coordinating the case conference: • Discuss with the practice manager how the practice team may help coordinate a case conference.
	Identify a template for recording the case conference: • Discuss with the practice manager whether the clinical software has a template for this purpose.

Appendix 11 – Bernie's care journey



[1] The 12-month assessment periods are dependent on each patient's quarterly assessment start date

[2] Rural loading to be applied where appropriate

Alt text: Figure 6 summaries Bernie's care journey. A centre timeline goes from Jul to Jun horizontally, with each month represented by a circle. Above the timeline the servicing requirements are represented. In quarter one - two regular services, a comprehensive medical assessment, and a care plan contribution. Two non-incentive services are also delivered. In quarter two – two regular services and two non-incentive health care interactions. In quarter three - two regular services, a residential medicines management review, a case conference, and a care plan contribution, as well as two non-incentive interactions. In quarter four - two regular services and one non-incentive appointment. Beneath the centre timeline the assessment period and payment schedule is represented. Every three months are grouped together as a Quarterly Assessment Period. Beneath each Quarterly Assessment Period is the text 'Assessment of eligibility by Services Australia 5 business days after the end of the assessment period. $75 per patient per quarter to the responsible provider. $32.50 per patient per quarter to the practice'. The four Quarterly Assessment Periods are combined into the Annual Assessment Period containing the text 'Quarter 4 payment encompasses eligible regular services and care planning service requirements'.

All information in this publication is correct as of August 2024.