GUIDELINES
for the
AGED CARE GP PANELS INITIATIVE
August 2007
Guidelines For The Aged Care GP Panels Initiative

Publications Number: P3 -2282

Copyright Statements:

Paper-based publications
(c) Commonwealth of Australia 2007
This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without prior written permission from the Commonwealth. Requests and inquiries concerning reproduction and rights should be addressed to the Commonwealth Copyright Administration, Attorney-General’s Department, Robert Garran Offices, National Circuit, Barton ACT 2600 or posted at http://www.ag.gov.au/cca

Internet sites
(c) Commonwealth of Australia 2007
This work is copyright. You may download, display, print and reproduce this material in unaltered form only (retaining this notice) for your personal, non-commercial use or use within your organisation. Apart from any use as permitted under the Copyright Act 1968, all other rights are reserved. Requests and inquiries concerning reproduction and rights should be addressed to Commonwealth Copyright Administration, Attorney-General’s Department, Robert Garran Offices, National Circuit, Barton ACT 2600 or posted at http://www.ag.gov.au/cca
Contents

1) Background 1
   a) Government Direction 1

2) The Initiative 1
   a) Development of the Initiative 1
   b) Aims 2
   c) The Participants 3
   d) Funding 4

3) Roles and Responsibilities 5
   a) Department of Health and Ageing 5
   b) The Divisions Network 6
   c) GPs 7
   d) Allied Health Service Providers 8
   e) Residential Aged Care Facilities (RACFs) 8
   f) Geriatricians 9

4) GP Panels 10
   a) Definition of Panels 10
   b) Appointment of GPs and Allied Health Service Providers to Panels 10
   c) Panel Activities 11
   d) Funding – GP Remuneration 13
   e) Funding – Allied Health Service Provider Remuneration 13
   f) Funding - Other Activities 14

5) Division Support Work 15
   a) Activities of Divisions 15
   b) Funding - Divisions Support Work 16
   c) Reporting Requirements 17

6) Performance, Monitoring and Evaluation 18
   a) Types of Data 18
   b) Performance Indicators 18
   c) Evaluation 22
7) **GP Panel Arrangements**
   a) Stakeholder Consultation 23
   b) Departmental Consultation 23
   c) Establishing/Changing GP Panel Arrangements 23
   d) Contacts 26
   e) Resources 28

8) **Related Initiatives**
   a) Enhanced Primary Care (EPC) 31
   b) Comprehensive Medical Assessment (CMA) 31
   c) Residential Medication Management Reviews (RMMR) 32

9) **Appendix A** 34
1) Background

a) Government Direction

Residents of aged care facilities are amongst the sickest and frailest of Australians, often having complex care needs requiring multidisciplinary providers. Some residents of residential aged care facilities (RACFs) experience difficulties in keeping the services of GPs and allied health service providers who could provide regular consultations for residents. This is especially the case where a resident does not have a regular doctor and the RACF does not employ allied health service providers on a contract basis.

The Aged Care GP Panels Initiative (Panels Initiative) which commenced on 1 July 2004 has been successful in facilitating relationship building between GPs, Divisions of General Practice and RACFs, increasing access to primary care services for RACFs and improving quality of care for residents. Until June 2007, only GPs were included on the Panels as, when this Strengthening Medicare Initiative started in 2004, data showed the number of GPs providing services in RACFs had been declining since 1997-98. GPs have a central role in providing primary care services in aged care facilities.

In the 2007-08 Federal Budget, the aged care Initiative was announced - improved health service for residents of RACFs, which is an expansion of the Panels Initiative to include allied health service providers. The expanded Panels Initiative will support GPs, allied health service providers and RACFs in accessing primary care options and multidisciplinary health care services. This expansion will allow allied health providers to participate on GP Panels and be remunerated in line with the current funding arrangements available to GPs under the Initiative.

The Panels Initiative is implemented and run through the Divisions of General Practice.

2) The Initiative

a) Development of the Initiative

The Panels Initiative was initially developed after the Department established an Implementation Advisory Group (IAG) of consumers, GPs, peak groups for aged care providers, peak GP organisations, Divisions, aged care nurses and pharmacists, to provide advice on program scope, implementation, funding and evaluation. The IAG provided valuable advice to the Department on these program issues.

It is important to note that some RACFs, GPs and Divisions were already working together to address the issues of medical access for residents. The Panels Initiative complements and builds on this work.

The Initiative, which began on 1 July 2004, is progressing well and at 30 June 2006, 299 Panels
were operating nationally, with 1,615 GP members. Out of approximately 3,054 RACFs, 2,098 were participating in the Initiative—which was 69% of all RACFs in Australia funded by the Australian Government.

In 2006, the Department considered how to further improve the quality of, and access to, primary care services for the aged, both in the community and in RACFs. Gaps in access to allied health care in RACFs were identified which lead to the Initiative being expanded to include allied health service providers.

b) Aims

The Panels Initiative has four (4) main aims. These are:

1. To improve access to appropriate medical and primary care for all aged care residents through:
   - the provision of comprehensive assessment of medical needs for new and existing residents as required;
   - general practice and allied health consultations for residents of RACFs;
   - providing medical and primary care for residents whose usual GP or other primary care arrangements have broken down; and
   - ensuring access to emergency or after hours care.

2. To increase participation of GPs in aged care initiatives aimed at improving quality of care, including through:
   - sourcing and adapting quality care protocols; and
   - GP participation in quality care activities.

3. To increase participation of allied health service providers in aged care initiatives aimed at improving quality of care, including through:
   - sourcing and adapting quality care protocols; and
   - allied health service provider participation in quality care activities.

4. To ensure GPs, allied health service providers and Divisions are working more effectively with RACFs to:
   - identify key areas of concern;
   - implement measures to address concerns raised; and
   - reduce barriers to GP and allied health service provider involvement in RACFs.

The Panels Initiative has been designed to supplement, and not replace, existing arrangements. Where successful arrangements are already in place in RACFs, this Initiative will provide an opportunity for RACFs, GPs, allied health service providers and Divisions to work together to enhance and further establish those arrangements.
c) The Participants

The key participants in the Panels Initiative include:

- GPs;
- Allied health service providers (as defined below);
- RACFs;
- Divisions of General Practice (Divisions);
- State Based Organisations (SBOs);
- Australian General Practice Network (AGPN);
- The Australian Government Department of Health and Ageing; and
- Other participants including Geriatricians and other health care providers.

For the purpose of the Aged Care GP Panels Initiative, an allied health service may include a service provided by:

- Aboriginal Health Workers
- Aboriginal Mental Health Workers
- Audiologists
- Chiropractors
- Counsellors
- Diabetes Educators
- Dieticians/nutritionists
- Dental Hygienists
- Exercise Physiologists
- Occupational Therapists
- Oral Hygienists
- Orthoptists
- Orthotists/Prosthetics
- Osteopaths
- Physiotherapists
- Podiatrists
- Psychologists
- Radiographers
- Registered Nurses, with specialist roles
- Social Workers
- Speech Pathologists
Registered nurses can be funded under the Panels initiative, but only in specialist roles, such as with asthma management, diabetes education, or in mental health. Practice nurses cannot generally be funded under the Panels Initiative.

Divisions may fund other allied health professionals not listed above, subject to the Division obtaining written approval from the Department. Factors taken into account by the Department in considering any such request from the Division include:

- whether employing the allied health professional fits the objectives of the Panels Initiative;
- whether the allied health professional has appropriate and recognised qualifications to perform his or her proposed role; and
- whether employing the allied health professional meets the needs of the community as identified through Divisional planning.

This approval would normally be done through approval of Annual Plans and alterations to Annual Plans. A requesting Division should address the factors above in the request. The Division also needs to satisfy itself through its recruitment processes that the individual professional will safely and effectively perform his or her role.

Allied health service providers employed under the Panels Initiative should have recognised educational qualifications. The allied health service provider should be registered/accredited, if required for that profession, and should qualify for membership of their relevant professional association.

d) Funding

The Panels Initiative is being implemented via the Divisions of General Practice Network. The Initiative comprises of three separate funding streams to support the establishment of local Panels. These include:

1. GP remuneration stream – which includes funding for GPs undertaking Panel activities;
2. Allied health service provider remuneration stream – which includes funding for allied health service providers undertaking Panel activities.
3. Division support work stream – which includes funding for the Divisions network to undertake activities to support Panels.

Funding for Panel activities will enable Divisions to purchase the time of Panel GPs and allied health service providers to undertake activities within the scope of these guidelines. These funds are not to be used for patient clinical management. Divisions administer the Panel activity payments to Panel GPs and allied health service providers through contractual arrangements.

This funding is provided to Divisions, SBOs and the AGPN through contractual arrangements with the Department of Health and Ageing.
3) Roles and Responsibilities

a) Department of Health and Ageing

The Department’s Central Office (in Canberra), and each of the Department’s State and Territory Offices have a role in managing the Initiative.

**Central Office**

Central Office has the following responsibilities:

- establishing the policy framework;
- developing and maintaining program guidelines;
- publicising the Panels Initiative and communicating requirements;
- articulating relationships with other program areas;
- determining and putting in place funding models and arrangements;
- determining and establishing reporting requirements;
- setting up contracts;
- managing the contract for the National Coordinator based at the Australian General Practice Network Ltd (AGPN);
- monitoring and managing the Panels Initiative (including adjustment where needed);
- evaluating and reporting on the Panels Initiative;
- making payments to Divisions and SBOs in accordance with contractual arrangements as of October 2007; and
- data acquisition including MBS data.

**State and Territory Offices**

The State and Territory Offices have the following responsibilities:

- publicising the Panels Initiative and communicating requirements;
- establishing and managing contractual arrangements with Divisions of General Practice and State Based Organisations;
- making payments to Divisions and SBOs in accordance with contractual arrangements until September 2007;
- monitoring the implementation of activities;
- analysing reports provided by Divisions and SBOs; and
- assisting Divisions with obtaining data to assist with planning, including advice on opening of new RACFs.

Communication with the Department about the Panels Initiative should be with the relevant State or Territory Office in the first instance.
b) The Divisions Network

The Divisions network comprises of the Australian General Practice Network (AGPN), the State Based Organisations (SBOs) and the Divisions of General Practice (Divisions) and they each have an important role in implementing, promoting and managing this Initiative.

**Australian General Practice Network**

The AGPN has been funded to provide national leadership, coordination and advice in developing, implementing and managing the GP Panels.

Specifically, the role of AGPN in the Initiative is to:

- provide national leadership and support for Divisions, principally through SBOs, in achieving the aims of the Panels Initiative;
- coordinate and synthesise the views of the Divisions network to contribute to the policy and program development of the Panels Initiative;
- establish and maintain relationships with relevant aged care peak bodies and other relevant peak bodies in order to promote and further develop the Panels Initiative;
- facilitate the open dissemination of information and resources throughout the Divisions network and other relevant organisations;
- further promote good models and good practice in order to reduce duplication of effort across Divisions;
- promote and facilitate open lines of communication, including the dissemination of best practice models throughout the Network; and
- facilitate the optimum uptake of the expanded Panels Initiative by allied health service providers.

**State Based Organisations**

State Based Organisations (SBOs) are funded to work with Divisions and RACFs in their state to promote the Initiative and provide support to Divisions in the management of this Initiative.

In particular, the role of SBOs under the Panels Initiative is to:

- provide leadership at the state level by contributing to national policy development and program outcomes of the Panels Initiative;
- work with, assist and support Divisions to implement and manage the Panels Initiative;
- work with Divisions to promote the Panels Initiative and share information about successful Panels arrangements;
- work in partnership with key aged care and related stakeholders to establish linkages and improve outcomes; and
- facilitate the optimum uptake of the expanded Initiative by Divisions and best practice models.
**Divisions of General Practice**

Divisions of General Practice have a key role in the implementation and operation of GP Panels and undertaking related activities to improve access to GP and allied health care services for residents of RACFs.

The role of Divisions of General Practice is to:

- undertake local liaison, development and administrative support work for the Panels Initiative;
- work with RACFs in their area to develop local responses to barriers;
- work with GPs, allied health service providers and RACFs to determine activities to address needs at the local level;
- promote interest among GPs and allied health service providers in providing services to residents of RACFs;
- facilitate the implementation and operation of the Panels Initiative and undertake related activities to achieve the Panels Initiative’s aims; and
- share information across the Division network through the AGPN.

c) GPs

GPs have an important role in undertaking locally identified activities aimed at improving access and quality of care for residents of RACFs.

Under the Panels Initiative, participating GPs will be required to:

- participate on local Panel arrangements;
- participate in quality improvement projects;
- work flexibly with staff of RACFs to improve access to, and quality of, care for residents of RACFs;
- work with Divisions and RACFs to determine activities to address local needs;
- undertake specified activities which have been identified as local priorities; and
- work with allied health professionals to enable GPs to facilitate the provision of medical care and to build multidisciplinary teams.
d) Allied Health Service Providers

Allied health service providers have an important role in undertaking locally identified activities aimed at improving access and quality of care for residents of RACFs.

Under the Panels Initiative, participating allied health service providers will be required to:

• support and work with GPs to enable GPs to facilitate the provision of medical care and to build multidisciplinary teams;
• participate in quality improvement projects;
• participate on local Panel arrangements;
• work flexibly with staff of RACFs and GPs to improve access to, and quality of, care for residents of RACFs;
• work with Divisions and RACFs to determine activities to address local needs; and
• undertake specified activities which have been identified as local priorities.

e) Residential Aged Care Facilities (RACFs)

There is no specific funding for RACFs under the Panels Initiative and participation is voluntary. However, there are many potential benefits for both residents and staff of RACFs when participating in the Initiative including the opportunity for staff of RACFs to work with GPs, allied health service providers and Divisions to develop flexible solutions to improve access to high quality care for RACF residents, and to seek support and advice from GPs, allied health service providers and Divisions.

Other benefits may include:

• more timely access to primary medical care for residents;
• improved quality medical care to residents;
• improved communication between GPs, allied health service providers and RACF staff;
• reduction in unnecessary and inappropriate emergency transfers to hospital;
• ability of homes to use the Panels Initiative to make changes to local processes, networks and supports; and
• assistance in homes meeting accreditation standards.

RACFs are an important group in this Initiative and should they choose to participate, their responsibilities include:

• working with their Division, GPs and allied health service providers to identify current service delivery arrangements (including which GPs and allied health service providers currently provide service) and service delivery gaps and pressures. This will assist Divisions and GPs to better understand the needs of the RACF and its residents;
• working with the Division to select appropriate Panel arrangements and activities that best suit the expectations and preferences of all stakeholders;
• identifying the key priorities to improve access to GP and allied health service provider services for residents of RACFs;
• working with their Division to appoint appropriate GPs and allied health service providers to participate in the Panel arrangements (eg by identifying those GPs that already have significant resident patient load, and/or contribute to existing quality arrangements);
• working cooperatively with Panel GPs and allied health service providers to facilitate Panel activities for the benefit of RACF residents; and
• working with their Division, local RACFs, Panel GPs and allied health service providers to source and adapt protocols and tools to streamline GP and allied health service provider involvement.

Divisions who currently involve unaccredited RACFs in their Panels activities are required to inform their STO Departmental representative in their annual plan. Divisions who wish to involve unaccredited RACFs in their future Panels activities are required to contact the STO Department representative prior to providing funding for activities. The decision on whether to provide funding will be made on a case by case basis.

f) Geriatricians

It is recognised that Geriatricians can provide a source of support to Panels through participating on advisory committees and providing expert advice on the development of protocols to meet the needs of residents of RACFs, GPs and allied health service providers and provision of education sessions to RACF staff and health care providers.

Geriatricians may support the aims of the Initiative in a number of ways, including through:

• contributing to facilitating up-skilling and education for Panel GPs, allied health service providers and/or RACFs in the Divisions region;
• providing specialist advice as needed to assist with complex clinical conditions;
• assisting to improve continuity of care and access to medical records and assessments that are undertaken by a Geriatrician; and
• providing vital links with regional aged care services.

While there is no specific funding under the Panels Initiative for the participation of Geriatricians, if a Panel identifies a need for Geriatrician participation in their local panel arrangement, funds under both the GP remuneration and Divisional Support streams may be used to engage the services of a Geriatrician. When using the GP remuneration in a flexible way, such as this, there must be agreement from GPs on the panel around the use of these funds.
4) GP Panels

a) Definition of Panels

For the purpose of the Panels Initiative, the term Panel is used to describe a list, or group, of GPs and allied health service providers who have agreed to undertake priority activities. Each Panel must include one (1) participating GP. These activities have been locally determined by the Division in partnership with RACFs, GPs and allied health service providers in line with these program guidelines. The work of GPs and allied health service providers participating on the Panels arrangements should complement and build on successful activities already being undertaken in RACFs in the Division, or assist with the development of new activities.

There is flexibility for different arrangements to operate in different Divisions and even within the same Division to ensure that local needs are addressed. The Panel arrangement that is established should take into account the needs of residents as well as the needs of RACFs and workforce issues for GPs and allied health service providers.

The Panel arrangements will not necessarily include all GPs and allied health service providers who provide services within RACFs. However, all GPs and allied health service providers in the area, as well as residents of RACFs, should benefit from the activities undertaken by participating GPs and allied health service providers.

b) Appointment of GPs and Allied Health Service Providers to Panels

GPs and allied health service providers do not need to be a member of a Division in order to participate in the Initiative. In appointing GPs and allied health service providers to Panels, Divisions should ensure that they are aware of the work already being undertaken by GPs and allied health service providers in homes within the Division, and of the needs of RACFs.

A key consideration for Divisions in appointing GPs and allied health service providers will be to ensure that those GPs with a strong track record of working with RACFs are supported to continue and expand this work. Other GPs and allied health service providers with an interest in working with RACFs should also be supported to take part in the Initiative.

Divisions should also consider the specific skills and attributes required to undertake Panel activities. Aspects for consideration may include:

1. Demonstrated interest and skills in aged care, such as:
   • high case load of patients in RACFs; and
   • training in geriatrics/aged care and/or willingness to undertake relevant additional training.
2. Demonstrated ability to work cooperatively with RACFs and/or other health professionals in quality activities, such as:
   - previous or current membership of medication advisory committees or quality care committees; and
   - previous or current contributor to improving quality in RACFs.

3. Demonstrated skills in liaising with other GPs and allied health service providers to achieve agreed outcomes, such as:
   - experience in coordination of roster arrangements; and
   - experience in working with others to develop agreed protocols.

The appointment of GPs and other allied health service providers to Panels should be based on a range of criteria to ensure consistency and transparency.

Divisions may remunerate GPs and other allied health service providers who belong to a different Division under the Panel arrangements. This allows flexibility for those GPs and allied health service providers to participate in Panels when covering a different geographical area to where their practice is situated. Contractual arrangements will need to be worked out between the GPs, and allied health service providers participating in the Panel arrangements and the Division.

As Divisions, in partnership with RACFs, make the final decision on the membership of the Panel, due care must be taken when electing to appoint some GPs and allied health service providers and not others. Where the Division and RACFs determine that a GP and/or allied health service provider should not participate in the Panel arrangements, care must be taken by the Division to avoid alienating the GP and the allied health service provider.

Divisions should also consider sustainability of the Panel arrangements in relation to the workforce. If those GPs and allied health service providers are providing services to RACFs in a particular area are close to retirement age, Divisions should develop strategies to attract a younger workforce to the aged care environment.

c) Panel Activities

All Divisions must have at least one (1) Panel in operation. Divisions will be required to work with GPs, allied health service providers and RACFs to identify relevant activities to be undertaken by Panels. Activities must be aimed at improving both access to medical care and quality of care for residents of RACFs.

Divisions, in partnership with GPs, allied health service providers and RACFs, should develop approaches that fall within the scope of the Panels Initiative. They should take into account the needs of residents and RACFs, the range and location of RACFs and the interests of participating GPs and allied health service providers.
The core activities that Panels arrangements must cover are:

- addressing issues of resident access to GPs and allied health service providers, including for residents without a usual GP, or whose usual GP arrangements have broken down;
- participating in RACFs quality improvement activities;
- sourcing or adapting protocols that assist in improving medical care for residents and streamlining GP and allied health service providers' activities; and
- addressing barriers to primary care service provision.

To cover core activities specified above, Panels may undertake a range of activities which include, but are not limited to:

- recruiting a cooperative roster of GPs and allied health service providers;
- recruiting GPs and allied health service providers prepared to provide care to residents, including residents without a usual GP, or whose usual GP arrangements have broken down;
- sourcing or adapting protocols for emergency care, medication management, GP and allied health service provider communication with RACFs;
- promoting the use of protocols among GPs and allied health service providers in RACFs;
- developing protocols where none exist;
- participating in committees, such as medication advisory committees or quality care committees;
- undertaking activities that coordinate/support GP work in RACFs;
- undertaking preventative health activities or programs such as falls prevention education;
- providing education to RACFs staff, residents and carers;
- working with RACFs and Divisions to identify and implement solutions to barriers for integration, and to encourage a merging of the cultures of RACFs and general practice;
- implementing mechanisms for continuity of care; and
- sharing resources for improvement in care provision.
d) Funding – GP Remuneration

There are three basic options for remunerating GPs participating in Panel arrangements. These include:

1. remunerating GPs for time spent undertaking Panel activities as described above (eg on an hourly basis);

2. remunerating GPs for Panel activities through a retainer payment - this should be commensurate with the level of services expected; and

3. remunerating GPs based on outcomes achieved which could include developing medication management or emergency care protocols where none exist.

The payment method employed within the Division will depend upon the model developed jointly by the Division, GPs, allied health service providers and RACFs. The payment method should match the model developed at the local level and the models must address local priorities. Divisions must remunerate GPs through contractual arrangements.

e) Funding – Allied Health Service Provider Remuneration

There are three basic options for remunerating allied health service providers participating in Panel arrangements. These include:

1. remunerating allied health service providers for time spent undertaking Panel activities as described above (eg on an hourly basis);

2. remunerating allied health service providers for Panel activities through a retainer payment - this should be commensurate with the level of services expected; and

3. remunerating allied health service providers based on outcomes achieved which could include developing medication management or emergency care protocols where none existed.

The payment method employed within the Division will depend upon the model developed jointly by the Division, allied health service providers, GPs and RACFs. The payment method should match the model developed at the local level and the models must address local priorities. Divisions must remunerate allied health service providers through contractual arrangements.
f) Funding - Other Activities

Although these streams of funding are provided specifically for GPs and allied health service providers, this funding may be used flexibly to assist with Division support work or other activities if the following conditions are met:

- funding for the Panels Initiative is not used for any other programs run by Divisions;
- funding for the Panels Initiative is not made available for patient clinical management;
- funding for the Panels Initiative is not used for activities that others (e.g., RACFs) are already funded to provide; and
- divisions must gain written agreement from the GP Panel and the Department when using the GP and allied health service provider funds in a more flexible way.
5) Division Support Work

a) Activities of Divisions

When implementing the Panels Initiative, Divisions will need to be responsive to local needs. To the extent possible, Divisions should involve a multidisciplinary team in decision making in relation to the Initiative. Such teams may include:

- GP and allied health education/training providers;
- Directors of Nursing/staff of RACFs;
- Geriatricians/other healthcare providers;
- Aged Care Assessment Team manager or members; and
- Pharmacists.

As part of the Panels Initiative, Divisions will be expected to undertake a number of core activities at a local level including:

- consulting with GPs, allied health service providers and RACFs to identify current service delivery arrangements, service delivery gaps and pressures, and current quality improvement activities within RACFs;
- consulting with GPs, allied health service providers and RACFs to identify key priorities within the Division boundaries to improve access to GP and allied health service provider services for residents and to address quality improvement activities within RACFs;
- selecting and establishing appropriate models that best suit local needs and the expectations and preferences of GPs, allied health service providers, residents and RACFs;
- liaising and communicating with GPs, allied health service providers, RACFs and other relevant stakeholders;
- engaging GPs and allied health service providers to participate on the Panel arrangements in collaboration/partnership with RACFs;
- establishing and managing contractual arrangements with Panel GPs and allied health service providers;
- promoting interest among GPs and allied health service providers in providing services to residents of RACFs;
- sharing resources and working with other Divisions to implement and sustain the Panels Initiative;
- monitoring, evaluating and reporting on the implementation and operation of the Panels Initiative in their area;
- reviewing and adapting the model operating within the Division dependant on changing needs; and
- working with GPs, allied health service providers and RACFs to establish or support quality activities.
Divisions may engage with the aged care sector at a local level in a number of ways, including through:

- a mail out and/or e-mail to RACFs with information about the Initiative including details of the Division’s area in which they fall;
- regional level workshops to be developed in partnership between Divisions and State aged care peak bodies;
- local level meetings and promotion of benefits and activities; and
- presentations at relevant conferences (eg on models which are working well).

Divisions should work with staff of local RACFs and may also need to establish links with ‘head offices’ of groups or chains of RACFs. Collaborative work with other Divisions as well as the SBO and the AGPN may assist in this.

To gain a further understanding of the types of activities currently being implemented by the Divisions of General Practice nationally including the models implemented by Divisions, and the types of activities that are being undertaken through the Panels Initiative, see the Australian General Practice Network website at http://www.agpn.com.au/site/index.cfm?display=2488.

b) Funding - Divisions Support Work

Under the Panels Initiative, funding for Divisions support work may be used for the employment of a project officer as well as for other costs at a local level including (but not limited to):

- costs associated with the administration of the Panels Initiative;
- costs associated with up-skilling and facilitating specialist advice (eg from a geriatrician);
- costs related to renting a location for education/training purposes;
- costs associated with the development of resources to strengthen the Panels Initiative; and
- payments to non-GP professionals and service providers.

These costs should be planned for and identified in Divisions’ Annual Budgets which must be approved by the relevant State or Territory Office. Prior to submission to the relevant State and Territory office, each Division must consult with relevant SBO and the AGPN to ensure that there is no duplication in work that may have been undertaken elsewhere in the Divisions network.
c) Reporting Requirements

**Divisions of General Practice**

Under the Panels Initiative, Divisions are required to report on their activities, progress and outcomes. They must provide a number of reports to the Department including:

- an Agreement Plan;
- Annual Plans;
- Annual Budgets;
- 6 Month Reports (due in February each year);
- 12 Month Reports (due in September each year); and
- Aged Care GP Panel Standard Data Items (collected in the 6 & 12 Month Reports).

*Please note: that the information collected in this form is currently under review.*

Divisions should refer to their funding agreements for more specific information on their reporting requirements, and associated timeframes, under the Panels Initiative. When providing reports to the Department, Divisions must use the templates provided by the Department.

**State Based Organisations**

State Based Organisations (SBOs) are also required to report on their activities, progress and outcomes under the Panels Initiative. SBOs must provide a number of reports to the Department including:

- Annual Plans;
- Annual Budgets;
- 6 Month Reports; and
- 12 Month Reports.

SBOs should refer to their funding agreements for more specific information on their reporting requirements, and associated timeframes, under the Panels Initiative. When providing reports to the Department, SBOs must use the templates provided by the Department.

**Australian General Practice Network (AGPN)**

The Australian General Practice Network are funded to undertake the role of national coordinator for the Panels Initiative which primarily involves sharing best practice models throughout the Network along with facilitating optimum uptake of the expanded Panels Initiative. As such, they are also required to report to the Department on their activities, progress and outcomes under their funding agreement.
6) Performance, Monitoring and Evaluation

a) Types of Data

The Department collects information to assist in monitoring the progress of the Initiative and to determine the extent to which the Initiative is meeting its objectives. This information will assist the Department to obtain a better understanding of the operation of the program to inform future policy advice.

The Department collects information from:

- 6 and 12 Month Reports from the Divisions network including:
  - Aged Care GP Panel Standard Data Items;
  - National Quality and Performance System Performance Indicators;
  - Aged Care GP Panel Performance Indicators;
- Medicare activity data;
- Survey of RACFs;
- Survey of GPs and allied health service providers; and
- Annual Survey of Divisions Data

When examining the data, the Department recognises the need to consider the data in context.

b) Performance Indicators

Division Performance Indicators

The Performance Indicators relate to each of the Program outcomes to be achieved, and to the establishment and management of the Panels Initiative.

Information on the Performance Indicators will be drawn from the Division Reports, a survey of RACFs and Medicare Australia data. There are a number of indicators for each outcome to ensure a comprehensive picture is gained of overall performance.

Each Division will be required to comprehensively report on their achievements and activities undertaken against the Performance Indicators.
**Aged Care GP Panels Initiative Indicators**

In addition to the compulsory indicators under the National Quality and Performance System (NQPS), there are a number of program level performance indicators that Divisions must report against in their 6 and 12 Month Reports including:

1. **Improved access**
   - RACFs’ advice that access to GP and allied health services has improved.

2. **Increased involvement in RACFs’ quality activities**
   - proportion of RACFs that have GP and allied health service provider involvement in their quality improvement activities.
   - RACF satisfaction with the outcomes of GP and allied health service provider involvement in their quality improvement activities.

3. **Effective partnerships and collaboration**
   - RACFs’ advice that the Panels Initiative is undertaking work to address key concerns;
   - key priorities to address needs within the Division's boundaries have been identified;
   - Aged Care GP Panel is operational;
   - transparent and accountable processes for the Panels Initiative member selection and appointment is established and maintained; and
   - the Panels Initiative is built on and amended in light of the initiatives development.

**Workforce Planning**

The Department will provide the following data to Divisions for workforce planning purposes on an annual basis.

1. **Improved access**
   - number of residential aged care GP services as a ratio to Full Time Equivalent GPs.
     - Using data from Medicare residential item numbers and GP data; and
   - the age and gender of GPs providing residential aged care services in the Participant’s region is more comparable with the national average.
     - Using GP data.
Survey of RACFs

Information on the following performance indicators will be collected through the survey of RACFs:

1. Improved access
   • RACFs advice that access to GP and allied health services has improved.

2. Increased involvement in aged care homes’ quality activities
   • proportion of RACFs that have GP and allied health service provider involvement in their quality improvement activities; and
   • RACFs satisfaction with the outcomes of GP and allied health service provider involvement in their quality improvement activities.

3. Effective partnerships and collaboration
   • communication and partnerships are established and maintained between GPs, allied health service providers and RACFs.
   • RACFs, allied health service providers and GPs are working effectively together to improve access to medical care for residents of RACFs.
   • RACFs’ advice that Panels Initiative is undertaking work to address key concerns.

Apart from the above performance information, Divisions must also provide information relating to the establishment and management of Panels Initiative including:

• identification of key priorities to address needs within the Division’s boundaries;
• whether Divisions have an operational Panel;
• standard data items such as number of panels and number of GPs and allied health service providers per Panel;
• transparent and accountable processes for appointment of Panel GPs and allied health service providers are established and maintained;
• the Panel model is built on and amended in light of the Initiative’s development; and
• appropriate expenditure of funds has occurred.

In addition, the Department will also need to collect performance information relating to:

• the performance of the AGPN and SBOs;
• its own performance;
• the scope and achievements of the Initiative overall;
• how well accountability requirements have been met; and
• broader policy questions about workforce, access and quality in the residential aged care sector.

Division’s should refer to their funding agreements with the Department for more detailed information about specific reporting requirements for these performance indicators.
State Based Organisations Performance Indicators

Each SBO will also be required to comprehensively report on their achievements and activities undertaken against the Performance Indicators. These Performance Indicators include:

1. Improving Access
   • increase in access to medical services for residents of RACFs.
     — divisional indicators aggregated at a State/Territory level; and
     — descriptive information from the 6 Month Report and 12 Month Report.

2. Quality Improvement Strategies
   • an increase in the extent of an evidence base that demonstrates best practice at the State/Territory level.
     — descriptive information from 6 Month Report and 12 Month Report.
   • increase in RACFs satisfaction with the outcomes of GP and allied health service provider involvement in their quality improvement activities.
     — RACF survey undertaken by Department.

3. Effective Partnerships
   • support and assistance has been provided to members of the Divisions network in implementing, operating and developing the Panel Initiative arrangements.
     — descriptive information from the 6 Month Report and 12 Month Report.
   • awareness amongst all stakeholders at the State/Territory level of the Panels Initiative and its developments.
     — descriptive information from 6 Month Report and 12 Month Report.
   • communication and partnerships are established and maintained between aged care peak bodies, professional organisations and services at the State/Territory level.
     — advice from Aged Care Peak Bodies; and
     — descriptive information from 6 Month Report and 12 Month Report.
   • key State/Territory priorities to address needs have been identified.
     — descriptive information from 6 Month Report and 12 Month Report.
   • progress has been made towards addressing key State/Territory priorities under the Panels Initiative.
     — descriptive information from 6 Month Report and 12 Month Report.
   • The extent of participation and assistance in policy development at the State/Territory level.
     — descriptive information from 6 Month Report and 12 Month Report.

SBO’s should refer to their funding agreements with the Department for more detailed information about specific reporting requirements for these performance indicators.
c) Evaluation

A review of the Panels Initiative will be conducted by Australian Healthcare Associates from May to September 2007.

The purpose of this review is to determine if the current program is adequately achieving its objectives. The reviewer will assess the effectiveness, appropriateness and efficiency of the Initiative.

Based on the results of this review, an evaluation framework will be developed. An evaluation is expected to be conducted using this framework in 2010-11.

A consultant will be engaged to undertake a survey of RACFs on a biennial basis from 2007-08 and undertake a survey of GPs and allied health service providers on a biennial basis from 2008-09 (on alternative years) in order to assess the progress of the Initiative.
7) GP Panel Arrangements

a) Stakeholder Consultation

Divisions will be required to undertake stakeholder consultation to identify current service delivery arrangements, service delivery gaps and pressures. Divisions will need to identify the key priorities within the Division boundaries to improve access to GP and allied health service provider services for residents of RACFs. At a minimum this would include consultation with:

- RACFs;
- GPs;
- Allied health service providers; and
- Consumers.

Depending on local circumstances, Divisions may also undertake discussions with a range of groups relevant to the Initiative, including:

- State/Territory Health Department;
- Private medical services (e.g., private hospitals including bush nursing hospitals);
- Pharmacies that supply medicines to RACFs;
- Aboriginal and Torres Strait Islander health services and advisory mechanisms; and
- Medical deputising and locum services, which may be able to assist Divisions to determine workforce gaps and pressures and provide advice on how to best implement the Initiative in that area.

Divisions are required to periodically review stakeholders’ needs. Ongoing monitoring of the needs of aged care residents within a Division should occur as part of this process.

b) Departmental Consultation

Subject to approval from their STO, Divisions may fund other appropriately qualified health professionals not listed in these Guidelines, or involve unaccredited RACFs in Panel activities. Divisions who plan to implement Panel funding arrangements not covered by the Guidelines should contact their STO representative in the first instance.

c) Establishing/Changing GP Panel Arrangements

The process for establishing a Panel is expected to vary depending on the local circumstances of the Division such as:

- the number and distribution of GPs and allied health service providers in the Division;
- the level of GP and allied health service provider interest in participating in Panel arrangements;
- the needs of the residents of RACFs in the Division; and
- arrangements already in place in RACFs within the Division.
The following outlines some of the steps that Divisions might take when establishing or changing panel arrangements. These are not intended to be prescriptive – it will be appropriate for different processes to operate in different Divisions.

i  The Division provides RACFs, GPs and allied health service providers in the Division with information on the Initiative and invites them to a meeting/workshop.

ii A possible agenda for this meeting/workshop might include:
   • identifying gaps and pressures to primary care access/quality;
   • identifying possible solutions to gaps and pressures (within the scope of the Initiative);
   • developing a list of priority actions; and
   • identifying next steps (eg timing and items for discussion for the next meeting).

iii Following the meeting, the Division draws up a Charter of Priorities from the priority activities identified at the meeting.

iv The Division circulates this Charter of Priorities to all RACFs, GPs and allied health service providers for comments and/or holds a second meeting to finalise priority actions for the Panel that will be established in the Division.

v The Division contacts/writes to all RACFs to identify which GPs and allied health service providers are involved in providing services to residents and/or participating in quality Initiatives.

vi Once the Division knows which GPs are interested, the Division meets with Directors of Nursing (or RACF staff as appropriate) of RACFs in the Division to agree which (and how many) GPs should participate in the Panel arrangements.

vii The Division contacts/writes to all GPs and allied health service providers in the Division (including GPs and allied health service providers who are not members of the Division) and to GPs and allied health service providers outside the Division who are providing services to determine their interest in undertaking the activities identified in the Divisional Charter of Priorities.

viii A selection process is undertaken if necessary.

ix The Division notifies the successful/unsuccessful GPs and allied health service providers.

x The Division arranges a meeting for GPs and allied health service providers on the Panel, Directors of nursing (or staff as appropriate) of RACFs to agree how the Panel will operate.
xi A possible agenda for this meeting might include discussion and clarification surrounding:

- the roles of Panel GPs, allied health service providers, RACFs and the Division;
- how Panel GPs and allied health service providers will be remunerated (eg hourly or using retainer payments);
- the scope of activities which can be achieved within the allocated funding;
- what activities the GPs and allied health service providers will do and the timing of these activities; and
- how the Panel GPs and allied health service providers, RACFs and Division will communicate and how often (eg may elect a liaison officer for the Panel who meets with/works with RACFs and/or Division and then reports back to other Panel members); and
- next steps (eg agree actions, set up next meeting).

xii The Division develops and circulates to meeting participants an action plan which includes activities, timeframes and a statement of roles and responsibilities, based on what was agreed at the meeting.

xiii Once roles and activities have been finalised, the Division establishes a contract with each Panel GP and allied health service provider clearly identifying payment arrangements and expected activities and outcomes for Panel activities.

xiv The Panel begins operating in accordance with the agreed action plan.
d) Contacts

Department of Health and Ageing

Communications relating to the Panels Initiative should be directed to the relevant State or Territory Office as identified below.

New South Wales
Program Manager
Aged Care GP Panels Initiative
GPO Box 9848
SYDNEY NSW 2001
Phone: (02) 9263 3569

Northern Territory
Program Manager
Aged Care GP Panels Initiative
GPO Box 9848
DARWIN NT 0801
Phone (08) 8946 3401

Queensland
Program Manager
Aged Care GP Panels Initiative
GPO Box 9848
BRISBANE QLD 4001
Phone (07) 3360 2614

South Australia
Program Manager
Aged Care GP Panels Initiative
GPO Box 9848
ADELAIDE SA 5001
Phone: (08) 8237 8319

Victoria
Program Manager
Aged Care GP Panels Initiative
GPO Box 9848
MELBOURNE VIC 3001
Phone: (03) 9665 8906

Western Australia
Program Manager
Aged Care GP Panels Initiative
GPO Box 9848
PERTH WA 6848
Phone: (08) 9346 5430

Tasmania
Program Manager
Aged Care GP Panels Initiative
GPO Box 9848
HOBART TAS 7001
Phone: (03) 6221 1426

ACT
Program Manager
Aged Care GP Panels Initiative
GPO Box 9848
CANBERRA ACT 2601
Phone (02) 6289 3360

Should you wish to contact the Central Office of the Department, you may do so via the Aged Care GP Panels email agedcaregppanels@health.gov.au.
AGPN, SBO, Aged Care and Allied Health Organisation Contacts

Information and support relating to the implementation and management of the Panels Initiative may also be obtained from the AGPN as listed below.

Australian General Practice Network
PO Box 4308 MANUKA ACT 2603 Phone: (02) 6228 0800 www.agpn.com.au

Alliance of NSW Divisions Limited
GPO Box 5433
Sydney NSW 2001
Phone (02) 9239 2900
www.answd.com.au

General Practice Queensland
GPO Box 2546
Brisbane QLD 4001
Phone: (07) 3105 8300
www.qdgp.org.au

General Practice Divisions Victoria
Level 1
458 Swanston St
CARLTON VIC 3053
Phone: (03) 9341 5200
www.gpdv.com.au

General Practice and Primary Health Care NT
GPO Box 2562
DARWIN NT 0801
Phone: (08) 8982 1050
www.gpphcnt.org.au

Western Australian General Practice Network
Suite 1
4 Sarich Way, Technology Way
BENTLEY, WA, 6102
Ph: (08) 9742 2922
www.wagpnetwork.com.au

SA Divisions of General Practice
1st Floor
66 Greenhill Road
WAYVILLE SA 5034
Phone: (08) 8271 8988
www.sadi.org.au

ACT Division of General Practice
PO Box 3571
WESTON CREEK ACT 2611
Phone: (02) 6287 8099
www.actdgp.asn.au

General Practice Tasmania
GPO Box 1827
HOBART TAS 7001
Phone (03) 6224 1114
www.gptasmania.com.au
e) Resources

**Commonwealth Department of Health and Ageing**

Aged Care GP Panels  

Comprehensive Medical Assessments  

Residential Medication Management Review  

Resources for aged care clinicians  

Review of Pricing Arrangements in Residential Aged Care – Full Report  

Residential Aged Care Entry Pack  

Residential Care Manual  

Other Residential Care Manuals  

Palliative Care  

**Other Websites**

Palliative Care Australia – Guidelines for a Palliative Approach in Residential Aged Care  

Royal Australian College of General Practitioners – Silver Book 3rd edition  
http://www.racgp.org.au

Aged and Community Services Australia: Residential Care News and Updates  

**Australian General Practice Network**

Aged Care GP Panels  

Aged Care Resource Directory  
8) Related Initiatives

The Panels Initiative was implemented as part of a broader set of changes being introduced to strengthen and protect Medicare including a number of new Medicare items that improve access to services for people living in RACFs. These include the Enhanced Primary Care items, in particular Comprehensive Medical Assessments and Residential Medication Management Reviews.

The following Medicare Items can be claimed by GPs who are providing clinical services in a RACF.

<table>
<thead>
<tr>
<th>MBS Item Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Practitioner Attendances</strong></td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Consultation at Residential Aged Care Facility – brief consultation.</td>
</tr>
<tr>
<td>35</td>
<td>Consultation at Residential Aged Care Facility – less than 20 minutes duration.</td>
</tr>
<tr>
<td>43</td>
<td>Consultation at Residential Aged Care Facility – lasting for at least 20 minutes or a professional attendance of less than 40 minutes duration.</td>
</tr>
<tr>
<td>51</td>
<td>Consultation at Residential Aged Care Facility – at least 40 minutes duration.</td>
</tr>
<tr>
<td><strong>Other Non Referred Attendances</strong></td>
<td></td>
</tr>
<tr>
<td>92</td>
<td>Consultation at Residential Aged Care Facility - brief consultation of not more than 5 minutes duration.</td>
</tr>
<tr>
<td>93</td>
<td>Consultation at Residential Aged Care Facility - standard consultation of more than 5 minutes duration but not more than 25 minutes duration.</td>
</tr>
<tr>
<td>95</td>
<td>Consultation at Residential Aged Care Facility - long consultation of more than 25 minutes duration but not more than 45 minutes duration.</td>
</tr>
<tr>
<td>96</td>
<td>Consultation at Residential Aged Care Facility - prolonged consultation of more than 45 minutes duration.</td>
</tr>
<tr>
<td><strong>Comprehensive Medical Assessment</strong></td>
<td></td>
</tr>
<tr>
<td>712</td>
<td>Comprehensive Medical Assessment in an RACF or consulting room.</td>
</tr>
<tr>
<td><strong>Enhanced Primary Care items</strong></td>
<td></td>
</tr>
<tr>
<td>731</td>
<td>Contribution to a Multidisciplinary care plan in a RACF or consulting room by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician).</td>
</tr>
<tr>
<td>734</td>
<td>Organise and coordinate a Case Conference in a RACF where the conference time is at least 15 minutes, but less than 30 minutes.</td>
</tr>
<tr>
<td>736</td>
<td>Organise and coordinate a Case Conference in a RACF where the conference time is at least 30 minutes, but less than 45 minutes.</td>
</tr>
<tr>
<td>738</td>
<td>Organise and coordinate a Case Conference in a RACF where the conference time is at least 45 minutes.</td>
</tr>
<tr>
<td>MBS Item Number</td>
<td>Description</td>
</tr>
<tr>
<td>-----------------</td>
<td>-------------</td>
</tr>
<tr>
<td>775</td>
<td>Participate in a case conference in a RACF where the conference time is at least 15 minutes, but less than 30 minutes.</td>
</tr>
<tr>
<td>778</td>
<td>Participate in a case conference in a RACF where the conference time is at least 30 minutes, but less than 45 minutes.</td>
</tr>
<tr>
<td>779</td>
<td>Participate in a case conference in a RACF where the conference time is at least 45 minutes.</td>
</tr>
<tr>
<td><strong>Residential Medication Management Review</strong></td>
<td></td>
</tr>
<tr>
<td>903</td>
<td>Residential Medication Management Review - payable for one RMMR service for new residents on admission to a Residential Aged Care Facility and for continuing residents on an as required basis.</td>
</tr>
<tr>
<td><strong>After Hours Items</strong></td>
<td></td>
</tr>
<tr>
<td>5010</td>
<td>Consultation at a RACF – after hours brief consultation.</td>
</tr>
<tr>
<td>5028</td>
<td>Consultation at a RACF - examination of the patient with implementation of a management plan in relation to 1 or more problems, OR a professional attendance of less than 20 minutes duration involving components of a service.</td>
</tr>
<tr>
<td>5049</td>
<td>Consultation at a RACF - lasting at least 20 minutes, OR a professional attendance of less than 40 minutes duration.</td>
</tr>
<tr>
<td>5067</td>
<td>Consultation at a RACF - lasting at least 40 minutes, or a professional attendance of at least 40 minutes duration.</td>
</tr>
<tr>
<td>5260</td>
<td>Consultation at a RACF - brief consultation of not more than 5 minutes duration.</td>
</tr>
<tr>
<td>5263</td>
<td>Consultation at a RACF - standard consultation of more than 5 minutes duration but not more than 25 minutes duration.</td>
</tr>
<tr>
<td>5265</td>
<td>Consultation at a RACF - long consultation of more than 25 minutes duration but not more than 45 minutes duration.</td>
</tr>
<tr>
<td>5267</td>
<td>Consultation at a RACF - prolonged consultation of more than 45 minutes in duration.</td>
</tr>
</tbody>
</table>

*Please note: The table above should be used as a guide only. For a more detailed description of each item refer to the Medicare Benefits Schedule.*
a) Enhanced Primary Care (EPC)

MBS item numbers 730, 731, 734, 736, 738, 778, 779.

EPC Medicare items are intended to provide more preventive care for older Australians and improve care coordination between GPs and other health professionals, by providing care for people of any age with chronic conditions and complex care needs.

EPC Medicare Items provide a framework for a multidisciplinary approach to health care through a more flexible, efficient and responsive match between patient’s needs and services.

EPC items cover:

- Health Assessments;
- Chronic Disease Management (previously known as Care Plans); and
- Multidisciplinary Case Conferencing.

EPC items for contribution to a care plan and for organising or participating in multidisciplinary case conferences are available for aged care residents.

Where GPs contribute to a multidisciplinary care plan, some patients may also be able to access Medicare rebates for up to five (5) allied health services, (MBS Item numbers 10950 – 10970) and three (3) dental care services (MBS Items numbers 10975 – 10977) each calendar year.

b) Comprehensive Medical Assessment (CMA)

MBS item number 712.

CMAs were introduced on 1 July 2004. CMAs are closely aligned with GP Panels and assist in achieving better access and quality of care for residents of RACFs. CMA is a Medicare item involving a personal attendance by the resident’s usual GP. The item provides a Medicare rebate for a full systems review of a patient, which provides important information for their care planning and medication management.

CMAs involve a GP taking a detailed medical history, conducting a comprehensive medical examination, developing a list of diagnoses or problems, and providing a written summary of the outcomes for the resident’s records.

CMAs are available to new permanent residents on admission to an RACF and existing residents as required. Medicare benefits will be payable for a maximum of one CMA per resident in any twelve-month period.

For further details visit the Department’s website at www.health.gov.au/epc.
c) Residential Medication Management Reviews (RMMR)

MBS item number 903.

RMMRs were introduced on 1 November 2004 for permanent residents of RACFs. They support GPs working in collaboration with pharmacists to review the medication management needs of residents who are likely to benefit from such a review. This includes residents for whom quality use of medicines may be an issue or who are at risk of medication misadventure because of their medical condition or medication regimen.

A RMMR is available to a new resident on admission into a RACF and to existing residents.

Medicare benefits are available for one RMMR for a resident in any 12 month period, except where there has been a significant change in medical condition or medication regimen. A RMMR should generally be undertaken by the resident’s usual GP.

For further details visit the Department’s website at www.health.gov.au/epc

Increase Medicare Rebates for GPs visiting residential aged care facilities

The 2007/08 Budget measure Aged care – improved health services for residents of RACFs will also increase Medicare rebates for GP attendances in residential aged care facilities from 1 November 2007.

The fees for the majority of GP services in aged care facilities have a derived fee structure. Derived fees have a base component which is the same as for other services of the same length and complexity performed in-surgery, and a “call-out” component. The “call-out” component is added to the base fee and paid only once per visit being apportioned across all patients seen in that visit.

For attendances by Vocationally Recognised GPs (VR GPs) in residential aged care facilities the call-out fee will increase by $18. For attendances by Other Medical Practitioners (OMPs) the call-out fee will increase by $14.05 for standard consultations and by $12.45 for brief, long and prolonged consultations in residential aged care facilities.

For example, where a VR GP sees one patient in a residential aged care facility for a standard consultation (MBS item 35) the rebate is currently the fee for MBS item 23 (in-surgery standard consultation) + $22.45 “call-out” component. From 1 November 2007 this will be the fee for MBS item 23 + $40.45.

The measure will also increase the fee for contributions to multidisciplinary care plans for patients with chronic conditions and complex care needs in residential aged care (MBS item 731) and in the community (MBS item 729). The fees for both items will increase by $17.55 from 1 November 2007. For a comprehensive list the Medicare fee increases, please see Appendix A.
These fees will also be indexed in line with the Medicare Benefits Schedule indexation from 1 November 2007.

Medicare Rebates available for allied health service providers in residential aged care facilities

Medicare rebates are available for certain services provided by eligible allied health professionals, dentists and dental specialists for people who have chronic conditions and complex care needs, and who are being managed by their GP under an Enhanced Primary Care (EPC) plan. Care plans developed for residents of RACFs, where GPs contribute to a multidisciplinary care plan and claim using the Chronic Disease Management (CDM) item (731) are eligible ‘EPC plans’. Further details about item 731 can be found on the Department of Health and Ageing website, www.health.gov.au.

A Medicare rebate of $46.80 per service is available for up to five (5) allied health services per eligible resident per calendar year. In addition, people whose dental problems are exacerbating their chronic condition may be eligible to receive a Medicare rebate of $77.95 per service, for up to three (3) eligible dental care services per calendar year.

In respect of residents assessed as low care, approved providers are required to assist residents to access health practitioner and therapy services, including arranging for the practitioner or therapist to visit the home if necessary. This level of assistance must be provided at no cost to the resident; however, the resident may be asked to bear the actual cost of the service. Low care residents for whom eligible EPC Plans are in place are eligible for the Allied Health and Dental Care rebates in respect of those services recommended in their EPC Plans.

While all residents (where the GP has contributed to their care plan and made an appropriate referral) are eligible for relevant allied health services under Medicare, in most cases high care residents should already be receiving all the necessary care and services to meet their assessed care needs, except dental care at no additional cost over and above the resident fee allowed under the Aged Care Act (see Schedule 1 of the Quality of Care Principles 1997).

In practice, this means that high care residents would not routinely need to be referred for allied health services under Medicare as the RACF is expected to provide such specified care and services to residents as part of their normal care responsibilities.

In summary, these allied health Medicare services are not intended to replace any services already expected to be provided at no additional cost by an RACF as a requirement of the Aged Care Act 1997. They are intended to augment existing services and add to the health care referral options for residents of RACFs with chronic conditions and complex care needs.

Further information on the Chronic Disease Management (CDM) items can be found at www.health.gov.au/internet/wcms/publishing.nsf/Content/pcd-programs-epc-chronicdisease.

A.22 of the general explanatory notes in the Medicare Benefits Schedule also provides information.
Information on the allied health and dental care items available under Medicare can be found at www.health.gov.au/epc or in the Medicare Benefits Schedule Allied Health and Dental Services supplement – November 2006.

Further information on Specified Care and Services, can be found at Schedule 1 of the Aged Care Principles 1997 or in Chapter 12 of the Residential Care Manual.

9) Appendix A

2007-08 Budget measure - Aged Care - Improved health services for residents of aged care homes. Changes to Medicare benefits for attendances* in residential aged care facilities - 1 November 2007

**Note the fees for GP attendances are indicative only and will be indexed from 1 November 2007 in line with indexation of the rest of the Medicare Benefits Schedule.

<table>
<thead>
<tr>
<th>Patients</th>
<th>Level A</th>
<th>Level B</th>
<th>Level C</th>
<th>Level D</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fee/100% benefit</td>
<td>Fee/100% benefit</td>
<td>Fee/100% benefit</td>
<td>Fee/100% benefit</td>
</tr>
<tr>
<td></td>
<td>Current</td>
<td>Including Budget increase**</td>
<td>Current</td>
<td>Including Budget increase**</td>
</tr>
<tr>
<td>Insurgery fee</td>
<td>$14.70</td>
<td>$14.70</td>
<td>$32.10</td>
<td>$32.10</td>
</tr>
<tr>
<td>One</td>
<td>$37.15</td>
<td>$55.15</td>
<td>$54.55</td>
<td>$72.55</td>
</tr>
<tr>
<td>Two</td>
<td>$25.90</td>
<td>$34.90</td>
<td>$43.30</td>
<td>$52.30</td>
</tr>
<tr>
<td>Three</td>
<td>$22.20</td>
<td>$28.20</td>
<td>$39.60</td>
<td>$45.60</td>
</tr>
<tr>
<td>Four</td>
<td>$20.30</td>
<td>$24.80</td>
<td>$37.70</td>
<td>$42.20</td>
</tr>
<tr>
<td>Five</td>
<td>$19.20</td>
<td>$22.80</td>
<td>$36.60</td>
<td>$40.20</td>
</tr>
<tr>
<td>Six</td>
<td>$18.45</td>
<td>$21.45</td>
<td>$35.85</td>
<td>$38.85</td>
</tr>
<tr>
<td>Seven +</td>
<td>$16.35</td>
<td>$17.65</td>
<td>$33.75</td>
<td>$35.05</td>
</tr>
</tbody>
</table>
Fees and 100% benefits for other non-referred attendances (other than consulting rooms) at a residential aged care facility

<table>
<thead>
<tr>
<th>Patients</th>
<th>Brief</th>
<th>Standard</th>
<th>Long</th>
<th>Prolonged</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fee/100% benefit</td>
<td>Fee/100% benefit</td>
<td>Fee/100% benefit</td>
<td>Fee/100% benefit</td>
</tr>
<tr>
<td>In-surgery fee</td>
<td>Current</td>
<td>Including Budget increase</td>
<td>Current</td>
<td>Including Budget increase</td>
</tr>
<tr>
<td>One</td>
<td>$24.00</td>
<td>$36.45</td>
<td>$33.50</td>
<td>$47.55</td>
</tr>
<tr>
<td>Two</td>
<td>$16.25</td>
<td>$22.45</td>
<td>$24.75</td>
<td>$31.75</td>
</tr>
<tr>
<td>Three</td>
<td>$13.65</td>
<td>$17.80</td>
<td>$21.85</td>
<td>$26.50</td>
</tr>
<tr>
<td>Four</td>
<td>$12.35</td>
<td>$15.50</td>
<td>$20.35</td>
<td>$23.90</td>
</tr>
<tr>
<td>Five</td>
<td>$11.60</td>
<td>$14.10</td>
<td>$19.50</td>
<td>$22.30</td>
</tr>
<tr>
<td>Six</td>
<td>$11.10</td>
<td>$13.15</td>
<td>$18.90</td>
<td>$21.25</td>
</tr>
<tr>
<td>Seven +</td>
<td>$9.20</td>
<td>$9.75</td>
<td>$16.70</td>
<td>$17.25</td>
</tr>
</tbody>
</table>

* Round the Clock Medicare items for after-hours GP attendances in residential aged care facilities will also increase.