

General Practice in Aged Care Incentive – Monitoring and Evaluation Framework

Australian Government Department of Health, Disability
and Ageing

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Nous Group acknowledges Aboriginal and Torres Strait Islander peoples as the First Australians and the Traditional Custodians of country throughout Australia. We pay our respect to Elders past, present and emerging, who maintain their culture, country and spiritual connection to the land, sea and community.

This artwork was developed by Marcus Lee Design to reflect Nous Group's Reconciliation Action Plan and our aspirations for respectful and productive engagement with Aboriginal and Torres Strait Islander peoples and communities.

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Document version control

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1.0	30/08/2024	Nous	Refined draft based on feedback from expert advisors and the Department. Data collection tools are still draft, pending ethics submission and final approval.

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1 Introduction

This section provides background information on the General Practice in Aged Care Incentive (the Incentive) and outlines the purpose of this document, the Monitoring and Evaluation Framework.

1.1 Background and context

The Incentive is part of the response to the Royal Commission into Aged Care Quality and Safety and the Strengthening Medicare reforms

The Australian Government is committed to improving consistent, proactive primary care for residents of residential aged care homes (RACHs), investing \$112 million over four years in the Incentive. From July 2024, eligible providers and practices have been able to register through MyMedicare to receive incentive payments for delivery of continuous, quality care to their registered residents living in RACHs.¹ The Incentive was developed by the Department of Health and Aged Care (the Department) in response to recommendations and findings of the Royal Commission into Aged Care Quality and Safety, and the Strengthening Medicare Taskforce.

The Incentive aims to improve primary care for Australians living in residential aged care homes

The Incentive aims to improve continuity of care for residents living in residential aged care homes by incentivising their usual GP/practice to provide regular visits, care planning, health assessment and medication review services. Around 7000 general practices, 145 Aboriginal Community Controlled Health Services (ACCHS) and 31 Primary Health Networks (PHNs) will be incentivised to provide proactive, consistent primary care to around 185,000 residents in RACHs at any one time.² The objectives of the Incentive are to:

- Improve access to care for RACH residents by providing better remuneration for General Practitioners (GPs) and practices who care for RACH residents.
- Incentivise and reward proactive face-to-face visits and regular, planned reviews.
- Support care planning, coordination and a multidisciplinary approach.
- Shift the focus from volume of servicing to resident-centred care.

Practices and providers will be paid quarterly if they meet servicing requirements. An annual amount of \$300 for providers and \$130 for practices, per resident, is available on top of all eligible Medicare Benefit Scheme (MBS) rebates or Department of Veterans' Affairs (DVA) service reimbursement where a defined bundle of care is delivered. This bundle of care comprises of:

- a minimum number and frequency of face-to-face³ GP visits to the RACH resident.
- annual delivery of MBS or DVA services associated with care planning such as focused assessment of a resident's needs, multidisciplinary care planning or a multidisciplinary care conference.

Appendix A provides further detail on the Incentive.

¹ Eligible practices must be an accredited general practice, or eligible for an exemption under MyMedicare, registered in MyMedicare and the Organisation Register, and registered in the Incentive sub-program. Eligible providers must be linked to their eligible practice in the Organisation Register and be declared as the Responsible Provider of eligible services to the registered patient. Eligible residents must permanently live in an aged care home, be registered in MyMedicare with the eligible registered practice, have the Incentive indicator selected on their MyMedicare profile by their practice and have a Responsible Provider identified by the practice.

² Australian Institute of Health and Welfare (AIHW), People using aged care, GEN Aged Care data, 2023.

³ Rural and remote areas can provide services via telehealth using eligible MBS items

PHN grants, Services Australia funding and implementation support aim to increase uptake of the Incentive

In addition to payments to GPs and practices, the Incentive is supported by several activities including:

- **PHN capacity building grants:** These are grants provided for PHNs to work with local RACHs, GPs, practices and/or ACCHS to increase access to primary care services.
- **PHN thin market grants:** These are competitive grants for PHNs to identify regional gaps and work with local RACHs, GPs, practices and/or ACCHS to design, implement and manage solutions.
- **Services Australia funding:** This funding is for Services Australia to deliver system enhancements to implement the Incentive criteria and make incentive payments to eligible providers and practice who meet the Incentive servicing requirements.
- **Best practice guidance and tools:** Tools and materials were developed to support practices, providers and RACHs to deliver best practice care to older people under the Incentive.
- **Communication and change management activities:** The Department is undertaking engagement and communications activities to raise awareness of the Incentive and increase uptake.

Call out box 1: PRACTICE INCENTIVE PROGRAM GENERAL PRACTITIONER AGED CARE ACCESS INCENTIVE (PIP GP ACAI)

The introduction of the Incentive coincides with the discontinuation of the PIP GP ACAI, which ceased on 31 July 2024. Uptake of the PIP GP ACAI suggested the previous incentive amount was too low, and the volume-based service structure was inappropriate to motivate the cross section of GPs and practices required to provide regular care to RACH residents.⁴ The Royal Commission also found that the PIP GP ACAI was not effective. The Incentive aims to address the limitations of the PIP GP ACAI. Key differences include incentivising care from the same provider/practice, including delivery of care planning items within servicing requirements and promoting proactive care.

1.2 Purpose of the evaluation

Nous Group (Nous) has been engaged by the Department to undertake an evaluation of the Incentive between September 2024 and June 2027. This evaluation will support the overall evaluation of Strengthening Medicare measures. The objectives of monitoring and evaluation are to:

- Establish a baseline on the level of primary care services in RACHs before start of the Incentive.
- Assess the effectiveness of implementation of the Incentive to support continuous improvement.
- Assess the extent to which the Incentive achieved the intended outcomes.
- Assess the appropriateness of the Incentive funding model to achieve the policy intent.
- Inform future policy decisions, including improvements to the Incentive and related incentives.

1.3 Purpose of this Monitoring and Evaluation Framework

This Monitoring and Evaluation Framework outlines how to assess whether the Incentive has met its goals and objectives. The document details the monitoring and evaluation methods, including data collection and analysis, and highlights key considerations for implementation.

Call out box 2: STAKEHOLDER CONSULTATION

⁴ Department of Health and Aged Care, Internal Policy Paper, General Practice in Aged Care Incentive, supplied to Nous 10/07/2024 by Initiatives Design Team, based on internal Department analysis of MBS data, unpublished data.

Nous developed the Monitoring and Evaluation Framework in consultation with input from the Department, primary care sector (including GPs), RACHs, PHNs, peak bodies and other Australian Government Departments. A full list of the organisations who contributed can be found in Appendix B.

2 About the Incentive and context for evaluation

This section provides detail about the design of the Incentive and the context in which it is being implemented and evaluated.

2.1 About the Incentive

The design of the Incentive recognises many factors will contribute to better primary care service delivery in RACHs

These factors include varying levels of access to primary care services across regions, the unique needs of aged care residents, and the ongoing reforms in primary care and aged care. In response to this complexity, the Incentive has been deliberately crafted to address specific barriers, while aligning with the broader reform environment. Key features of the design worth noting include:

- **A shift to proactive, regular care and care planning:** The servicing requirements shifts the focus of primary care delivery to quality of care, rather than volume. The requirement for regular, planned visits is intended to promote proactive, preventative care, rather than reactive care.
- **Promotion of continuity of care:** The Incentive promotes proactive continuity of care delivered by the same GP and practice, through voluntary enrolment of a resident to their provider in MyMedicare.
- **Payment to the provider and practice:** Unlike the previous PIP GP ACAI, The Incentive provides an incentive to both the practice and provider, in recognition of the administrative effort.
- **Available to all GPs, however, is targeted at specific subgroups:** The Incentive assumes only some GPs and practices will be incentivised to participate. There is an expectation that:
 - GPs that currently deliver services in RACHs will be incentivised to continue to do so as they are meant to be better remunerated.
 - some GPs may re-orient to aged care, by refining their business models.
 - GPs will be more inclined to continue to deliver care to existing patients when they become a resident of aged care.⁵
- **Has a built-in expectation of multidisciplinary care delivery:** The inclusion of other GP practice staff⁶ in regular service delivery and multidisciplinary care plans and case conferences in care planning services encourages the provision of multidisciplinary care. This is important for RACH residents as a medically complex cohort with higher levels of care needs.⁷
- **Is part of the broader Strengthening Medicare package of reforms:** The Incentive is part of a package of reforms, which includes the triple bulk billing incentive. When combined with triple bulk billing, the reforms aim to incentivise behaviour (or practice) change.
- **Expands the role of PHNs to support RACHs and Aboriginal Community Controlled Health Services (ACCHOs):** PHNs will collaborate with GPs, practices, RACHs and ACCHOs to link residents with a regular GP. In thin markets, PHNs can access a competitive funding pool to design a local solution.

⁵ As reported in stakeholder consultations during the design of the Monitoring and Evaluation Framework, July/August 2024.

⁶ Such as nurses and Aboriginal and Torres Strait Islander health workers

⁷ Diane Gibson, Who uses residential aged care now, how has it changed and what does it mean for the future?, *Australian Health Review*, December 2020.

2.2 The policy, operating and stakeholder context

The policy, operating and stakeholder context raise implications for the evaluation

Implementation of the Incentive is taking place within a complex policy, operating, and stakeholder environment. Major reforms are underway in primary care, such as the implementation of the Strengthening Medicare Taskforce Report recommendations, and in aged care. Table 1 provides an overview of this context. Key implications for the evaluation include the need to:

- **Adopt realistic expectations about the impact of the Incentive:** The Incentive is one of many factors influencing whether residents have better access to regular primary care in RACHs. It addresses financial barriers but does not tackle systemic issues (e.g. workforce shortages). This means there must be a realistic approach to evaluating its impact, recognising the external confounding factors.
- **Recognise differences across rural and remote settings compared to metro settings:** There are differences in how primary care is delivered in rural and remote areas compared to metropolitan areas. These differences are important to understand in the evaluation, for example, when assessing the factors that help or hinder uptake across different regions and geographic settings.
- **Consider that the Incentive is being introduced alongside the MyMedicare platform:** As the first incentive to be integrated with the MyMedicare platform, there may be unique challenges and opportunities that arise. The evaluation must account for the early-stage adoption of the platform and its influence on the effectiveness and uptake of the Incentive.

Table 1 | Policy, operating and stakeholder factors relevant to the evaluation

Factor	Description	Implication for the Incentive and evaluation
Major reform agenda in aged care	The Incentive coincides with significant national reforms in aged care, following the Royal Commission into Aged Care Quality and Safety's recommendations in 2021. Recently, the government has implemented enhanced Aged Care Standards for RACHs, introduced a New Aged Care Act, and mandated 24/7 registered nurse (RN) coverage at aged care facilities.	The evaluation will need to consider other factors in aged care that may influence the uptake and effectiveness of the Incentive. The active aged care reform agenda may also make identifying the specific contribution of the Incentive on its intended outcomes more challenging.
Major reform agenda in primary care	The Incentive is also being introduced at a time of major reform in primary care, with the ongoing Strengthening Medicare agenda following the Strengthening Medicare Taskforce in 2022. Concurrent primary care initiatives include Australia's Primary Care 10 Year Plan 2022-23, new Medicare bulk billing incentives, and other primary care workforce initiatives.	The evaluation will need to consider other factors in the primary care sector that may influence the uptake, effectiveness of the Incentive. The active primary reform agenda may also make identifying the specific contribution of the Incentive on its intended outcomes more challenging.

Factor	Description	Implication for the Incentive and evaluation
First incentive to be delivered through the new MyMedicare platform	The Incentive is the first to be hosted and paid through the new voluntary patient and provider enrolment platform MyMedicare. Eligible providers need to be registered with MyMedicare and specifically for the Incentive. They are then able to be linked to a resident who has registered with MyMedicare to be eligible for the Incentive.	As this is the first incentive, initial uptake may be slower, particularly as providers and residents may not be registered with MyMedicare. The launch of MyMedicare in late 2023 has been met with some GP apprehension about potential future payment structures. This perspective could affect both uptake and sentiment regarding the Incentive.
Complexity of medical needs of aged care residents and the care they require	Most exits from RACHs are due to death (84 per cent of exits), with a median length of stay for these residents of 22.8 months. ⁸ This means that the medical and care needs of residents are likely to extend to end of life care. These needs are often high, and resident requires both proactive planned services, as well as reactive and unplanned visits from GPs.	Evaluation of the Incentive will focus on resident experience, continuity of care and avoiding unnecessary hospitalisations, rather than improved health outcomes. There is a risk that the Incentive may inadvertently create perverse incentives by emphasising preventive care within monthly timeframes. Residents will still need short-notice/on-call care from GPs, and it will be important to monitor whether access to this care is maintained.
Barriers to GPs working in aged care	The past Practice Incentive Program is currently under review ⁹ , however there is still a gap in supply of GPs to deliver services in RACHs. There are financial disincentives for GPs to provide care to patients in RACHs. ¹⁰ Delivering care to RACH residents involves travel time, often longer appointments given the medical complexity of many residents, and disruption to workflow relative to standard care delivered in a practice setting.	This evaluation will assess whether the financial incentive encourages GPs to change their behaviour. It will analyse GP participation and withdrawal rates, to assess whether the incentive is sufficient to sustain GPs to continue to deliver services in RACHs, led to incremental improvements across different regions. and encourage GPs to start delivering services or deliver more regular services.
The new incentive replaces a previous incentive, the PIP GP ACAI	PIP GP ACAI aimed to incentivise GPs to provide increased services to residents of RACHs, responding to known system and financial barriers. It had four tiers of payment based on the volume of services delivered by a GP in a calendar year. ACAI ceased on 31 July 2024, as the new Incentive began.	It is likely that GPs will continue to compare the financial benefits received through ACAI with the new incentive. As ACAI was volume based, it did not incentivise continuity of care between the same provider/practice and there was concern that it did not promote proactive care in RACHs. It will be important to examine the relative uptake and impact of the new incentive compared to ACAI.

⁸ Australian Institute of Health and Welfare, People leaving aged care, GEN Aged Care Data 2022-23, (accessed 10 August 2024). <https://www.gen-agedcaredata.gov.au/topics/people-leaving-aged-care>

⁹ Consultation Briefing, Review of General Practice Incentives, July 2024, see: [review-of-general-practice-incentives-consultation-briefing-paper.pdf \(health.gov.au\)](#)

¹⁰ Stephen Burgess, Jenny Davis, Ameer Morgans, General practice and residential aged care: A qualitative study of barriers to access to care and the role of remuneration, *Australasian Medical Journal*, 2015.

Factor	Description	Implication for the Incentive and evaluation
<p>The primary care landscape is fundamentally different in rural and remote areas compared to metropolitan areas</p>	<p>In rural and remote areas many GPs provide services in RACHs out of necessity as there may be a lack of GPs available. It may be the same GP that visits RACHs also working after hours and working at the local hospital, whereas in a metro area these roles are filled by different people. In some communities, local provision of residential aged care care is integrated with hospital care within a multi-purpose service (MPS) for which local GPs may constitute the main medical workforce. There are also exemptions in place for the 24/7 RN requirement for RACHs located in Modified Monash Model (MMM) 5, 6, or 7 areas.</p>	<p>This may result in variation in uptake across regions. Where there may be flexibility within metro for some GPs to pivot fully to RACH delivery, this may not be possible in rural and remote areas where GPs need to provide services across the region by necessity.</p> <p>If RN coverage isn't available or is subject to the policy exemption, RACH will be more reliant on general practitioner visits.</p>

Call out box 3: INTERSECTIONS WITH FIRST NATIONS AGED CARE

First Nations people may have different experiences and care needs to the general population in the aged care system. First Nations individuals may enter aged care from a younger age, having access to aged care homes from the age of 50, and have a higher rate of comorbidities and chronic conditions.¹¹

The Incentive has not been designed to specifically target First Nations residents. There are other aged care initiatives that may intersect with the Incentive that the evaluation will need to consider. This includes *the National Aboriginal and Torres Strait Islander Flexible Aged Care Program*, which delivers a mix of culturally appropriate aged care services to meet community need, with most services located in rural and remote areas.

¹¹ Australian Institute of Health and Welfare, Insights into vulnerabilities of Aboriginal and Torres Strait Islander people aged 50 and over, August 2023. (accessed 10 August 2024) <https://www.aihw.gov.au/reports/indigenous-australians/vulnerabilities-aboriginal-torres-strait-50-over/summary>

3 Monitoring and evaluation approach

This section outlines the monitoring and evaluation approach, including the Incentive program theory, key evaluation questions and national evaluation indicators.

3.1 Monitoring and evaluation objectives and scope

Monitoring and evaluation will drive improvements to the Incentive and measure its impact

Monitoring and evaluation have different but complementary roles for understanding the impact of the Incentive. **Monitoring** will oversee implementation, with regular data collection enabling an understanding of whether the Incentive is being delivered as expected. **Evaluation** will assess whether the Incentive has made a difference and identify improvements for how it could better achieve its intended impact.

There are five objectives of the monitoring and evaluation of the Incentive:

1. Establish a baseline¹² of the pre-implementation primary care service in RACHs.
2. Support the effective implementation of the Incentive.
3. Assess the outcomes and impact of the Incentive (all components).
4. Assess the appropriateness of the Incentive funding model.
5. Inform future policy decisions.

Given the evaluation aims, the evaluation includes process, outcome and economic components:

- **Process component:** This refers to assessing implementation of the Incentive, including all components (such as PHN grants, Services Australia funding, best practice guidelines and Departmental communication and change management activities).
- **Outcome component:** This refers to understanding the extent to which intended outcomes were achieved, and the factors that helped or hindered achieved of observed outcomes.
- **Economic component:** This refers to understanding the cost-effectiveness of the Incentive.

There are areas of the broader policy landscape that are out of scope for this evaluation:

The focus of this evaluation is on primary care delivery within the aged care system. This captures GPs and general practices, but also other providers such as ACCHSs, Aboriginal Medical Services (AMS) and PHNs. Consideration will also be given to the flow on impacts of the Incentive on the hospital setting where possible, captured in the outcomes of this evaluation.

Several areas are out of scope for this evaluation:

- **A detailed examination of non-financial barriers for GPs:** Non-financial barriers not addressed by the Incentive might include incompatible IT systems at RACHs, insufficient nursing staff for clinical handovers and additional care, or a lack of properly equipped private examination rooms. These issues may come up during stakeholder consultations as factors influencing the uptake of the Incentive. While they will be noted, the evaluation will primarily focus on understanding how the Incentive is affecting GP behaviour and the delivery of primary care services.

¹² The evaluation commenced prior to establishing the baseline. The baseline will be obtained retrospectively using historical data, surveys and consultations.

- **A detailed review of RACH settings:** Facilities and equipment available in each RACH will vary. An assessment of RACH facilities is not within the scope; however, will be noted as necessary if raised by stakeholders as factors that may impact GP experience or uptake of the Incentive.
- **Comparing the clinical efficacy of care in the RACH setting to the hospital setting:** The policy behind the Incentive is partly based on the idea that it is better for residents to receive medical care in their residential aged care home (RACH) rather than in a hospital. This evaluation will not compare the appropriateness or effectiveness of care provided in hospitals versus RACHs.
- **Evaluation of other initiative and incentives in primary care or aged care:** The evaluation will consider the intersections and confounding factors from other initiatives; however, it is not in-scope to evaluate them.

3.2 Program theory

Program theory allows for a comparison of what happened, to what was expected to happen

Program theory provides a rationale for what change is expected to happen, why, for whom, when and how. During evaluation, the program theory will provide the basis for understanding how the Incentive is expected to work, and what outcomes must be met for the Incentive to achieve its overall objectives. The program theory for the Incentive is described by two elements, a theory of change and the Program Logic, which are described in the following sections.

3.2.1 Theory of change

The theory of change expresses the change the Incentive is seeking to create and the assumptions about how this change is expected to occur. The theory of change for the Incentive is outlined in Figure 1.

Figure 1 | The Incentive Theory of Change¹³



3.2.2 Program Logic

The Program Logic captures the context of and expected inputs, activities, outputs and outcomes of the Incentive. It outlines the intended outcomes, across three categories of stakeholders: residents, carers and families, providers and system (see Figure 2 overleaf).

¹³ Citations from Figure 1 Theory of change: 1. Australian Institute of Health and Welfare (AIHW), People using aged care, GEN Aged Care data, 2023; 2. Australian Institute of Health and Welfare (AIHW), People's care needs in aged care, 2023; 3. Internal Department of Health and Aged Care analysis of MBS data, unpublished data, 2022; 4. Australian Institute of Health and Welfare (AIHW), People leaving aged care, 2023.

Figure 2 | Program Logic for the Incentive

CONTEXT	INPUTS	ACTIVITIES	OUTPUTS	OUTCOMES				
				SHORT TERM (1-2 years)	MEDIUM TERM (2-5 years)	LONG TERM (5+years)		
<p>Residents who are entering RACHs are closer to end-of-life than ever before. Most exits from permanent residential aged care is due to death (84%), with a median length of stay of 22.8 months.</p> <p>The Royal Commission into Aged Care Quality and Safety reinforced concerns that while some GPs are delivering high quality care, on average GPs were 'not visiting people receiving aged care at their residences, or not visiting enough, or not spending enough time with them to provide the care required.'</p> <p>The Royal Commission recommended a new model of primary care to encourage 'holistic, coordinated and proactive health care for the growing complexity of the needs of people receiving aged care'.</p> <p>Aged Care Quality Standards for aged care facilities have been strengthened to ensure residents receive evidence based, safe and person-centred clinical care.</p> <p>The 2022 Strengthening Medicare Taskforce Report recommended the introduction of blended funding models that integrates fee-for-service and incentives to better promote bundles of care for people who need it.</p> <p>There is ongoing reform to empower and fully utilise the broader health workforce to address severe aged care workforce shortages.</p> <p>Inadequate remuneration for the time and work involved in delivering GP services to resident living in a RACH compared to services undertaken in a GP practice setting is cited as a key factor affecting GP service delivery in RACHs.</p> <p>GP workforce challenges are amplified in rural and remote areas. In these areas, a GP often provides both primary and secondary care in the community, working in local hospital and visiting RACHs in addition to their GP practice work out of necessity.</p> <p>This Incentive replaces a volume-based aged care incentive offered in the Practice Incentive Program. The General Practitioner Aged Care Access Incentive (ACA) was decommissioned on 31 July 2024.</p> <p>The triple bulk billing incentive was introduced in November 2023 under Strengthening Medicare. Eligible bulk-billed residents will attract the triple bulk billing incentive.</p>	<p>\$112 million total over 4 years from 2023-24 for the Incentive</p> <p>Includes \$16.5 million over 4 years in grants for each PHN to work with local GPs, practices, RACHs and/or ACCHs</p> <p>Includes \$10.4 million over 4 years in grants for select PHNs to address gaps in thin markets</p> <p>Guidance and Tools to support practices, providers and RACHs to deliver best practice care to older people under the Incentive</p> <p>Primary Care Quality and Delivery Branch, Initiatives Design Section: policy and program design, implementation and management</p> <p>MyMedicare voluntary patient registration program for registered general practices, GPs and residents</p> <p>PHN's existing organisational structure and relationships with RACHs, ACCHOs, practices and GPs</p> <p>General Practitioner (GP) workforce</p> <p>Residential Aged Care Homes (RACHs)</p>	<p>RESIDENT</p> <p>Residents consent to register in MyMedicare and are enrolled in the Incentive</p>		<p>Residents registered on MyMedicare and with the Incentive (# and %)</p> <p>Primary care services received by residents living in RACHs (by MBS item, # and %)</p>	<p>Improved satisfaction with quality, appropriateness and timeliness of care</p> <p>Improved continuity of care with a consistent GP and GP practice</p> <p>Increased access to care planning services</p> <ul style="list-style-type: none"> Increased health assessments Increased development of care plans Increased RMMR services <p>Reduced avoidable hospital admissions</p> <p>Increased regularity of primary care services</p> <p>Increased access and use of multidisciplinary care teams</p> <p>Increased access to primary care in thin markets</p>	<p>Residents report improved experiences of primary care (*Primary Health Care 10-year quintuple aims)</p> <p>Residents experience better quality of life and end-of-life care</p>		
		<p>PROVIDER</p> <p>GPs and Practices / ACCHOs / AMs</p>		<p>GPs and practices register in MyMedicare and with the Incentive</p> <p>GPs and care team deliver minimum servicing requirements and regular visits to RACHs</p> <p>GPs and care team deliver primary care services that meet residents needs</p>	<p>GPs and practices registered on MyMedicare and with the Incentive (# and %)</p> <p>GPs and care teams that meet minimum servicing requirements</p> <p>GPs delivering primary care services to residents (# and %)</p> <p>Number of Residential Medicines Management Reviews (RMMR) services claimed for registered residents</p>			
		<p>RACHs</p> <p>Communication and promotion of the Incentive by RACHs</p>						
		<p>SYSTEM</p> <p>DEPARTMENT OF HEALTH AND AGED CARE</p>		<p>Communication and promotion of the Incentive to support uptake and implementation</p> <p>Development and dissemination of the Incentive guidelines</p> <p>Design of change management activities</p> <p>Development and distribution of Best Practice Guidance and Tools to support GPs deliver appropriate care in RACHs</p> <p>Development and administration of grant agreements with PHNs</p>	<p>Number of PHNs grant agreements to administer</p> <p>Communication with GPs, practices, RACHs and PHNs</p> <p>Incentive guidelines developed</p> <p>Best Practice Guidance and Tools developed</p> <p>Number of Incentive payments made to practices and GPs</p> <p>Number of PHNs commissioned to provide solutions for thin market regions</p>	<p>Increased awareness of the Incentive by providers</p> <p>Increased participation in the Incentive by providers</p> <p>Increased provision of regular primary care in RACHs by GPs and multi-disciplinary care teams</p> <p>Increased remuneration for GPs and practices for providing care at a RACH</p> <p>Strengthened and formalised relationships between residents, GP, practice, and other members of a resident's care team</p>	<p>Increased care coordination and collaboration between RACHs and GPs and practices</p> <p>Increased viability for practices and GPs to provide services in RACHs</p> <p>Improved experiences of GPs delivering services in RACHs</p> <p>Increased accreditation of GPs</p>	<p>The Incentive aids sector viability</p> <p>Improve work life of health care providers (*Primary Health Care 10-year quintuple aims)</p>
		<p>SERVICES AUSTRALIA</p> <p>Assessment of provider and practices incentive payment eligibility</p> <p>Administer incentive payments to GPs and practices</p>						
		<p>PHNS</p> <p>Engage and collaborate with GPs, practices, ACCHs and RACHs to support primary care service provision</p> <p>Communication and change management activities currently funded until 2026-2027.</p> <p>Design and implement locally tailored solutions to address thin market service gaps</p> <p>PHN program reporting</p>			<p>Development and implementation of tailored solutions to primary care access for residents in thin market regions</p>	<p>RACHs have an improved experience coordinating GP visits for residents through the support of PHNs</p>	<p>Improved experience for health workforce in RACHs</p>	<p>Modernise RACH workforce composition</p>
		<p>SYSTEM</p> <p>Increased primary care services in thin market regions</p> <p>Better coordination for primary care in RACHs through support of PHNs</p>					<p>Reduced polypharmacy for residents</p>	<p>Improve the cost-efficiency of the health system (*Primary Health Care 10-year quintuple aims) through reduced reliance on hospital settings for resident care</p>

A key consideration for this evaluation is access to services. Data for activities, outputs and outcomes will be disaggregated by rurality where possible.

Call out box 4: CAVEATS ON OUTCOMES

There are several points worth noting about outcomes in the Program Logic:

- **Attribution of short-term outcomes:** Caution is advised when attributing short-term outcomes solely to the Incentive, given the busy reform context (see Section 5.3 for detail on contribution analysis).
- **Long-term outcome measurement:** There are many new initiatives in the primary care space from Strengthening Medicare which all target the quintuple aims. This incentive addresses only select factors in primary care for aged populations. It will be difficult to isolate the Incentive's contribution to long-term outcomes given confounding factors (see Section 5.3 for detail on contribution analysis). Lastly, the evaluation runs to 2027, so some long-term outcomes may only be observed after this time.
- **Exclusion of long-term outcomes for residents, families and carers:** The Program Logic does not include long-term outcomes for residents, families and carers, given the relatively short median length of stay for residents in RACHs. It focuses on short- and medium-term outcomes related to satisfaction, experiences and access to care.
- **Outcomes detailed are what should occur if the Incentive is successful:** These outcomes capture the intent of program design and do not detail potential unintended outcomes of the Incentive. Qualitative consultation will explore whether any unintended outcomes are observed.

3.3 Key evaluation questions

Four overarching questions provide the structure for monitoring and evaluation

Key evaluation questions (KEQs) will guide data collection, analysis, and reporting for the Incentive's monitoring and evaluation. They were developed using the evaluation objectives and program theory (see Section 3.2) and refined with stakeholder consultation (see Appendix B). The KEQs will enable assessment of the Incentive's implementation, effectiveness, efficiency and sustainability.

Figure 3 | KEQs and their relation to the Program Logic

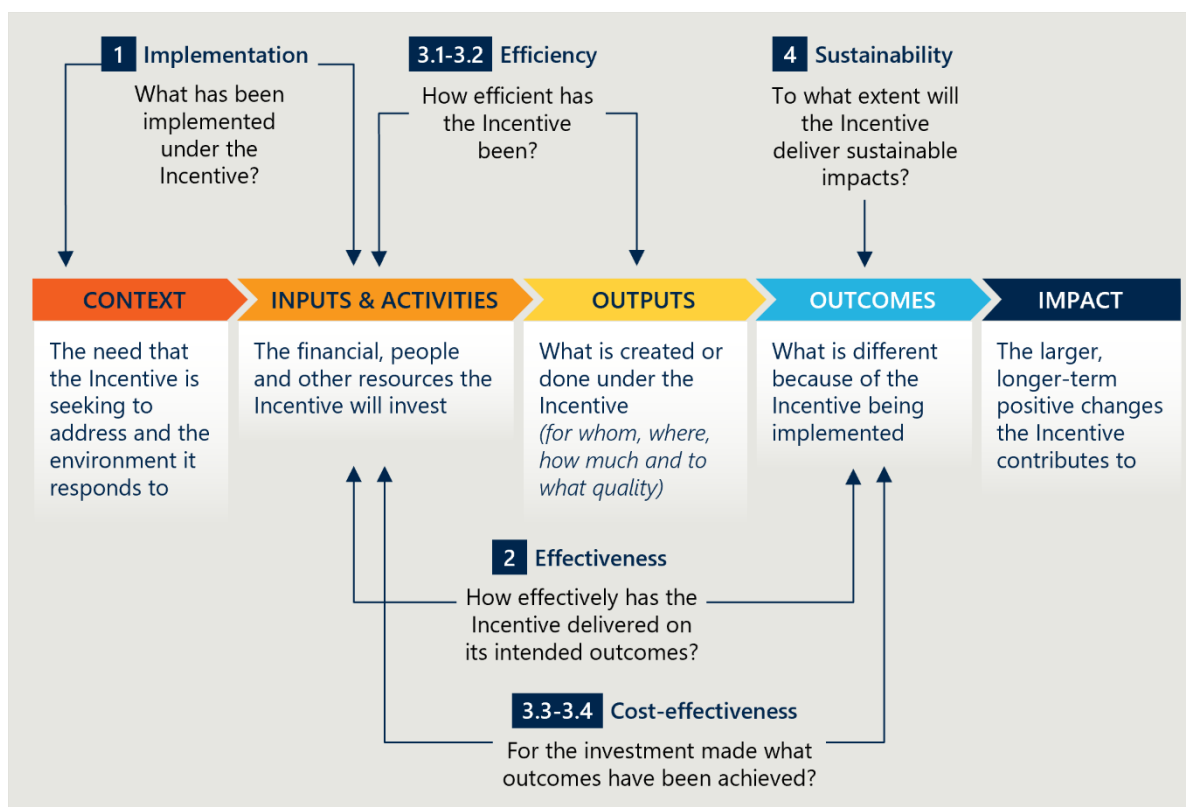


Table 2, overleaf, presents the KEQs, research questions and further detail on their intent.

Table 2 | KEQs

Research questions	Intent
1 IMPLEMENTATION: What has been implemented under the Incentive?	
1.1 What is important to understand about the context in which the Incentive is being implemented? (incl. the impact of intersecting reforms)	This question focuses on understanding the context surrounding the Incentive and assessing the extent to which implementation and uptake has occurred. Insights derived from this question will support future implementation programs. Both qualitative and quantitative data will be used to answer this question.
1.2 What has been implemented under the Incentive? What worked well and less well in implementation?	
1.3 What is the level of uptake of the Incentive for providers, GP practices and residents? (incl. by region, MMM, type of RACH, type of GP practice and age of GP)	
1.4 What factors helped or hindered uptake of the Incentive? (incl. consideration of the engagement and communication strategies).	
2 EFFECTIVENESS: How effectively has the Incentive delivered on its intended outcomes¹⁴?	
2.1 What were the intended short, medium and long-term outcomes?	This question explores the extent to which the Incentive was able to achieve the intended outcomes. Contribution will be challenging (see Section 5.3.4) due to the complex policy environment. There will opportunities to review aspects of the Incentive design ¹⁵ , in combination with stakeholder feedback, to recommend improvements. Both qualitative and quantitative data will be used to answer this question.
2.2 What was the baseline level of primary care services delivered in RACHs before the Incentive commenced?	
2.3 In comparison to the baseline, what difference has the Incentive made across the intended outcomes?	
2.4 What aspects of the Incentive were most and least effective? (including design, grants, implementation, administration and all elements of the Incentive)	
2.5 How satisfied are GPs, and practices with the Incentive? How satisfied are RACHs, residents, carers and families with their care under the Incentive?	
2.6 What, if any, unintended impacts have been observed? (incl. on the RACH workforce)	
3 EFFICIENCY: How efficient and cost-effective has the Incentive been?	
3.1 What resources (i.e. financial, human, infrastructure, digital) were allocated to the Incentive and for what purpose?	This question will assess how efficient the Incentive is: for the investment, what outputs were seen? It will consider how cost-effective the Incentive is: for the investment, what outcomes were achieved? It will require cost data and consider system-wide changes to resident outcomes and hospital admissions. Both qualitative and quantitative data will be used to answer this question.
3.2 How efficiently were these resources allocated? (i.e. for the investment and other allocated resources, what outputs were seen and do they align with the planned implementation of the Incentive)	
3.3 How cost-effective is the Incentive? (i.e. for the investment, what outcomes were achieved?)	
3.4 How cost effective is the Incentive, compared to alternate funding models? ¹⁶	
4 SUSTAINABILITY: To what extent will the Incentive deliver sustainable impact?	
4.1 To what extent are observed outcomes likely to be sustainable? Why or why not?	This question will assess the extent to which the Incentive has delivered sustainable behaviour and practice changes. It will consider the impact of the Incentive on different GP business model and in rural and remote areas. Both qualitative and quantitative data will be used to answer this question.
4.2 To what extent will general practices with different business models be economically impacted by the Incentive? (incl. which practice business models will be best off under the Incentive)	
4.3 What recommendations can be provided to enhance the effectiveness of the Incentive and inform future policies? (incl. options for more cost-effective care delivery for general practices who participate).	

¹⁴ Outcomes as stated in the program logic.

¹⁵ Including payment amount, telehealth eligibility and servicing requirements.

¹⁶ The Incentive will be compared to PIP GP ACAI quantitatively, and two other funding models, such as a salaried GP model and outcome payments model, through a desktop evidence review. The chosen models will be agreed upon during the evaluation.

3.4 Evaluation indicators

Evaluation indicators enable regular monitoring of the Incentive over time

The evaluation indicators reflect the evaluation objectives (Section 3.1) and the KEQs (Section 3.3). These indicators are a tool to measure progress against the outcomes in the Program Logic (see Section 3.2.3). Table 3 details 25 indicators, which are to be reported quarterly (noting the data for some may not be available quarterly). Indicators are intended to be disaggregated against dimensions such as the following (pending data availability in the data source for each indicator):

- MyMedicare status
- The Incentive indicator
- Type of RACH (private, public, not-for-profit)
- Resident type¹⁷ (permanent, transitional, short-term restorative, DVA)
- AN-ACC classification¹⁸
- Thin-market areas¹⁹ (received grant and did not receive grant)
- MMM for regionality
- Other regional coding (state/territory, PHN areas)
- GP practice model
- Size of GP practice
- GP demographic data including age.

Appendix C details the data source/s to measure indicators, and the expected data dimensions that are available. Appendix F maps evaluation indicators to the outcomes in the Program Logic. The evaluation indicators do not suppose directionality. This is to support the contextualisation of quantitative data with qualitative data to determine the success of the Incentive.

The Department has indicated several possible targets for the program that are under consideration. These relate to: resident registration, improved planning services, improved continuity of care, and commissioning in thin-market areas. These will be confirmed in Baseline reporting by the evaluation, following the Department's final consideration of recent policy changes. The indicators that correspond to targets have been highlighted in grey and bolded below in Table 3 to aid this consideration (indicators 3, 4, 7, 11, 15).

Table 3 | Evaluation indicators

#	Indicator
Activities	
1	Number and proportion of residents registered with MyMedicare.
2	Number and proportion of GPs and practices registered with MyMedicare.
3	Number of eligible care planning services received by registered residents in aged care homes.

¹⁷ Noting only permanent residents are eligible for the Incentive.

¹⁸ The Australian National Aged Care Classification (AN-ACC). This proposed use of AN-ACC to analyse activity based on AN-ACC classification will only occur if AN-ACC data can be linked to the relevant data sets by the Department within the scope of the evaluation. Details of AN-ACC classifications are available here: [AN-ACC assessment process and classification | Australian Government Department of Health and Aged Care](#)

¹⁹ Thin-market areas will be defined by those PHNs that were eligible to apply for the PHN capacity building grant from the Department. Rurality analysis will otherwise be conducted using the MMM.

#	Indicator
4	Number of eligible regular services received by registered residents in aged care homes.
5	Incentive payments received by GPs and practices
6	Quality of engagement between GPs and PHNs.
Outputs	
7	Number of GP service events per resident.
8	GP participation rates in aged care.
9	Collaboration between RACHs and GPs and GP practices.
Short Term (1-2 years)	
10	Registered resident satisfaction with primary care received in RACH.
11	Number of regular services provided by GP practice team members to registered residents in aged care homes.
12	GP practice revenues and costs by practice size and business model.
Medium Term (2-5 years)	
13	Number of Emergency Department (ED) presentations that do not require a hospital admission.
14	Number of unplanned hospital admissions for RACH residents.
15	Number of residents linked to regular GPs in MyMedicare
16	Ability for RACH to have timely 19F20 access to GPs.
17	GP practice viability ²⁰ F21.
18	GP and GP practice satisfaction in delivering primary care in RACHs.
19	RACH workforce satisfaction towards primary care.
20	Average number of medicines taken by RACH residents.
Long Term (5+ years)	
21	Resident quality of life because of regular, proactive care.
22	Pharmaceutical Benefit Scheme (PBS) medicines costs for RACH residents.
23	Number of after-hours services provided to RACH residents.
Other measures	
24	Total cost of the program ²¹ F22 versus incentive payments and changes in MBS items
25	Cost of the program versus the reduction in hospital admissions and presentations to ED.

There are challenges and limitations that may impact measurement of the indicators.

The indicators selected for this evaluation will face several challenges:

²⁰ Timely access refers to the ability of a RACH to arrange for a GP to see a resident when required, without undue delay, and will be measured qualitatively through RACH surveys and/or consultations. This is consistent with definitions in the Royal Commission into Aged Care Quality and Safety 2018, which note that timeliness is condition and circumstance dependent.

²¹ Viability considers the financial feasibility of the practice and workforce sustainability and will be measured qualitatively through GP practice manager surveys and/or consultations.

²² Including the cost of the grants and other activities that are part of the Incentive.

- **Contribution analysis of the Incentive to observed outcomes while interventions are underway:** The aged care primary care sector is experiencing significant reforms, with multiple interventions aimed at improving access and outcomes for residents in RACHs. Isolating the Incentive's specific contribution to these improvements requires triangulating different data sources, which is often complex.
- **Monitoring changes to primary care and evaluating impact of the Incentive needs data linkage:** Evaluating indicators across different data sources and dimensions requires linked data. Without comprehensive data linkage, it is challenging to correlate the indicator to changes in outputs and outcomes, as well as geographic analysis, which are essential for assessing the Incentive's effectiveness. The General Practice in Aged Care Incentive Indicator in MyMedicare is not currently linked to any data sets and this is essential to the evaluation.
- **Incomplete data sets and time-lagged data:** The data from the Australian Institute of Health and Welfare (AIHW) sometimes lacks completeness and timeliness. Not all states and territories contribute data consistently (Western Australia and Northern Territory do not contribute hospital related data to the National Health Data Hub (NHDH) and delays in data availability make it difficult to measure the impact of the Incentive on emergency department presentations and hospital admissions.
- **Different resolution of data sets:** Some datasets will disaggregate data by the listed dimensions proposed above (type of RACH, MMM, etc) and others may not. The evaluation will be limited by the highest resolution of the data; if the top-level data set is aggregated at a state and territory level, the evaluation will not be able to report at a PHN level. This is the case for some of the variables including GP practice model and GP age, which may only be captured in surveys or consultations. The evaluation may not be able to capture these in indicators.

4 Monitoring and evaluation methodology

This section details methodology and evaluation timing and provides a high-level data collection plan.

4.1 Overview of the methodology

The evaluation will employ an integrated mixed methods monitoring and evaluation approach

An overview of the methodology is provided in Figure 4 overleaf. Quantitative methods will be used to analyse program uptake, service delivery metrics, and cost-effectiveness, and to provide measurable indicators of the Incentive's performance. Qualitative methods, including surveys, consultations, and deep-dive site visits, will offer insights into the experiences of residents, families, carers, and other stakeholders. This integrated, multistage mixed-methods approach will enable evaluation of measure the Incentive's outcomes and evaluate its efficiency, effectiveness and sustainability.

4.2 Evaluation phases

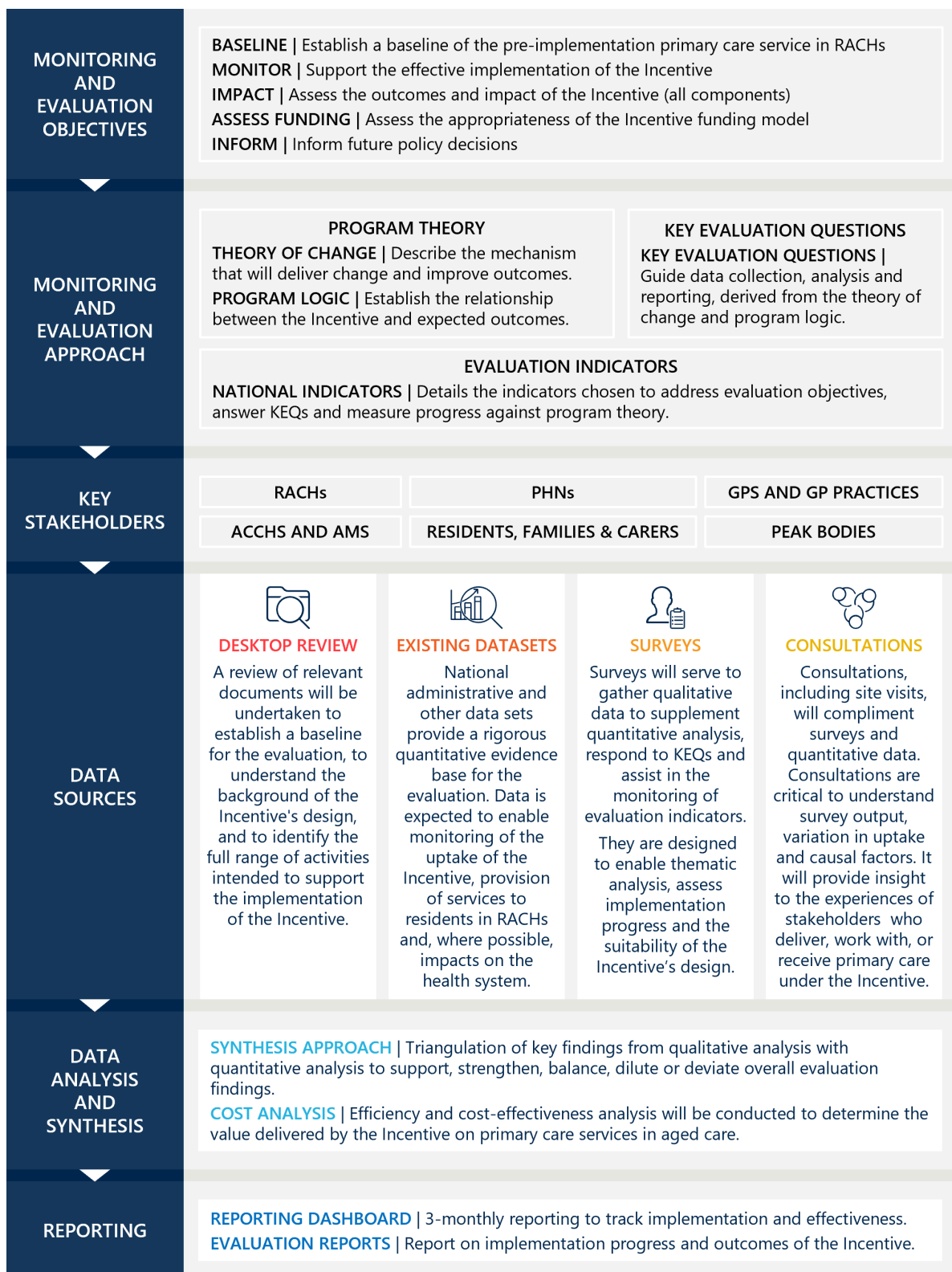
The evaluation will be conducted across four phases to ensure timely reporting aligned with the Department service order

Nous will deliver the evaluation between August 2024 to June 2027 over four phases:

- **Phase 1: Framework development (July 2024 to August 2024):** The purpose is to develop the Monitoring and Evaluation Framework and gain ethics approval.
- **Phase 2: Initial reporting (September 2024 to December 2024):** The purpose is to detail the evaluation baseline, providing early insights into the effectiveness of the Incentive and inform continual improvements during implementation.
- **Phase 3: Program monitoring (September 2024 to June 2027):** The purpose is to develop three-monthly reports on the implementation progress of the Incentive and deliver two formal progress updates discussing evaluation findings to date.
- **Phase 4: Final reporting (September 2026 to June 2027):** The purpose is to deliver a final evaluation report which will include cost-effectiveness analysis and comparison of identified outcomes with baseline data. The final report will inform program and policy decision making, and include lessons learned and recommendations.

Reporting periods are provided in Section 7.2.

Figure 4 | Overview of the monitoring and evaluation methodology







4.3 Data collection plan

Surveys, consultation, desktop review, and existing data will help answer KEQs

Consistent data collection from qualitative and quantitative sources will provide insights against KEQs (see Table 4). Further detail on data sources is in Section 5.2.

Table 4 | KEQs and evaluation indicators mapped against data sources

					
Research questions		DESKTOP REVIEW	EXISTING DATASETS	SURVEYS	CONSULTATIONS
1	IMPLEMENTATION: What has been implemented under the Incentive?				
1.1	What is important to understand about the context in which the Incentive is being implemented? (incl. the impact of intersecting reforms)	✓		✓	✓
1.2	What has been implemented under the Incentive? What worked well and less well in implementation?	✓		✓	✓
1.3	What is the level of uptake of the Incentive for providers, GP practices and residents? (incl. by region, MMM, type of RACH, type of GP practice and age of GP)		✓		✓
1.4	What factors helped or hindered uptake of the Incentive? (incl. consideration of the engagement and communication strategies)				✓
2	EFFECTIVENESS: How effectively has the Incentive delivered on its intended outcomes?				
2.1	What were the intended short, medium and long-term outcomes?	✓	✓	✓	
2.2	What was the baseline level of primary care services delivered in RACHs before the Incentive commenced?	✓	✓	✓	
2.3	In comparison to the baseline, what difference has the Incentive made across the intended outcomes? (incl. in thin markets)		✓		
2.4	What aspects of the Incentive were most and least effective? (including design, grants, implementation, administration and all elements of the Incentive)				✓
2.5	How satisfied are GPs, and practices with the Incentive? How satisfied are RACHs, residents, carers and families with their care under the Incentive?				✓
2.6	What, if any, unintended impacts have been observed? (incl. on the RACH workforce)		✓		✓
3	EFFICIENCY: How efficient and cost-effective has the Incentive been?				
3.1	What resources (i.e. financial, human, infrastructure, digital) were allocated to the Incentive and for what purpose?	✓		✓	✓
3.2	How efficiently were these resources allocated? (i.e. for the investment and other allocated resources, what outputs were seen and do they align with the planned implementation of the Incentive)		✓		
3.3	How cost-effective is the Incentive? (i.e. for the investment, what outcomes were achieved?)		✓		
3.4	How cost effective is the Incentive, compared to alternate funding models? ²³	✓	✓	✓	✓
4	SUSTAINABILITY: To what extent will the Incentive deliver sustainable impact?				
4.1	To what extent are observed outcomes likely to be sustainable? Why or why not?				✓
4.2	To what extent will general practices with different business models be economically impacted by the Incentive? (incl. which practice business models will be best off under the Incentive).				✓
4.3	What recommendations can be provided to enhance the effectiveness of the Incentive and inform future policies? (incl. options for more cost-effective care delivery for general practices who participate).				✓

²³ The Incentive will be compared to PIP GP ACAI quantitatively, and two other funding models, such as a salaried GP model and outcome payments model, through a desktop evidence review. The chosen models will be agreed upon during the evaluation.

5 Data collection and analysis





This section provides details on the data collection and analysis methods.

5.1 Overview of data collection methods

The ongoing monitoring and evaluation will use four main sources of data collection: desktop review, use of existing data sets, surveys, and consultation

Evaluation will use both quantitative and qualitative data collection methods, as shown in Table 5.

Table 5 | Summary of data sources

Type of data source	Rationale and purpose	Specific sources
 <p>DESKTOP REVIEW</p>	<p>Desktop research will be undertaken to establish a baseline for the evaluation, to understand the background of the Incentive's design, and to identify the full range of activities intended to support the implementation of the Incentive. Some documentation may help inform measurement of evaluation indicators.</p>	<ul style="list-style-type: none"> • Background policy documents • National reform plans • Royal Commission into Aged Care Quality and Safety • Aged Care Quality Standards • Others provided by the Department
 <p>EXISTING DATASETS</p>	<p>National administrative and other data sets provide a rigorous quantitative evidence base for the evaluation. Data is expected to enable monitoring of the uptake of the Incentive, provision of services to residents in RACHs and, where possible, impacts on the health system.</p>	<ul style="list-style-type: none"> • Services Australia MyMedicare • MBS data • PBS data • National Health Data Hub • National Aged Care Mandatory Quality Indicator Program
 <p>SURVEYS</p>	<p>Surveys will provide insights on the effectiveness of implementation including factors that drive or hinder uptake of the Incentive. They will also help to understand stakeholder experiences of the Incentive (from a range of perspectives) and the extent to which some intended outcomes have been achieved. They also help to fill data gaps.</p>	<ul style="list-style-type: none"> • RACH • GPs and GP practices • PHNs • Residents, families and carers
 <p>CONSULTATIONS</p>	<p>Consultations will compliment surveys and quantitative data. They are critical to explore themes identified through surveys, untangle the variation in uptake and causative factors, and experiences of stakeholders delivering, working with, and receiving primary care under the Incentive. Phase 4 will include 10 deep dive site visits.</p>	<ul style="list-style-type: none"> • RACH • GPs and GP practices • ACCHSs and AMSs • PHNs • Families and carers

Each of these data sources are described further below.

Call out box 5: THE PERSPECTIVES OF RESIDENTS WILL BE CAPTURED THROUGH SURVEYS

The experiences of residents in residential aged care homes are crucial to evaluating the impact of the Incentive on their access to proactive primary care. However, directly consulting with residents presents ethical and logistical challenges, as many may not be fully aware of the Incentive itself or able to comment on changes care access over time. Additionally, engaging residents through in-depth consultation can be disruptive and burdensome for residents and RACHs, particularly for residents with health or cognitive limitations. To minimise these challenges, the evaluation will gather residents' views through surveys, which are less intrusive and place a lower burden on participants. This method has proven effective in previous evaluations, allowing for the collection of valuable feedback without overwhelming residents. Insights from families and carers gained through surveys and consultations will complement this data, providing more comprehensive perspectives on the quality and consistency of primary care.

5.2 Data sources



DESKTOP REVIEW

The Incentive and supporting documentation

Purpose and rationale	A review of relevant documents will be undertaken to establish a baseline for the evaluation, to understand the background of the Incentive's design, and to identify the full range of activities intended to support the implementation of the Incentive.
Collection methodology	Documentation will be provided by the Department or by stakeholders in consultations. Nous will undertake limited desktop research of publicly available information where necessary.
Considerations	<p>Key documentation is expected to include:</p> <ul style="list-style-type: none">• Incentive related policy and guideline materials• National reform plans for primary care• Royal Commission into Aged Care Quality and Safety• Aged Care Quality Standards. <p>Given the vast array of potential documentation, the evaluation will not extend to materials from each PHN, RACH or GP practice (other than by exception, for example, for deep dive sites). This constraint is balanced by the insights gathered from surveys and consultations with stakeholders.</p>
Timing of collection	Desktop review will be undertaken during all phases.



EXISTING DATASETS

Existing datasets

Purpose and rationale	<p>National data sets will provide the quantitative data necessary to address KEQs, support the reporting of indicators and contribute to ongoing evaluation of the Incentive. The data sets will enable monitoring of the uptake of the Incentive, provision of services to residents in RACHs and, where possible, impacts on the health system. The evaluation analysis approach is detailed in Section 5.3.</p> <p>The evaluation will use three core data sets:</p> <ul style="list-style-type: none">• Services Australia – MyMedicare data to monitor GP and resident registrations and GP and resident matching.• MBS data to monitor service provision to residents in RACHs• PBS data will be used to monitor the impact the Incentive has on medication use in RACH residents. <p>Three additional, prospective data sets will be explored. The evaluation will test their usefulness, however there are possible issues with these data sets. In the case these datasets cannot be used for quantitative analysis, related KEQs and indicators will be evidenced with survey data and consultation.</p> <ul style="list-style-type: none">• AIHW – NHDH to evaluate the impact of the Incentive on outcomes identified in the Program Logic related to hospitalisation. There are known issues with timeliness of the linkage of this data set – the most recent reference period for this data only contains series up to 2022²⁴.• Aged Care Division - National Aged Care Mandatory Quality Indicator Program is a new Department held data set that may provide aggregate data on pharmacy and hospitalisation related indicators, the evaluation will explore this dataset. It may not have necessary disaggregation to be useful for reporting on the Incentive indicators.• AIHW - AN-ACC data is new dataset that classifies residents based on their care needs and the cost of care. The evaluation will explore this dataset if data linkage to understand if there are uptake trends across class. <p>The evaluation will be conducted over multiple years, Nous and the Department will monitor whether any new data or data sets become available that may be useful.</p>
Collection methodology	<p>The Department, through the Data Insights Section (DIS) team, will facilitate access to Services Australia MyMedicare, MBS, and PBS datasets, and NHDH datasets. The Quality Assurance Division (within the Aged Care Group of the Department) will support access to the National Aged Care Mandatory Quality Indicator Program. The Quality and Assurance Division (within the Aged Care Group of the Department) will support access to the National Aged Care Mandatory Quality Indicator Program.</p>
Considerations	<p>Three core data sets:</p> <p>Services Australia MyMedicare Data</p> <ul style="list-style-type: none">• Purpose: MyMedicare data is essential to monitor GP registrations, resident registrations and GP and resident matching.• Limitation: This data must be linked to other data sets to enable contextual analysis.• Use in reporting: This data is essential to the quarterly dashboards and all reports. <p>MBS Data</p> <ul style="list-style-type: none">• Purpose: MBS data is essential to monitor the difference the Incentive makes on service provision for RACH residents.• Limitation: MBS data must be linked to MyMedicare data for this to occur and will be analysed against several data dimensions to develop richer insights.• Use in reporting: This data is essential to the quarterly dashboards and all reports. <p>PBS data</p> <ul style="list-style-type: none">• Purpose: PBS data will be used to monitor the impact the Incentive has on polypharmacy and psychotropic medication use in RACH residents. PBS data represents medicines dispensed to residents, which is not a true representation of what a resident is administered.

²⁴ See NHDH data & data items, Data table reference period (accessed as at 18/08/24), link: <https://www.aihw.gov.au/reports-data/nhdh/data>

It also does not contain non-PBS medicines, over the counter or complimentary medicines.

- **Limitation:** Aggregate PBS data will have some use, but will be limited if it cannot be well-linked or correlated with PBS use specifically in the Incentive and in RACHs. If the NHDH does not get linked to MyMedicare, a custom linked data set with PBS and MyMedicare data will be requested.
- **Use in reporting:** If used, it will form part of the initial and final evaluation report.

Two prospective data sets:

The following two data sets are prospective data sets:

AIHW – NHDH

- **Purpose:** The NHDH hosts de-identified health data amalgamated from state, territory and Commonwealth data sources.²⁵
- The NHDH could be used for two main purposes:
 - to provide more detailed demographic data linked to Services Australia data sets, so these datasets can be analysed against the defined data dimensions (such as demographics of resident). However there are limitations with linkage.
 - to provide data on hospitalisations of residents – the NHDH contains detailed national data on hospitalisations, which can be used to measure indicators on changes in avoidable hospitalisations. However there are limitations with timeliness.
- **Limitations:** There are significant limitations with NHDH data use due to challenges with linking to MyMedicare data and timeliness of data linkage. The NHDH data set is time-lagged by more than a year (most recent reference period is 2022 at time of reporting), and the hospitalisation data set does not provide full national coverage, so this may be a challenge to the usefulness of this data for quarterly reporting. Further, NHDH needs to be linked to the Incentive indicator from MyMedicare. This linked data is necessary for quantitative contribution analysis and to analysing the Incentive outcomes related to regular service provision, patient and system outcomes.
- **If unavailable:** If NHDH data is unavailable – or not useful due to time lags – Nous will work with AIHW and the Department to obtain a custom data set that combines MyMedicare, MBS, PBS and hospitalisation data. If this data is still time-lagged or if linked data is not available, the Aged Care Division National Aged Care Mandatory Quality Indicator Program data on hospitalisations will be explored for usefulness in addition. If none of these datasets are available, these related outcomes will be analysed using survey data and consultations.
- **Use in reporting:** If used, it will form part of the initial and final evaluation report.

Aged Care Division - National Aged Care Mandatory Quality Indicator Program

- **Purpose:** this data will be used to conduct trend analysis on polypharmacy and psychotropic medicine usage, RACH workforce composition and resident hospitalisations. The data will be supplemented by consultations with identified RACHs.
- **Limitations:** Nous will seek access to data from the National Aged Care Mandatory Quality Indicator Program²⁶ provided quarterly by RACHs to the Department. This dataset will not be linked to MyMedicare and is limited to reporting on indicators at a RACH level.
- **If unavailable:** if unavailable these related outcomes will be analysed using survey data, and consultations.
- **Use in reporting:** If obtained, it will form part of the initial and final evaluation report.

AIHW – AN-ACC

- **Purpose:** this data will be used to explore and contextualise uptake rates based on resident AN-ACC class. hospitalisations.
- **Limitations:** Nous will seek access to data from the Department. If the data is not linked to MyMedicare data, the dataset will not be of use to the evaluation.
- **If unavailable:** this contextual analysis may be supplemented by engagements or case study analysis.
- **Use in reporting:** If obtained, it will form part of the initial and final evaluation report.

Additional considerations

Nous will not pursue state and territory level data collections to supplement national data sets.

²⁵ National Health Data Hub – Australian Institute of Health and Welfare. Available here: <https://www.aihw.gov.au/reports-data/nhdh>

²⁶ National Aged Care Mandatory Quality Indicator Program Manual 3.0 – Part A, accessed August 2024. Available here: <https://www.health.gov.au/sites/default/files/2023-11/national-aged-care-mandatory-quality-indicator-program-manual-3-0-part-a.pdf>

Timing of collection	<p>Core data sets: MyMedicare, PBS and MBS data will be provided to Nous by the Department quarterly, two weeks prior to the quarterly dashboard due date. It will also be used in formal progress updates and the initial and final evaluation report.</p> <p>Prospective data sets: If available, due to the time lags, NHDH data analysis will form part of the final evaluation report, for baselining. It is possible, but unlikely, that there will be significant change across the time-lagged data to fully measure hospital impacts from NHDH in the final evaluation report, but this will be explored.</p> <p>The Aged Care Division National Aged Care Mandatory Quality Indicator Program will be supplied to Nous as available.</p>
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SURVEYS OF A SAMPLE OF PHNS, GPs AND GP PRACTICES, RACHS AND RESIDENTS, FAMILIES AND CARERS

Surveys

Purpose and rationale	<p>Surveys will be used to gather qualitative data to supplement quantitative analysis, respond to KEQs and assist in the monitoring of evaluation indicators. They are designed to fill data gaps by enabling thematic analysis, assessing the progress of the Incentive’s implementation, the suitability of the Incentive’s design and identifying both barriers and enablers for its uptake. Details of the surveys can be found in Appendix D.</p> <p>Surveys will be distributed to four stakeholder groups:</p> <ul style="list-style-type: none"> • PHNs: to understand how funding provided to PHNs through the Incentive is being used, what impact the Incentive is having on GP matching and what activities are being conducted by the PHN to support implementation of the Incentive. • GPs and GP Practices: to understand the uptake of the Incentive including barriers, challenges and opportunities, the satisfaction of GPs with the Incentive and the how different business models are affected. • RACHs: to understand the uptake of the Incentive and its impact on primary care access in the RACH, and the impact on collaboration between primary care providers. • Residents, families and carers: to understand the impact of the Incentive on primary care access and delivery for residents, as well as quality of life.
Collection methodology	<p>Nous will use Qualtrics as the survey tool. Responses will be uniquely identifiable to enable responders to respond in their own time and enable Nous to conduct efficient follow-ups. Distribution mechanisms will be, for:</p> <ol style="list-style-type: none"> 1. PHNs: The Department and Brisbane North PHN will distribute the survey to all PHNs. Nous will monitor response rates and encourage responses as needed to ensure representation across jurisdictions, metro/regional/rural/remote PHNs and size and maturity of PHNs. 2. GPs and GP Practices: PHNs, RACGP and the Rural Doctors Association of Australia (RDAA) will distribute the survey to GPs. AAPM will distribute the survey to GP practice managers. The evaluation will review response rates between surveys and make recommendations to the distribution channel organisations or individuals to encourage responses where appropriate to try to ensure appropriate representation, which will aim to include feedback from GPs and GP practices that do not participate in the Incentive (particularly with the assistance of PHNs as a distribution mechanism). 3. RACHs: The Department will distribute the survey to all RACHs through existing mechanisms. Nous will review response rates and make recommendations to the distribution channel organisations or individuals to encourage responses where appropriate to try to ensure representation. 4. Residents, families and carers: Nous has engaged Council on the Ageing Australia (COTA) to distribute surveys. Nous will work with COTA and peak consumer groups where necessary to increase response rates.

Considerations	<p>Nous will develop tailored surveys for each stakeholder group.</p> <p>To encourage high participation rates, surveys will be low burden (< 15 minutes to complete) and consider respondent time and effort. Demographic information will be restricted to those essential for analysis, ensuring questions are clear and concise, with free text responses used only where necessary. All questions will be voluntary other than demographic questions.</p> <p>Ethics approval is necessary for the evaluation. The surveys, along with other relevant materials, will be included in the ethics application.</p> <p>Other considerations for each survey include:</p> <ol style="list-style-type: none"> 1. PHNs: Surveys will be distributed to all PHNs, with specific questions to inform evaluation of PHN's that received thin-market grants. 2. GPs and GP Practices: Pilot surveys will be distributed to a small number of GPs and GP practices prior to finalisation to test for useability and clarity. A tailored survey will be developed for GP practice managers to capture information such as GP practice viability and administrative impacts of the Incentive. 3. RACHs: Pilot surveys will be distributed to a small number of RACHs prior to finalisation to test for useability and clarity. 4. Residents, families and carers: Families and carers are included to supplement resident response rates. Responses from families and carers will be a proxy source for whether residents have better access to primary care and better quality of life. COTA will compensate survey respondents for their participation.
Use cases	<p>Surveys will be used for monitoring against indicators and in evaluation reports.</p>
Timing of collection	<p>The surveys will be conducted during Phase 2 (2025) and Phase 4 (2026) of the evaluation.</p>



CONSULTATIONS WITH A SAMPLE OF PHNS, GPs AND GP PRACTICES, ACCHS/AMSS, RACHS AND FAMILIES AND CARERS

Consultations

Purpose and rationale

Consultations will compliment surveys and quantitative data. They are critical to explore themes identified through surveys, untangle the variation in uptake and causative factors, and experiences of stakeholders delivering, working with, and receiving primary care under the Incentive.

Five types of stakeholders will be recruited for consultations:

1. **PHNs:** to understand the impact of the Incentive in thin-market areas, challenges and opportunities for marching residents with GPs and the impact of the Incentive on the provision of primary care activities in RACHs.
2. **GPs and GP Practices:** to understand implementation progress and lessons learned, the effectiveness of the Incentive design in changing care provision and impact on working relationships with primary care providers.
3. **ACCHS and AMSs:** to understand the challenges and opportunities associated with the Incentive in providing primary care for First Nations people in RACHs.
4. **RACHs:** to understand to understand implementation progress and lessons learned and the impact of the Incentive on primary care in RACHs.
5. **Families and carers:** to understand perceived change in access to primary care for aged care residents over time.

Collection methodology

1. **PHNs:** Nous will use survey responses to recruit participants for consultations. Nous will aim to consult with all PHNs and will engage with Brisbane North PHN,²⁷ and/or the PHN collective to encourage PHN participation where needed.
2. **GPs and GP Practices:** Nous will use survey responses to recruit participants for consultations. A selection of GPs that represent different levels of participation in the Incentive, different business models and demographics will be engaged, which may be 25 GPs for up 2 consults, each at 1 hour in length²⁸. If further participants are required to reach numbers RACGP, AAPM and PHNs will be contacted for recommendations.
3. **ACCHS and AMSs:** Nous will identify a list of potential ACCHS and AMSs and will test this list with NACCHO and the Department. Nous will conduct up to 8 focus groups /interviews.
4. **RACHs:** Nous will use survey responses to recruit participants for consultations. Where larger sample sizes are required, PHNs and the Department will be contacted for recommendations.
5. **Families and carers:** Nous will use survey responses to recruit participants for consultations. A representative sample of families and carers will be engaged, which may be 25 families and carers for 2 consults each²⁹. Where larger sample sizes are required, peak consumer groups, and COTA will be contacted for recommendations.

See Appendix E for a detailed stakeholder engagement plan.

Considerations

Recognising that primary care stakeholders are often time constrained and over engaged, particularly during normal business hours, the evaluation will adopt a flexible approach to consultations. An electronic platform will be used to schedule and book consultations with participants and a variety of time options will be offered outside of business hours to support engagement. Consultations will be virtual, unless otherwise agreed and no travel is required.

Consultation guides will help to maintain consistency over time.

Detail on the sampling approach is below:

- **PHNs:** Sampling will be reflective of different states and territories and rurality. The evaluation will approach PHNs at different stages of uptake and at different levels of implementation to ensure a spread of PHN experiences are covered.
- **GPs and GP Practices:** Sampling will be reflective of different business models (including corporate practice model, sole trader model, partnership model, visiting specialist model, fee-for-service model, integrated care model, PHN contracted model and bulk-billing

²⁷ Brisbane North PHN will only be engaged whilst they are contracted for change management purposes.

²⁸ Final number may vary based on available compensation and consult duration.

²⁹ Final number may vary based on available compensation and consult duration.

	<p>model). GPs will be reimbursed for their time at \$150 per hour as per the RACGP recommendations to a maximum of \$200 per GP.</p> <ul style="list-style-type: none"> • ACCHS and AMSs: Level of engagement of ACCHS and AMSs with the Incentive may be low due to competing interventions in the sector. • RACHs: Sampling will be reflective of different states and territories, rurality and presence of RNs in the facility. Where possible, multidisciplinary team members employed by facilities will be included in consultations, however the evaluation will be mindful of the workload and high administrative burden that these staff members may already experience, and participation will be optional. • Families and carers: Families and carers will be reimbursed \$100 per 60-minute consultation (or \$50 per 30-minute consultation).
Timing of collection	<p>Consultations will be conducted in:</p> <ul style="list-style-type: none"> • Phase 2 (2024) to supplement survey and quantitative analysis to establish a baseline. • Phase 3 (2025) in two rounds, approximately mid-2025 and early 2026. • Phase 4 (2026) in an intense manner to support the final evaluation report.

'Deep dive' site visits

Purpose and rationale	<p>The purpose of 'deep dive' site visits is to gain deeper insights into the factors that affect implementation, uptake, effectiveness and impacts of the Incentive, as well as offer comparative insights to inform contribution analysis. Nous will conduct up to 10 'deep dive' site visits. The outputs from the deep dive analysis will be incorporated into the final evaluation report in two ways:</p> <ol style="list-style-type: none"> 1. Incorporate insights throughout evaluation reports against relevant KEQs/research question findings. 2. Include detailed case studies for each deep dive in the final evaluation report.
Collection methodology	<p>Nous and the Department will jointly identify the 10 locations for the site visits in late 2025. They will be selected to represent a range of:</p> <ul style="list-style-type: none"> • GP practice models including corporate practice model, sole trader model, partnership model, visiting specialist model, fee-for-service model, integrated care model, PHN contracted model and bulk-billing model. • GPs and GP practices with varying levels of uptake of the Incentive. • Jurisdictions. • Regions, including metropolitan/regional/rural/remote. <p>Data and information from consultations, surveys and MyMedicare data (on uptake levels) will be used to inform the selection of the 10 sites.</p>
Considerations	<p>These will be conducted either virtually, in-person or a mix of both, to be confirmed during selection of sites in Phase 4.</p>
Timing of collection	<p>Deep dive analysis will be conducted in Phase 4 (2026) for inclusion in the final evaluation report.</p>

5.3 Data analysis

The evaluation will use qualitative and quantitative methods to analyse the data collected. Below sections detail the qualitative, quantitative and cost-effectiveness analysis methods and the triangulation approach.

5.3.1 Qualitative analysis

Qualitative data sources will include desktop research, qualitative survey responses and consultations. The qualitative analysis will provide more detail and nuance that cannot be understood from quantitative data alone. Nous will conduct thematic analysis of qualitative data. Thematic analysis involves:

- **Initial review.** The evaluation will review the information from desktop research, qualitative survey responses and consultations to develop a holistic understanding of the results.
- **Identify and code themes.** This involves recording or identifying similar, repeated content or patterns in the data that provide insights to the KEQs. Patterns are summarised and interpreted, then coded to develop an organised framework of thematic insights. Semantic (e.g. facts, statements) and latent (underlying ideas, concepts beyond the literal records) themes will be sought.
- **Review, modify and test themes.** This involves checking/testing the identified themes to ensure that, as far as possible, they are mutually exclusive and collectively exhaustive, and testing relevant emerging insights with key stakeholders in subsequent consultations. This allows the analysis team to test and modify codes in an iterative fashion. Themes may be refined, combined, split, weighted or discarded at this stage.
- **Define themes.** This involves analysis of each theme, determining the scope, focus and relationships between each theme and identifying findings from the consultations, desktop research or qualitative survey responses.

5.3.2 Quantitative analysis

Nous will use quantitative analysis to develop a robust evidence base. Specific methods are below. A detailed mapping of each method of analysis to KEQ's can be found in Appendix F Data Map and Plan.

Descriptive and inferential statistics

Statistical analyses will combine descriptive and inferential methods

Descriptive statistics describe what has happened. Descriptive statistics will be used to report on uptake of the Initiative and to report on the indicators. Analysis of uptake by AN-ACC classification will also be performed if linked data is available.

Inferential statistics, including time-series modelling, and regression analysis help to test hypotheses and to further understand circumstances where the intervention may have been effective or not. Inferential methods will be used as part of the analysis to answer KEQs of effectiveness – to understand how effectively the Incentive has delivered on its outcomes, and what impacts the Incentive may have had.

Information from surveys will be analysed in conjunction with outcomes indicators. Responses to surveys will be summarised with descriptive statistics such as the number and percentage of people who respond to each category of the Likert scale. Differences over time will be tested using t-tests for means and chi-square tests for proportions. Generalised estimating equation framework will be used to adjust for clustering of responses within RACHs if this is necessary.

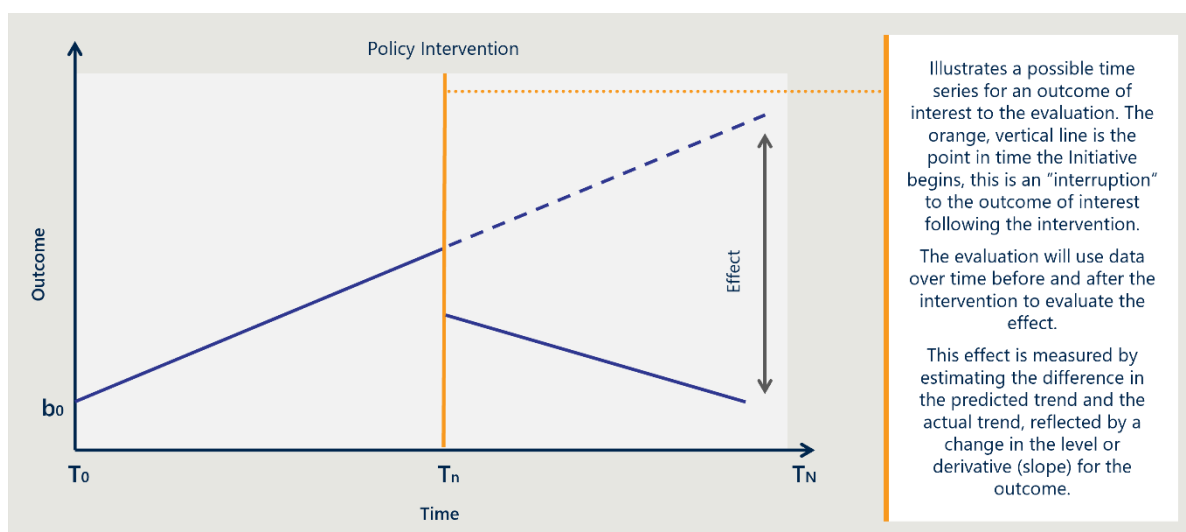
Interrupted times series (ITS) analysis

ITS analysis will estimate the Incentive's impact by comparing predicted and actual trends across resident and GP subgroups

ITS analysis is a quasi-experimental method that can be used to understand the effectiveness of the Incentive and if it is achieving its outcomes after implementation.

The underlying trend in the outcome of interest (e.g. the number of residents accessing primary care in RACHs) may be 'interrupted' with the commencement of the Incentive (see time T_n in Figure 5.). The effect due to the introduction of the Incentive will be estimated by considering the post 'interruption' period and estimating the difference between the predicted trend in the outcome based on the prior observations and the actual trend. The effect may be reflected in a change in the level of the outcome (the intercept), a change in the trend in the outcome (the slope), or both.

Figure 5 | Illustration of interrupted time series method



Indicators that have consistent time series will be analysed using ITS analysis. This involves analysing trends in monthly summaries of the outcomes, prior to and following implementation of the Incentive. The approach relies on estimating reliable trends in the outcome over the period before the start of the intervention (i.e. the Incentive). Due to the impact of COVID-19, which may have had an impact on the outcomes, it is important to extend the prior period to well before 2020, ideally back to 2012

A challenge for ITS analysis will be that analysing data at an individual resident level will likely not be useful due to short timeframes of residence in RACH and deteriorating health being common. ITS will most likely be useful at the facility level, or at an aggregate across residents, to understand the effect of the Incentive. Subgroup analysis will be conducted to assess whether the change is consistent across geographical areas (defined by thin markets, MMM, SES) and GP characteristics.

Mediation analysis

Mediation analysis will strengthen causal inferences in the absence of a comparison group

Mediation analysis is a statistical approach used to understand the process by which an independent variable influences a dependent variable through one or more intervening variables. For this evaluation, it will be used to strengthen the evidence for causal associations between the Incentive and observed outcomes.³⁰

³⁰ Judea Pearl (2012) The causal mediation formula--a guide to the assessment of pathways and mechanisms, DOI: [10.1007/s11121-011-0270-1](https://doi.org/10.1007/s11121-011-0270-1)

The strength of evidence for causal associations estimated from an ITS may be weak due to confounding factors. While comparison groups are often used to control for such influences, the Incentive's design does not include a strict comparator or control group. (It would not be feasible to include one, because this would mean denying a level of care to residents). Mediation analysis offers an alternative method to improve the strength of causal inferences.

In this evaluation, it is reasonable to anticipate that there will be graduated uptake of the Incentive, with some residents potentially not receiving care under it. Uptake will also be variable across different general practices. This variation in uptake levels across practices, regions and RACHs provides an opportunity for mediation analysis. Structural equation models will be used to determine if areas with higher levels of Incentive registration demonstrate greater improvements in outcomes compared to those with lower registration. This method leverages the graduated effect observed with increasing levels of uptake, effectively creating a range of comparison points rather than relying on a single comparator group.

By employing mediation analysis, the evaluation can strengthen the evidence that observed changes in outcomes are attributable to the introduction of the Incentive, providing a more robust basis for causal inferences in this evaluation.

5.3.3 Efficiency and cost-effectiveness analysis

The evaluation will assess the Incentive's efficiency by analysing cost per unit of intended output

The evaluation will analyse the efficiency of the Incentive. The aim will be to determine the cost per unit of intended outputs in the program. This involves comparing the costs of delivering the Incentive (which includes program implementation costs, operational costs and grants) to the intended outputs (which include number of eligible primary care services provided to residents, number of residents receiving eligible primary care and number of services provided per resident). This analysis can be conducted using linked MBS data to determine a cost per service unit.

The evaluation will determine the Incentive's cost-effectiveness by estimating the cost per unit of outcome achieved

The aim of cost-effectiveness analysis will be to determine the cost per unit of target outcomes, establishing the value delivered for each dollar invested in the Incentive.

A cost-benefit analysis will estimate the Incentive's cost-effectiveness by comparing its costs to its monetised outcomes. This will be achieved by estimating the costs of delivering the Incentive (which includes program implementation costs, operational costs and grants). Then, the monetary value of the outcomes the Incentive has achieved for the system (reduction in hospital admissions and presentations to emergency departments) will be estimated. The dollar value of the outcome will be estimated using hospitalisation data and use of the National Weighted Activity Unit (NWAU) and National Efficient Price (NEP) to calculate the financial impacts on the system. This is outlined in Equation 1.

Equation 1 | High level indicative cost benefit analysis overview

$$\text{Net benefit of incentive} = (B_i - C_i)$$

$$\text{Cost of incentive} = C_i = C_{\text{implementation}} + C_{\text{operations}} + C_{\text{grants}} + \epsilon(\text{other costs})$$

$$\text{Benefit of incentive} = B_i = \left(\sum_n^N \text{NWAU}_n \times \text{NEP}_n \right) + \epsilon_1(\text{bereavement reduction}) + \epsilon_2(\text{improved QALY})$$

N = number of avoidable hospitalisation

NWAU = National Weighted Average Units

NEP = National Efficient Price

Quantification of other possible non-financial benefits such as bereavement reduction for family and carers or increased Quality Adjusted Life Years (QALY's) for residents will be considered residual and will not be included in the cost-benefit analysis. This evaluation will not include a dollar quantification of the

Incentive's impact on residents' quality of life. Although positive outcomes, such as improved quality of life, are among the expected benefits, conducting cost-benefit and cost-effective analyses that accurately captures this will be out of scope. This will result in a more defensible estimate of the cost-benefit.

The impact of the triple bulk billing incentive will also be considered. A time series analysis comparing the triple bulk billing incentive data before and after implementing the Incentive, both in aged care and out of aged care settings, will form the basis for a difference in difference analysis.

Nous will explore how cost-effective different components of the overall Incentive funding were in achieving their intended outcomes. This will include the cost to administer the program compared to incentive payments and an analysis of the ancillary funding provided to PHNs to support implementation and how much value this delivered for the sector.

Accurately quantifying changes in hospitalisation is a challenge. The NHDH is the preferred data source, however it has a time lag for all linked data. Therefore, it may only be useful for informing a baseline and is likely not useful for measuring changes in hospitalisations during the evaluation. The evaluation will explore alternatives including:

- Using data available through the National Aged Care Mandatory Quality Indicators will be explored as alternative data source, but may not link specifically to enrolment in the Incentive.
- Using proxy qualitative data sources such as additional questions in surveys or consultations.
- Using the deep dive sites to understand changes in hospitalisations at specific sites, as a proxy for understanding national changes in hospitalisations. This would involve consultations and potentially working with RACHs at deep dive sites to understand any hospitalisations / transfer data they hold that is useful.
- Taking a jurisdictional approach as a proxy for national impacts and explore a state-based data and case study to understand impacts on hospitalisations, such as through working with CHeReL in NSW.

If specific hospital data sources are not available, estimates will be made informed by surveys and consultations to complete the analysis.

The cost-benefit analysis will include sensitivity analysis using two methods

First, a worst/best case analysis for any variables that had to be estimated will create base, worst, and best -case scenarios to provide a range of potential outcomes. This will help identify if further investigation of critical elements is needed. Second, partial sensitivity analysis will examine how net benefits change when key variables are adjusted across their plausible ranges. This will clarify how uncertainty in specific variables, such as compliance costs or benefit forecasts, affects the overall results, enabling informed decision-making.³¹

Cost-effectiveness of the Incentive will be compared to the PIP GP ACAI and selected other models

The KEQs on effectiveness ask: *How cost effective is the Incentive, compared to alternate funding models?* The previous incentive in place was the PIP GP ACAI. This will be used as a baseline and a comparator for quantitative analyses of the cost effectiveness of the Incentive. Two other models for incentivising GPs, such as a salaried GP model and outcome payments model, will be compared to the Incentive through an evidence review, based on desktop research.

³¹ See Office of Impact Analysis Guidance Note on Cost Benefit Analysis, July 2023: <https://oia.pmc.gov.au/sites/default/files/2023-08/cost-benefit-analysis.pdf>

5.3.4 Contribution analysis and triangulation of different data sources

Contribution analysis will assess the Incentive's impact in the absence of a control group

Given the complexity of the primary care aged care space and the presence of multiple programs, establishing the Incentive's direct contribution to intended outcomes is challenging. The evaluation will use the Program Theory, combined with evidence gathered through comprehensive data collection.

Analysis of the contribution of each Incentive intervention will be done by comparing areas with significantly different uptake rates and examining trends in relation to implementation activities. Additionally, the qualitative findings from surveys, consultations, and deep-dive analyses (see section 5.2) will provide insights into the Incentive's specific impact on observed outcomes.

This multi-faceted approach will support informed judgements about the Incentive's contribution, even in a non-experimental context.

Triangulation of different data sources will test evaluation findings

A critical part of conducting a robust evaluation that can withstand scrutiny is the validation of findings – that is, where possible, comparing the insights from different data sources. Nous will triangulate data with surveys, consultations and deep dives to:

- understand the complex context in which the Incentive has been implemented, considering other programs in the primary care aged care sector and their impacts of primary care in RACHs.
- contextualise challenges with the Incentive that impede uptake or efficient use of resources.
- provide insights on any differences in outcomes that have been observed.
- identify areas for further investigation and discussion.

5.3.5 Data handling and analytics practices

Nous will use best practices to manage, and quality assure quantitative analysis. These include securely storing data, version controlling analysis code using git software, using the Targets pipeline approach to coordinate the pieces of computationally demanding analysis, and code review will be undertaken for all output produced. Quantitative analysis will be conducted using the R statistical programming language, and Microsoft Excel for descriptive statistics and simple charts.

5.3.6 Privacy and data management

Nous manages all information in accordance with relevant privacy and data security legislation, regulations and public sector policies and procedures for data storage and retention. Nous has a comprehensive suite of Information Security and Privacy policies and educates staff on the importance of designating and managing sensitive information. Nous will implement the following for this evaluation:

- only data relevant to the evaluation will be collected.
- the volume of personal or identifying information will be minimised as far as possible.
- all electronic information will be stored on private network servers protected by firewalls.
- document management/collaboration systems will be hosted on a secure private cloud in Australia.
- receipt of key documents and datasets will be tracked in central project registers.
- stored data will be destroyed at the end of the evaluation, as well as all personal information.

6 Engagement plan

This section provides the plan for stakeholder engagement during the evaluation.

6.1 Stakeholder engagement plan

Stakeholder engagement will be guided by a set of considerations across four phases

There are several considerations that will guide engagement:

- **Ethical engagement:** All engagement will be conducted ethically. Interviewers will be clear in advance about the purpose and how information will be used, not collect personal information, be clear participation is voluntary and provide questions in advance.
- **Diversity of methods:** Engagement will include online surveys, individual interviews, focus groups and workshops to encourage broad participation. Most engagements will be virtual.
- **Flexibility:** Engagement will recognise the demanding schedules of stakeholders, particularly GPs and health professionals. Stakeholders will be offered flexible times including after-hours options, varying lengths (15, 30 and 60 minutes) and opportunities for written feedback.
- **Fair compensation:** GPs will be compensated for their time in line with RACGP guidance (\$150 per hour to a maximum of \$200 for 90 minutes). Families and carers will be compensated at a maximum of \$200 for two consults each.
- **Trauma informed and culturally safe methods:** For engagements with families and carers, interviewers will create supportive and non-threatening environments and offer participants control over their engagement, including format and timing. For all engagements, but particularly those with ACCHs/AMSs, interviewers will ensure cultural protocols are respected. Feedback from participants will guide continuous adaptation of practices to ensure sensitivity to trauma and cultural needs.

There are three main types of engagement:

1. **Regular progress-focused meetings with the Department:** The purpose is for Nous to provide updates on progress of the evaluation and flag risks. The Initiatives Design Section will provide reform context and updates on implementation. These will occur on a regular cycle as agreed by Nous and the Department. Nous will also engage with the DIS and HERD as needed.
2. **Two main rounds of engagements to inform evaluation findings:** The purpose of these engagements is to provide insights against KEQs to inform monitoring and evaluation findings. These engagements will occur in Phase 3 (80 hours) and Phase 4 (80 hours). Engagements will involve PHNs, GPs and GP Practices, ACCHS and AMSs, RACHs and families and carers. There will be limited engagement in Phase 2 (10 hours) to fill data gaps as needed in forming the evaluation baseline.
3. **One round of 'deep dive' site visits in Phase 4 (2026):** The purpose of 'deep dive' site visits is to gain deeper insights into the factors that affect implementation, uptake, effectiveness and impacts of the Incentive, as well as offer comparative insights to inform contribution analysis. Ten sites will be selected for 'deep dive' site visits. (These are included in the 80 hours of Phase 4 consultation).

Table 6 provides a high-level engagement plan, with the detail provided in Appendix E.

Table 6 | High-level stakeholder engagement plan

Stakeholder	Purpose	Phase		
		2	3	4
Regular engagement with the Department				
Initiatives Design Section	<ul style="list-style-type: none"> Understand implementation progress, including of communication and change management activities. Monitor evaluation progress and monitor and manage risks. Provide insights on the reform context during the evaluation. 	●	●	●
Data Insights Section	<ul style="list-style-type: none"> Facilitate access to existing data sets (see section 5.2 for detail). 	●	●	●
HERD	<ul style="list-style-type: none"> Advise on evaluation methods and ensure alignment with the Strengthening Medicare evaluation programs. 	●	●	●
Regular engagement to inform evaluation				
PHNs	<p>Brisbane North PHN: Facilitate engagement with PHNs.</p> <p>All PHNs:</p> <ul style="list-style-type: none"> Understand the baseline of primary care provision in RACHs. Understand progress and effectiveness of implementation, including barriers and enablers (and in thin markets). Understand progress towards intended outcomes, such as collaboration between PHNs and local primary care services. 	●	●	●
GPs and GP Practices	<ul style="list-style-type: none"> Understand the baseline of primary care provision in RACHs. Understand progress and effectiveness of implementation, including barriers and enablers (and in thin markets). Understand satisfaction and experiences of GPs and practices. Understand progress towards intended outcomes, including proactive care and collaboration between PHNs and local primary care services. Understand the impact of the incentive for different 	●	●	●

	business models.			
ACCHS and AMSs	<ul style="list-style-type: none"> Understand the baseline of primary care provision in RACHs. Understand the suitability of the design of the Incentive in improving primary care service delivery for First Nations residents of RACHs. Understand progress and effectiveness of implementation, including barriers and enablers (and in thin markets). Understand experiences of GPs who uptake (or do not use) the Incentive. 	●	●	●
RACHs	<ul style="list-style-type: none"> Understand the baseline of primary care provision in RACHs. Understand any impacts on timely access to primary care in RACHs Understand the impacts on RACH, residents and GP collaboration. Explore any impacts of the Incentive on the RACH workforce. 	●	●	●
Families and carers	<ul style="list-style-type: none"> Understand whether access to primary care has changed. Understand the impact on experiences and quality of life for residents. 	●	●	●
Deep dive engagements with 10 sites				
A range of stakeholders at each site	<ul style="list-style-type: none"> Develop rich insights about the factors that affected the Incentive implementation, uptake, effectiveness and impact. Explore collaboration between practice and primary care stakeholders 			●

7 Implementation considerations

This section details governance arrangements, reporting requirements and challenges and limitations.

7.1 Governance arrangements

The Department of Health and Aged Care will oversee governance of this evaluation

The Primary Care Division of the Department will oversee the evaluation. The First Assistant Secretary and Assistant Secretary of the division are the ultimate decision-makers. Deliverable sign-off sits with Director of the Initiatives Design Section, Primary Care Quality and Design Branch, Primary Care Division, Primary and Community Care Group. The Initiatives Design Section will manage the evaluation.

Table 7 details the roles and responsibilities of key stakeholders in the evaluation.

Table 7 | Evaluation roles and responsibilities

Stakeholder	Role	Responsibilities
Nous team	Evaluators	Deliver the evaluation in line with the Monitoring and Evaluation Framework
Department stakeholders		
Initiative Design Section	Project management and governance	Monitor evaluation progress and risks Keep Nous informed of any policy or Initiative design changes Review and provide advice to help interpret evaluation findings Connecting Nous to the stakeholders Facilitate access to data and documentation as required
Data Insights Section	Data access and advice	Supply of relevant data Review and feedback on reports
MyMedicare team	Provide advice	Advise on MyMedicare platform functionality Facilitate access to data Review and feedback on reports
General Practice Reference Group (GPRG)	Provide advice and support access to GPs	Review and provide advice to help interpret evaluation findings Support contact to GPs for consultation and survey
Primary Care Strategy Branch	Provide advice	Review and feedback on reports
Service Delivery Division, Ageing and Aged Care Group	Provide advice	Review and feedback on reports
HERD	Provide advice	Review and feedback on methods and evaluation reports
Strengthening Medicare Implementation Oversight Committee	Endorser	Review and endorse evaluation reports as outlined in Table 8
Other stakeholders		
COTA	Sub-contractor	Distribute surveys to residents, families and carers

7.2 Reporting

A series of reports that serve multiple purposes will be produced throughout the evaluation

Evaluation reports will include:

- **Initial evaluation report**, which will establish a baseline and provide early insights into the effectiveness of the Incentive.
- **Formal progress reports**, which will include an update on the uptake of the Incentive, a summary of findings and progress of the evaluation.
- **3-monthly reporting dashboards**, which will consist primarily of data to monitor uptake of the Incentive. Some dashboards may include more findings as agreed between Nous and the Department.
- **Final evaluation report**, which will analyse all data and provide comprehensive findings and recommendations.

The details are summarised in Table 8.

Table 8 | Summary of evaluation reports

Phase	Report	Purpose	Due date	Endorsement
2	Initial evaluation report	<ul style="list-style-type: none"> • Establish baseline. • Provide early insights into effectiveness of initiative. • Review of implementation activities to date. • Early insights into barriers and enablers. 	December 2024	Strengthening Medicare Implementation Oversight Committee
	2025 Formal progress update	<ul style="list-style-type: none"> • Uptake of the Incentive to date. • Full update on findings to date. • Discussion on interpretation of the findings. • Discussion on progress of the evaluation. 	January 2025	Director, Initiatives Design Section, Department of Health and Aged Care
3	2026 Formal progress update	<ul style="list-style-type: none"> • Uptake of the Incentive to date. • Full update on findings to date. • Discussion on interpretation of the findings. • Discussion on progress of the evaluation. 	January 2026	Director, Initiatives Design Section, Department of Health and Aged Care
	3-monthly reporting dashboards	<ul style="list-style-type: none"> • Uptake of the Incentive, reported against various data dimensions. • Findings from consultations will be reported at a high level as available. • Identify areas for continuous quality improvement or further exploration. 	Every 3 months starting January 2025 and ending April 2027	Director, Initiatives Design Section, Department of Health and Aged Care
4	Final evaluation report	<ul style="list-style-type: none"> • Uptake of the Incentive to date • Comparison of Incentive to baseline • Efficiency and cost-effectiveness analysis • Other models for exploration 	June 2027	Strengthening Medicare Implementation Oversight Committee

-
- Impacts on GP practice viability
 - Continuous improvement and policy recommendations
 - Lessons learnt, barriers and enablers.
-

7.3 Evaluation challenges and limitations

Tackling challenges and limitations will require a flexible approach

There are several challenges and limitations for this evaluation, which relate to the measurement of the evaluation outcomes and data collection. Overall, these may impact the representativeness or validity of evaluation findings if not appropriately managed. A flexible approach, where risks are actively identified and mitigated, is needed to deliver on evaluation objectives. Evaluation challenges and limitations include:

- **It will be difficult to isolate the contribution of the Incentive to observed outcomes given contributing factors:** The aged care and primary care sectors are experiencing significant reforms, and there are multiple interventions aimed at improving access and outcomes for residents in RACHs. It will be challenging to separate the impact of the Incentive from the other initiatives, especially initiatives introduced before the Incentive such as the triple bulk billing incentive.
- **Some long-term outcomes may be achieved after the evaluation period has ceased:** It is anticipated that the Incentive will contribute to the achievement of long-term outcomes after five years for residents, providers and the Australian health system. However, as this evaluation will run from 2024 to 2027, the achievement of some of anticipated long-term outcomes may occur years after the evaluation has finished. The evaluation will strive to monitor for early indications for long-term outcomes where possible.
- **There are limitations for residential aged care and primary care data:** The indicators for this evaluation have been developed to balance the objectives of monitoring with the limitations of data available and the practicality of measurement. Access to high quality and comprehensive data in RACHs and from GPs and practices presents many challenges for the evaluation, outlined in section 3.4. These challenges mean that the evaluation approach will have to be flexible, including sourcing alternative datasets. Qualitative data may be used to fill any gaps in unavailable quantitative data.
- **It will be challenging to access high quality data on avoidable hospitalisations:** The NHDH is the proposed source of detailed national data on hospitalisation that can be used to measure indicators or changes in avoidable hospitalisations. There are significant potential limitations with NHDH for this purpose due to the dataset being time-lagged by more than a year, not providing full national coverage and challenges with linkage to MyMedicare data. The NHDH is the preferred data source to measure the outcomes relating to hospitalisation, however if its use is deemed unviable, state level data or the National Aged Care Mandatory Quality Indicators could be explored as alternative data sources, in conjunction with consultations to complete the analysis, see further detail in Section 5.3.
- **Sufficient size and representativeness of participants for surveys and consultation:** A critical input for the evaluation is the views of residents, families and carers, GPs and GP practices, RACHs and PHNs. It is possible that some stakeholders may be difficult to engage due to availability constraints or low desire. Nous will ensure adequate engagement as set out in Section 5.2 that identifies the best approach for engagement that meets the need of each stakeholder, considerations to encourage high participation rates and minimise burden. Nous will also draw on the Department, peak bodies and other organisations to identify participants and connect them to the surveys and consultations.

7.4 Ethics approach

Nous is committed to conducting an ethical evaluation and will seek approvals from Bellberry Human Research Ethics Committee

Nous will ensure that the evaluation adheres to the highest standard of ethical conduct. Nous' methodology has been developed to ensure the design and conduct of the evaluation is consistent with the relevant ethical requirements outlined within the following codes of practice:

- The *National Statement on Ethical Conduct in Human Research 2023* (the National Statement),³² published by the Australian National Health and Medical Research Council (NHMRC), the Australian Research Council and Universities Australia.
- Advice and guidance from the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) including the *AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research (2020)*.³³
- The ethical requirements for evaluation specified in the *Guidelines for the Ethical Conduct of Evaluations* published by the Australian Evaluation Society.³⁴

Based on the above ethical frameworks, the evaluation team have determined that review by a Human Research Ethics Committee (HREC) is warranted. Nous will seek ethics approvals from Bellberry HREC in September 2024, prior to the commencement of evaluation activities.

There are three main ethical considerations for this evaluation.

The potential ethical risks, and their mitigation strategies, are laid out in Table 9.

Table 9 | Ethical considerations for the evaluation

Ethical consideration	Mitigation strategy
<p>Risk to participants</p> <p>The evaluation will engage with residents of RACHs, and their carers and families, via surveys, focus groups, and interviews.</p> <p>Residents of aged care homes are considered "people in dependent or unequal relationships" according to section 4 of the National Statement. It is also likely that some evaluation participants belong to other groups identified in the National Statement, including "people with a cognitive impairment, intellectual disability, or a mental illness"; "people highly dependent on medical care"; and Aboriginal and/or Torres Strait Islander peoples.</p> <p>As laid out in the National Statement, research and quality improvement activities involving these groups require higher levels of ethical assurance. They may be less able to give informed consent, and may be at a higher risk of harm or discomfort, especially if interviews or surveys bring up memories of negative or distressing experiences.</p> <p>There is also a low risk of vicarious trauma to project team members for the same reason.</p>	<p>Nous will work with COTA, National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIAACC), and other consumer representative groups to develop data collection tools and consent protocols that are safe and appropriate. Nous will not engage with participants who cannot provide consent.</p> <p>Nous will establish proactive wellbeing check-ins and comprehensive debrief and support mechanisms for team members.</p>

³² NHMRC, National Statement on Ethical Conduct in Human Research 2023, 2023 (accessed 12 August 2024) <https://www.nhmrc.gov.au/about-us/publications/national-statement-ethical-conduct-human-research-2023>

³³ AIATSIS, AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research, 2020 (accessed 14 August 2024). <https://aiatsis.gov.au/research/ethical-research/code-ethics>

³⁴ Australian Evaluation Society, Guidelines for the Ethical Conduct of Evaluations, July 2013 (accessed 12 August 2024) https://www.aes.asn.au/images/AES_Guidelines_web_v2.pdf?type=file

Ethical consideration	Mitigation strategy
<p>Data linkage</p> <p>The evaluation will access national de-identified datasets like MyMedicare, MBS, the NHDH, and others. It will also likely require linkages between some of these datasets. While these datasets have robust de-identification protocols in place, there is still a risk of potentially re-identifiable data being inadvertently provided to Nous and/or being then reported inappropriately.</p>	<p>Nous will work closely with relevant data custodians to develop protective data settings and protocols.</p> <p>The Nous team includes team members with extensive experience working with sensitive data for evaluation.</p> <p>The Nous team also has rigorous review and assurance processes in place to catch potentially inappropriate reporting prior to publication.</p>
<p>Data that is not routinely collected</p> <p>The evaluation will collect and analyse primary data from the surveys and consultation rounds. These datasets will be non-identifiable, but are not routinely collected. There is a low risk that the benefits of the evaluation may not outweigh the burden of collection and risks of data generation, analysis, and reporting.</p>	<p>Nous will develop a Data Management Plan that addresses intentions related to generation, collection, access, use, analysis, disclosure, storage, retention, disposal, sharing and re-use of data and information, the risks associated with these activities and any strategies for minimising those risks.</p> <p>As outlined above, Nous will work closely with consumer representative organisations to ensure the appropriateness of evaluation data approaches.</p>

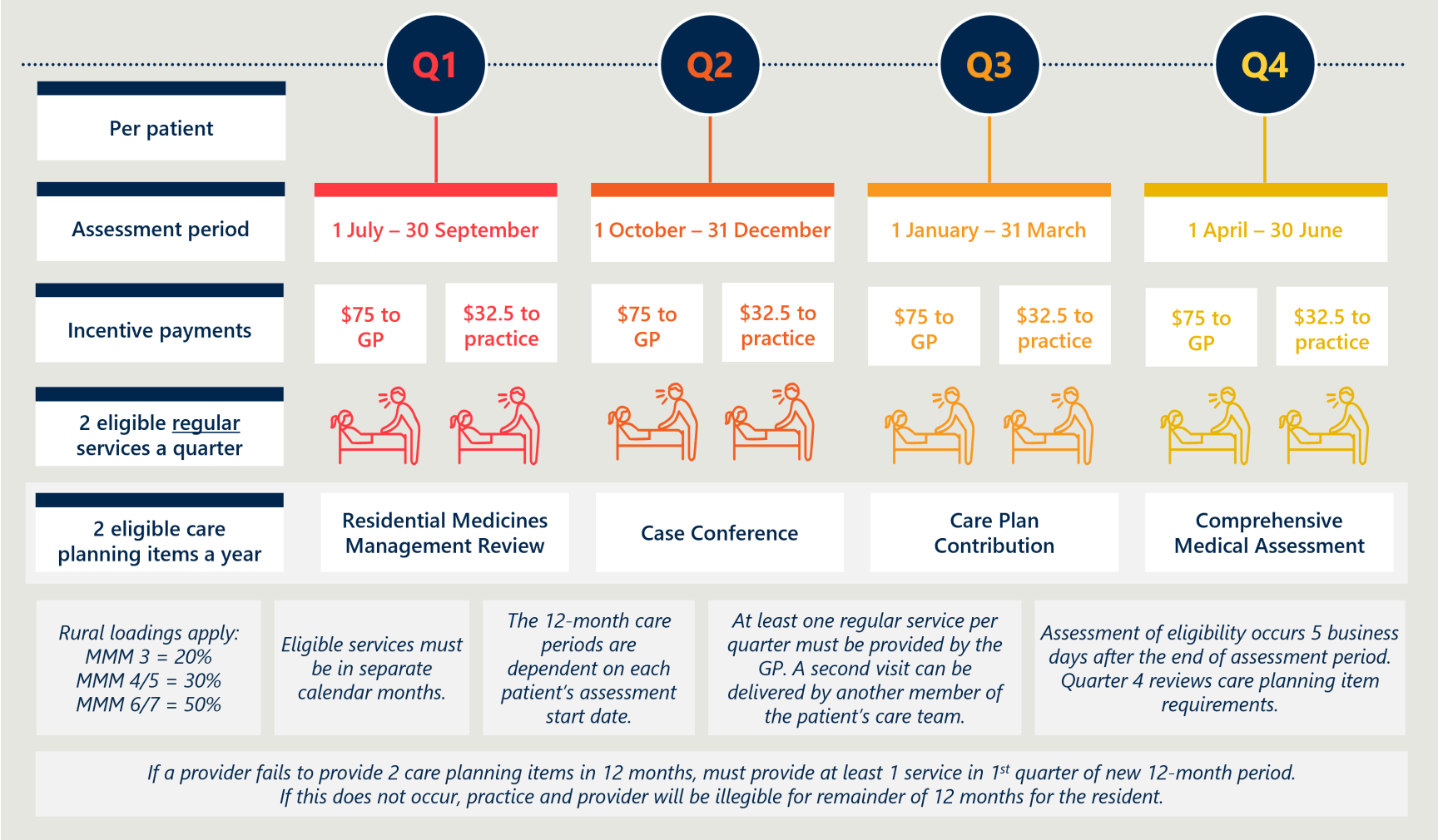
Glossary

Term or acronym	Definition
AAPM	Australian Association of Practice Management
ACCHS	Aboriginal Controlled Community Health Service
ACCHOs	Aboriginal Community Controlled Health Organisations
AIHW	Australian Institute of Health and Welfare
AMS	Aboriginal Medical Service
AN-ACC	Australian National Aged Care Classification
COTA	Council on the Ageing
The Department	The Department of Health and Aged Care
ED	Emergency Department
GPs	General Practitioners
HERD	Health Economics and Research Division
The Incentive	General Practice in Aged Care Incentive
IT	Information Technology
KEQ	Key Evaluation Questions
MBS	Medicare Benefits Scheme
MMM	The Modified Monash Model
NHDH	National Health Data Hub
PBS	Pharmaceutical Benefits Scheme
PHNs	Primary Health Networks
PIP GP ACAI	Practice Incentive Program General Practitioner Aged Care Access Incentive
QALYs	Quality Adjusted Life Years
RACGP	The Royal Australian College of General Practitioners
RACHs	Residential Aged Care Homes
RDAA	Rural Doctors Association of Australia
RN	Registered Nurse

Appendix A About the Incentive

This appendix provides a summary of the assessment periods and eligibility requirements for GPs and GP practices to receive incentive payments.

Figure 6 | Summary of the Incentive assessment periods and service requirements



Appendix B Stakeholders who provided input on the Monitoring and Evaluation Framework

This appendix lists the stakeholders involved in development of this Monitoring and Evaluation Framework.

Table 10 | Stakeholders engaged in the development of the Monitoring and Evaluation Framework

Stakeholder group	Role
Initiatives Design Section, Department of Health and Aged Care	Project team
Health Interface Team	Provide context and background on the PHN related work in the aged care sector
MyMedicare Team	Provide context and background on the MyMedicare implementation and data currently available
Health Economics Research Division	Provide context on the Strengthening Medicare Division overarching Monitoring and Evaluation Framework and advice on feasibility of evaluation plan
Data Insights Section	Provide advice on accessibility and availability of data through the Department
Department of Veteran Affairs (DVA)	Representative stakeholder for veterans
Brisbane North Primary Health Network	Representative stakeholder for PHNs
Aged & Community Care Providers Australia (ACCPA)	Representative stakeholder for RACH providers
Strengthening Medicare General Practice Reference Group (GPRG)	Representative stakeholder for GPs
National Aboriginal and Torres Strait Islander Ageing and Aged Care Council (NATSIAACC)	Representative stakeholder for First Nations people
COTA	Representative stakeholder for residents and carers
Prestantia	Contractor responsible for developing Best Practice Guidelines and Tools
Services Australia	Provide context on the MyMedicare platform, payment capability and Incentive eligibility assessment for providers and practices

Appendix C Detailed information on evaluation indicators

This appendix provides detail on the evaluation indicators. The order of indicators in this appendix will align to the order in the body of the document in the Final version.

Table 11 | Detailed evaluation indicators

#	Indicator	Data dimensions	Rationale	Primary source	Secondary source	Frequency of collection	Limitations
1	Number and proportion of residents registered with MyMedicare.	<ul style="list-style-type: none"> All residents ³⁵ General Practice in Aged Care Incentive indicator³⁶ AN-ACC class Thin-market areas MMM Region. 	To monitor uptake rates. Track RACH resident registrations in MyMedicare to consider of RACH resident registration is barrier to uptake.	MyMedicare.		Quarterly reporting.	<ul style="list-style-type: none"> Disaggregation by resident limited to pre-determined characteristics in the dataset.
2	Number and proportion of GPs and practices registered with MyMedicare.	<ul style="list-style-type: none"> General Practice in Aged Care Incentive indicator Thin-market areas MMM Region GP practice size GP practice business model. 	To monitor uptake rates. Track GP practice registrations in MyMedicare to consider if GP practice registration is barrier to uptake.	MyMedicare.		Quarterly reporting.	<ul style="list-style-type: none"> Disaggregation by GP practice model limited to pre-determined characteristics in the dataset.
3	Number of eligible care planning services received by registered residents in aged care homes.	<ul style="list-style-type: none"> All residents General Practice in Aged Care Incentive indicator AN-ACC class Thin-market areas MMM Region. 	To track the number of care planning MBS service items as stated in the Incentive guidelines provided to residents, assessing the impact of the Incentive on care planning services.	MyMedicare/MBS.		Quarterly reporting.	<ul style="list-style-type: none"> Linked data set not currently available. Without linked data, the evaluation will be unable to identify which residents were enrolled in the Incentive.

³⁵ The dimension all residents indicates the analysis of the data for the relevant indicator for all residents without any filters applied.

³⁶ The General Practice in Aged Care Incentive indicator is an indicator within the MyMedicare system that indicates a practice has registered with the Incentive and is selected on a resident's MyMedicare profile by their practice.

#	Indicator	Data dimensions	Rationale	Primary source	Secondary source	Frequency of collection	Limitations
4	Number of eligible regular services received by registered residents in aged care homes.	<ul style="list-style-type: none"> All residents General Practice in Aged Care Incentive indicator AN-ACC classification Thin-market areas MMM Region. 	To track the number of regular MBS service items as stated in the Incentive guidelines provided to residents, assessing the impact of the Incentive on frequency and regularity of GP services.	MyMedicare/MBS.		Quarterly reporting.	<ul style="list-style-type: none"> Linked data set not currently available. Without linked data, the evaluation will be unable to identify which residents were enrolled in the Incentive.
5	Incentive payments received by GPs and practices.	<ul style="list-style-type: none"> General Practice in Aged Care Incentive indicator Thin-market areas MMM Unique GP/practices \$ per patient Number per patient. 	To evaluate the volume and value of incentive payments received by GPs and GP practices. Will aid understanding of relationship between services provided to eligible residents with incentive payments made.	MyMedicare.		Quarterly reporting.	<ul style="list-style-type: none"> Disaggregation by GP practice model limited to pre-determined characteristics in the dataset.
6	Quality of engagement between GPs and PHNs.	<ul style="list-style-type: none"> General Practice in Aged Care Incentive indicator Thin-market areas MMM Region GP practice size GP practice business model. 	Evaluate the activities conducted by PHNs on GPs and GP practices.	GP practice survey.		<ul style="list-style-type: none"> 2025 2026. 	<ul style="list-style-type: none"> Limited by the response rates and representative nature of responses as to the level of depth and rigour of the evaluation insights.
7	Number of GP service events per resident.	<ul style="list-style-type: none"> All residents General Practice in Aged Care Incentive indicator AN-ACC classification Thin-market areas MMM Total number of service events Total number of residents Number and proportion of residents receiving regular services (>8 services per year separate by calendar months). 	To monitor the overall level of service delivery to RACH residents, assessed by multiple dimensions. Assess the pre-Incentive and post-Incentive number and proportion of residents receiving regular services and the total number of residents receiving GP care in RACHs.	MyMedicare/MBS.		Quarterly reporting.	<ul style="list-style-type: none"> Disaggregation by resident and GP limited to pre-determined characteristics in the dataset.

#	Indicator	Data dimensions	Rationale	Primary source	Secondary source	Frequency of collection	Limitations
8	GP participation rates in aged care.	<ul style="list-style-type: none"> All residents General Practice in Aged Care Incentive indicator AN-ACC classification Thin-market areas MMM Unique GP/practices Region GP age. 	To track the number of GPs providing MBS services in RACHs to understand the level of GP engagement in RACHs. This indicator will explore GP trends, including whether the Incentive has impacted the overall number of GPs providing care in RACHs.	MyMedicare/MBS.		Quarterly reporting.	<ul style="list-style-type: none"> Linked data set not currently available. Without linked data, the evaluation will be unable to identify which residents were enrolled in the Incentive.
9	Collaboration between RACHs and GPs and GP practices.	<ul style="list-style-type: none"> Collaboration between RACHs and GPs and GP practices. 	Understand the extent to which the Incentive influenced the level of collaboration between RACHs and GPs and GP practices and the impact on care coordination.	<ul style="list-style-type: none"> GP practice survey RACH survey. 		<ul style="list-style-type: none"> 2025 2026. 	<ul style="list-style-type: none"> Limited by the response rates and representative nature of responses as to the level of depth and rigour of the evaluation insights.
10	Registered resident satisfaction with primary care received in RACH.	<ul style="list-style-type: none"> Thin-market areas MMM Region. 	Reflect resident perceptions on the accessibility and quality of primary care post-Incentive, signifying impact on patient-centred care.	Resident survey.		<ul style="list-style-type: none"> 2025 2026. 	<ul style="list-style-type: none"> Limited by the response rates and representative nature of responses as to the level of depth and rigour of the evaluation insights.
11	Number of regular services provided by GP practice team members to registered residents in aged care homes.	<ul style="list-style-type: none"> All residents General Practice in Aged Care Incentive indicator Thin-market areas MMM Region. 	To track the involvement of the broader GP practice team to support resident primary care, assessing the impact of the Incentive on GP practice team involvement.	MyMedicare/MBS.		Quarterly reporting.	<ul style="list-style-type: none"> Linked data set not currently available. Without linked data, the evaluation will be unable to identify which residents were enrolled in the Incentive.

#	Indicator	Data dimensions	Rationale	Primary source	Secondary source	Frequency of collection	Limitations
12	GP practice revenue and costs by practice size and business model.	<ul style="list-style-type: none"> Thin-market areas MMM Region GP practice size GP practice business model. 	Analyse the financial impacts of GP participation by different practice types, informing the economic viability under the Incentive. Cost data will be obtained qualitatively, and revenue data associated with the Incentive can be obtained through incentive payment data.	<ul style="list-style-type: none"> MBS GP practice manager survey GP practice consultations. 		<ul style="list-style-type: none"> 2025 2026. 	<ul style="list-style-type: none"> Limited by the response rates and representative nature of responses as to the level of depth and rigour of the evaluation insights.
13	Number of Emergency Department (ED) presentations that do not require a hospital admission.	<ul style="list-style-type: none"> Thin-market areas MMM Region Resident type (permanent, transitional, short term, DVA) All residents General Practice in Aged Care Incentive indicator 	Assess the impact of the Incentive on ED presentations that do not require a hospital admission. It is hypothesised that regular, proactive primary care and strengthened relationships between primary care providers and RACHs would reduce the number of ED presentations that do not require a hospital admission.	AIHW - NHDH	<ul style="list-style-type: none"> National Aged Care Mandatory Quality Indicator Program Deep dive case studies 	<ul style="list-style-type: none"> 2025 2026 	<ul style="list-style-type: none"> Linked data set not currently available. Without linked data, the evaluation will be unable to identify which residents were enrolled in the Incentive. The NHDH is time-lagged by more than a year and does not provide full national coverage. This may be a challenge to the usefulness of this data.
14	Number of unplanned hospital admissions for RACH residents.	<ul style="list-style-type: none"> Thin-market areas MMM Region Resident type (permanent, transitional, short term, DVA) All residents General Practice in Aged Care Incentive indicator 	To assess the impact of the Incentive on unplanned hospital admission. It is hypothesised that regular, proactive primary care would reduce the number of unplanned hospital admissions for RACH residents.	AIHW - NHDH	<ul style="list-style-type: none"> National Aged Care Mandatory Quality Indicator Program Deep dive case studies 	<ul style="list-style-type: none"> 2025 2026 	<ul style="list-style-type: none"> Linked data set not currently available. Without linked data, the evaluation will be unable to identify which residents were enrolled in the Incentive. The NHDH is time-lagged by more than a year and does not provide full national coverage. This may be a challenge to the usefulness of this data.
15	Number of residents matched to regular GPs in MyMedicare	<ul style="list-style-type: none"> All residents General Practice in Aged Care Incentive indicator Thin-market areas MMM Region 	To determine the success of the matching process in connecting RACH residents with regular GPs.	MyMedicare		Quarterly reporting	<ul style="list-style-type: none"> Non-standard definition of regular services Linked data set not currently available. Without linked data, the evaluation will be unable to identify which residents were enrolled in the Incentive.

#	Indicator	Data dimensions	Rationale	Primary source	Secondary source	Frequency of collection	Limitations
16	Ability for RACH to have timely access to GPs.	<ul style="list-style-type: none"> Thin-market areas MMM Region RACH with RN RACH without RN RACH type 	<p>Assess the extent to which the Incentive impacted the timely access of GPs for RACHs.</p> <p>Timely access refers to the ability of a RACH to arrange for a GP to see a resident when required, without undue delay, and will be measured qualitatively through RACH surveys and/or consultations. This is consistent with definitions in the Royal Commission into Aged Care Quality and Safety 2018, which note that timeliness is condition and circumstance dependent.</p>	RACH survey		<ul style="list-style-type: none"> 2025 2026 	<ul style="list-style-type: none"> Limited by the response rates and representative nature of responses as to the level of depth and rigour of the evaluation insights.
17	GP practice viability.	<ul style="list-style-type: none"> Thin-market areas MMM Region GP practice size GP practice business model 	<p>Examine business sustainability of GP practices involved in aged care within the context of the Incentive. Viability considers the financial feasibility of the practice and workforce sustainability.</p>	<ul style="list-style-type: none"> GP practice manager survey GP practice consultations 		<ul style="list-style-type: none"> 2025 2026 	<ul style="list-style-type: none"> Limited by the response rates and representative nature of responses as to the level of depth and rigour of the evaluation insights.
18	GP and GP practice satisfaction in delivering primary care in RACHs.	<ul style="list-style-type: none"> Thin-market areas MMM Region GP practice size GP practice business model GP age 	<p>Understand GP satisfaction with the Incentive to inform continuous improvement.</p>	GP practice survey		<ul style="list-style-type: none"> 2025 2026 	<ul style="list-style-type: none"> Limited by the response rates and representative nature of responses as to the level of depth and rigour of the evaluation insights.
19	RACH workforce satisfaction towards primary care.	<ul style="list-style-type: none"> Thin-market areas MMM Region RACH with RN RACH without RN RACH type 	<p>Assess the impact of regular, proactive primary care and strengthened relationships and collaboration on RACH workforce satisfaction.</p>	RACH survey		<ul style="list-style-type: none"> 2025 2026 	<ul style="list-style-type: none"> Limited by the response rates and representative nature of responses as to the level of depth and rigour of the evaluation insights.

#	Indicator	Data dimensions	Rationale	Primary source	Secondary source	Frequency of collection	Limitations
20	Average number of medicines taken by RACH residents.	<ul style="list-style-type: none"> All residents General Practice in Aged Care Incentive indicator Thin-market areas MMM Region Psychotropic medicines 	Assess the impact of the Incentive on polypharmacy and the use of psychotropic medicines in RACH residents.	AIHW - NHDH	<ul style="list-style-type: none"> MyMedicare/PBS National Aged Care Mandatory Quality Indicator Program 	<ul style="list-style-type: none"> 2025 2026 	<ul style="list-style-type: none"> Linked data set not currently available. Without linked data, the evaluation will be unable to identify which residents were enrolled in the Incentive. The NHDH is time-lagged by more than a year and does not provide full national coverage. This may be a challenge to the usefulness of this data. Does not factor in non-PBS and non-prescription medicines. Prescribed medicines does not translate to taken or administered medicines
21	Resident quality of life because of regular, proactive care.	<ul style="list-style-type: none"> Thin-market areas MMM Region 	Although challenging to quantify within this evaluation, aim to glean perceptions of residents' quality of life as influenced by regular, proactive care facilitated by the Incentive.	Resident survey		<ul style="list-style-type: none"> 2025 2026 	<ul style="list-style-type: none"> Limited by the response rates and representative nature of responses as to the level of depth and rigour of the evaluation insights.
22	PBS medicines costs for RACH residents.	<ul style="list-style-type: none"> All residents General Practice in Aged Care Incentive indicator Thin-market areas MMM Region 	Assess the financial implications on medication costs potentially influenced by regular, proactive GP care under the Incentive.	AIHW - NHDH	MyMedicare/PBS	<ul style="list-style-type: none"> 2025 2026 	<ul style="list-style-type: none"> Linked data set not currently available. Without linked data, the evaluation will be unable to identify which residents were enrolled in the Incentive. The NHDH is time-lagged by more than a year and does not provide full national coverage. This may be a challenge to the usefulness of this data. Unable to account for changes to cost of medicines due to factors such as constraint supply, stock shortages and new product launches.
23	Number of after-hours services provided to RACH residents.	<ul style="list-style-type: none"> All residents General Practice in Aged Care Incentive indicator Urgent Non-urgent Thin-market areas MMM Regular provider Any provider 	Assess the accessibility and responsiveness of primary care to RACH resident's after-hours.	MyMedicare/MBS		Quarterly reporting	<ul style="list-style-type: none"> Linked data set not currently available. Without linked data, the evaluation will be unable to identify which residents were enrolled in the Incentive.

#	Indicator	Data dimensions	Rationale	Primary source	Secondary source	Frequency of collection	Limitations
24	Total cost of the program versus the Incentive payments and increases changes in MBS items		Understand the efficiency of the program in delivering incentive payments and eligible service items.	MyMedicare/MBS		2026	<ul style="list-style-type: none"> Linked data set not currently available. Without linked data, the evaluation will be unable to identify which residents were enrolled in the Incentive.
25	Cost of the program versus the reduction in hospital admissions and presentations to emergency departments.		Assess the cost-effectiveness of the Incentive in achieving target outcomes. The aim is to determine the cost per unit of target outcomes, establishing the value delivered for each dollar invested in the Incentive.	AIHW - NHDH	National Aged Care Mandatory Quality Indicator Program	2026	<ul style="list-style-type: none"> Linked data set not currently available. Without linked data, the evaluation will be unable to identify which residents were enrolled in the Incentive. The NHDH is time-lagged by more than a year and does not provide full national coverage. This may be a challenge to the usefulness of this data.

Appendix D Data collection tools

This appendix provides the discussion questions that will guide consultations with stakeholder during the evaluation.

Survey instruments will be provided in a separate attachment.

Consultations are planned for:

- Phase 2 (2024) to supplement survey and quantitative analysis to establish a baseline.
- Phase 3 (2025) in two rounds, mid-2025 and early 2026.
- Phase 4 (2026) in a single round to support the final evaluation report.

Nous will conduct consultations with the following stakeholders:

1. General Practitioners (GPs) and managers of GP Practices
2. Aboriginal Community Controlled Health Services (ACCHS) and Aboriginal Medical Services (AMSs)
3. Residential Aged Care Homes (RACHs)
4. Primary Health Networks (PHNs)
5. Families and Carers of Aged Care Residents.

Please note:

- Nous will develop more detailed consultation guides that provide background and context to the Incentive and the evaluation, tailored to each stakeholder group, prior to each round of consultation.
- For consultations later in the evaluation, for example, after we have some emerging insights from surveys or quantitative data, Nous may also share early findings to seek advice from stakeholders on how to interpret and contextualise data and other findings (where appropriate and agreed by the Department).
- Nous will adjust discussion questions as needed between phases where minor improvements are needed. However, the discussion questions will largely remain the same to allow for comparability over time.
- The Families and Carers of Residents consultation guides will be tested with Council of the Ageing (COTA).
- Changes to the consultation guides may be made to align with recommendations from the ethics submission.

The remainder of this appendix provides the proposed discussion questions for each stakeholder group.

General Practitioners (GPs) and Managers of GP Practices – Consultation Questions

Purpose: to understand implementation progress and lessons learned, the effectiveness of the Incentive design in changing care provision and impact on working relationships with primary care providers.

Question	Relevant KEQ
<ul style="list-style-type: none"> Please tell us a bit about yourself, your practice, and any experience you have working with residents living in RACHs. Have you taken up the Incentive to date? What has been the extent of your use of the Incentive? 	1.3
<ul style="list-style-type: none"> From your perspective, what is important to understand about the context in which the Incentive is being implemented? <i>You may like to think about the impact of intersecting reforms such as the triple bulk billing incentive, or requirement for 24/7 RN care in RACHs, as examples.</i> 	1.1
<ul style="list-style-type: none"> What factors have impacted your decision about whether to uptake this Incentive (or not)? <i>You may like to think about factors such as the design of the Incentive itself, the communication and engagement activities used to inform practices about the incentive, your views on how it compares to the previous PIP ACAI, as well as other factors around the delivery of primary care into RACHs.</i> 	1.4, 3.4
<ul style="list-style-type: none"> If you have taken up the Incentive, how satisfied are you with the Incentive? <i>You may like to think about the servicing requirements, the use of MyMedicare and the payment amount, guidance and support from your PHN, and the extent to which it has improved access to timely, regular and proactive primary care for residents.</i> 	2.4, 2.5
<ul style="list-style-type: none"> If you have taken up the Incentive, has it changed how and when you deliver primary care into RACHs? Why, why not, and in what way? <i>You may like to think about whether it has impacted the following for you: Improved experience coordinating GP visits for residents through support of PHNs, increased care collaboration between RACHs, ACCHSs/AMs and GPs and practices, increased the ability of the sector to provide primary care into RACHs in regions where there are less GPs, increased provision of care using multi-disciplinary care teams.</i> 	2.3, 2.6
<ul style="list-style-type: none"> If you have taken up the Incentive, has it contributed to the financial sustainability of your practice? 	4.1, 4.2
<ul style="list-style-type: none"> What unintended impacts have you observed? For example, on the RACH workforce, or on rates of hospital transfers and admissions. 	2.6
<ul style="list-style-type: none"> What improvements, if any, would you recommend to the Incentive to enhance its effectiveness and ensure residents are more likely to be able to access receive consistent and appropriate primary care? <i>You may like to think about improvements to the servicing requirements, the Guidelines, the payment amount, related to use of the MyMedicare platform or others.</i> 	4.3

Aboriginal Community Controlled Health Services (ACCHS) and Aboriginal Medical Services (AMSs) – Consultation Questions

Purpose: to understand the challenges and opportunities for providing primary care for First Nations peoples who live in RACHs.

Question	Relevant KEQ
<ul style="list-style-type: none"> Please tell us a bit about your organisation, and any experience you have working with residents living in RACHs. Have you or your organisation taken up the Incentive to date? What has been the extent of your use of the Incentive? 	1.3
<ul style="list-style-type: none"> From your perspective, what is important to understand about the context in which the Incentive is being implemented? <i>You may like to think about the impact of intersecting reforms such as the triple bulk billing incentive, or requirement for 24/7 RN care in RACHs, as examples.</i> 	1.1
<ul style="list-style-type: none"> What factors have impacted your decision about whether to uptake this Incentive (or not)? <i>You may like to think about factors such as the design of the incentive itself, alignment with models of care appropriate for First Nations residents of aged care, the communication and engagement activities used to inform practices about the Incentive, your views on how it compares to the previous PIP ACAI, as well as other factors around the delivery of primary care into RACHs.</i> 	1.4, 3.4
<ul style="list-style-type: none"> If you have taken up the Incentive, how satisfied are you with the Incentive? <i>You may like to think about the servicing requirements, the use of MyMedicare and the payment amount, guidance and support from your PHN, as examples and the extent to which it has improved access to timely, regular and proactive primary care for residents</i> 	2.4, 2.5
<ul style="list-style-type: none"> If you have taken up the Incentive, has it changed how and when you deliver primary care into RACHs? Why, why not, and in what way? <i>Improved experience coordinating GP visits for residents through support of PHNs, increased care collaboration between RACHs, ACCHSs/AMSs and GPs and practices, increased the ability of the sector to provide primary care into RACHs in regions where there are less GPs, increased provision of care using multi-disciplinary care teams.</i> 	2.3, 2.6
<ul style="list-style-type: none"> If you have taken up the Incentive, has it contributed to the financial sustainability of your organisation? 	4.1, 4.2
<ul style="list-style-type: none"> What unintended impacts have you observed? For example, on the RACH workforce, or on rates of hospital transfers and admissions. 	2.6
<p>What improvements, if any, would you recommend to the Incentive? <i>You may like to think about improvements to the servicing requirements, the Guidelines, the payment amount, related to use of the MyMedicare platform or others or adaptations required to the design of the Incentive to support greater access to primary care for First Nations residents of RACHs</i></p>	4.3

Residential Aged Care Homes (RACHs) – Consultation Questions

Purpose: to understand to understand implementation progress and lessons learned and the impact of the Incentive on primary care in RACHs.

Question	Relevant KEQ
<ul style="list-style-type: none"> Please tell us about your organisation and any experience you have with GPs delivering primary care services to residents living in your RACH. 	
<ul style="list-style-type: none"> From your perspective, what is important to understand about the context in which the Incentive is being implemented? <i>You may like to think about the impact of intersecting reforms such as the triple bulk billing incentive, or requirement for 24/7 RN care in RACHs, as examples.</i> 	1.1
<ul style="list-style-type: none"> Has the Incentive changed when and how GPs and practices in your area deliver services to your RACH? Why, why not, and in what way? <i>You may like to think about whether it has impacted the following for you: Improved experience coordinating GP visits for residents through support of PHNs, increased care collaboration between RACHs, ACCHSs/AMs and GPs and practices, increased the ability of the sector to provide primary care into RACHs in regions where there are less GPs, increased provision of care using multi-disciplinary care teams..</i> 	2.3
<ul style="list-style-type: none"> From your perspective, what factors impact the decision of GPs and practices in your area about whether to uptake this incentive (or not)? <i>You may like to think about factors such as the design of the incentive itself, the communication and engagement activities used to inform practices about the incentive, your views on how it compares to the previous PIP ACAI, as well as other factors around the delivery of primary care into RACHs.</i> 	1.4, 2.4, 3.4
<ul style="list-style-type: none"> How satisfied are you with changes in the level of primary care available to your residents due to the Incentive? How satisfied are you with the quality of care provided? <i>You may like to consider changes in the level of access people have to primary care, the timeliness of care and the extent to which it is proactive care provided by a regular provider (as opposed to reactive care).</i> 	2.5
<ul style="list-style-type: none"> What unintended impacts have you observed? For example, on the RACH workforce, or on rates of hospital transfers and admissions, or overservicing. 	2.6
<ul style="list-style-type: none"> What improvements, if any, would you recommend to the Incentive to enhance its effectiveness and ensure residents are more likely to be able to access receive consistent and appropriate primary care? <i>You may like to think about improvements to the servicing requirements, the Guidelines, the payment amount, related to use of the MyMedicare platform or others.</i> 	4.3

Primary Health Networks (PHNs) – Consultation Questions

Purpose: to understand the impact of the Incentive in thin-market areas, challenges and opportunities for linking residents with GPs and the impact of the Incentive on the provision of primary care activities in RACHs.

Question	Relevant KEQ
<ul style="list-style-type: none"> Please tell us a bit about your PHN and their level of involvement with the Incentive. Are there any demographic or health service/system factors of your local area or region that could influence the uptake or impact of the Incentive are important to understand? 	1.3
<ul style="list-style-type: none"> From your perspective, what is important to understand about the context in which the Incentive is being implemented? <i>You may like to think about the impact of intersecting reforms such as the triple bulk billing incentive, or requirement for 24/7 RN care in RACHs.</i> 	1.1
<ul style="list-style-type: none"> What activities and/or initiatives have you delivered since the commencement on the Incentive? What factors helped or hindered your support in implementing the Incentive? <i>This may include tailored solutions and strategies delivered by PHNs to address challenges faced in underserved areas, and regions where there are less GPs.</i> 	1.2, 1.4
<ul style="list-style-type: none"> In your experience, how effective were the additional PHN grants at supporting the success of the Incentive? 	2.4
<ul style="list-style-type: none"> Has the Incentive changed when and how GPs and practices in your area deliver services to RACHs? Why, why not, and in what way? <i>You may like to think about whether it has impacted the following for GPs and practices in your area: Improved experience coordinating GP visits for residents through support of PHNs, increased care collaboration between RACHs, ACCHSs/AMs and GPs and practices, increased the ability of the sector to provide primary care into RACHs in regions where there are less GPs, increased provision of care using multi-disciplinary care teams.</i> 	2.3
<ul style="list-style-type: none"> From your perspective, what factors impact the decision of GPs and practices in your area about whether to uptake this incentive (or not)? <i>You may like to think about factors such as the design of the incentive itself, the communication and engagement activities used to inform practices about the incentive, your views on how it compares to the previous PIP ACAI, as well as other factors around the delivery of primary care into RACHs.</i> 	1.4, 2.4, 3.4
<ul style="list-style-type: none"> What unintended impacts have you observed? 	2.6
<ul style="list-style-type: none"> What improvements, if any, would you recommend to the Incentive to enhance its effectiveness and ensure residents are more likely to be able to access receive consistent and appropriate primary care? <i>You may like to think about improvements to the servicing requirements, the Guidelines, the payment amount, related to use of the MyMedicare platform or others.</i> 	4.3

Families and Carers of Aged Care Residents – Consult Questions

Purpose: to understand perceived change in access to primary care for aged care residents over time.

Question	Relevant KEQ
Living situation	
<ul style="list-style-type: none"> How long has your family member (or the person you care for) been living in residential aged care? Have they always been in this facility, or have they lived in other aged care homes before this? 	
GP before moving into aged care	2.3
<ul style="list-style-type: none"> Did they have a regular GP before moving into aged care? If yes, does that GP still look after them now? 	
Getting a new GP in aged care	2.3
<ul style="list-style-type: none"> If they didn't have a regular GP, or their previous GP no longer sees them, did the aged care home help find a new GP for them? Do they currently have a regular GP who visits them at the aged care home? 	
How often they see the GP	2.3
<ul style="list-style-type: none"> How often does your family member (or the person you care for) see their GP? 	
Access to the GP	2.3
<ul style="list-style-type: none"> In your experience, do they: <ul style="list-style-type: none"> Get to see a GP when they need to? See their regular GP most of the time? Get to see a GP when they are unwell or have an urgent issue? Have regular GP check-ups even when they aren't sick, for things like ongoing care, pain management, or mental health? Have access to other health professionals who help with their care, like geriatricians, physiotherapists, or nurses? 	
Satisfaction with care	2.5
<ul style="list-style-type: none"> Overall, how satisfied are you with the care your family member (or the person you care for) gets from their GP? 	
Changes over time	2.3
<ul style="list-style-type: none"> Do you think their access to a GP has changed over time? 	

Definitions that may be helpful for you:

Nurse Practitioner: A Nurse Practitioner is a registered nurse with advanced qualifications and skills, authorised to provide a range of healthcare services. These can include diagnosing and treating health conditions, prescribing medications, and ordering diagnostic tests. Nurse Practitioners work independently and collaboratively with other healthcare professionals, often in areas where access to GPs may be limited.

Primary care services: Primary care services refer to the first point of contact in the healthcare system, where people receive care for most of their everyday health needs. This includes services provided by GPs, Nurse Practitioners, and allied health professionals like physiotherapists and dietitians. Primary care focuses on preventing illness, managing chronic conditions, and addressing acute health concerns.

Care planning: Care planning involves creating a structured plan to address a person's healthcare needs. It usually includes regular check-ups, management of chronic conditions, pain management, mental health

support, and coordination with other healthcare providers. The aim is to ensure comprehensive and continuous care tailored to the individual's health requirements.

Access to timely care: Access to timely primary care services means being able to see a healthcare provider, such as a GP or Nurse Practitioner, within a reasonable timeframe when health issues arise. It includes both urgent care when someone is unwell and regular check-ups to manage ongoing health conditions, ensuring that health needs are met promptly and effectively.

Appendix E Detailed stakeholder engagement plan

This appendix provides a breakdown of the consultations per phase per stakeholder. Phase 2 requires 10 hours of stakeholder consultation; Phase 3 requires 80 hours of consultation with an additional 10 hours as needed and Phase 4 requires 80 hours of consultation with an additional 10 hours as needed.

Table 12 | Breakdown of stakeholder consultations per phase

Phase	PHNs	RACHs	GPs and GP Practices	ACCHS and AMSS	Families, Carers	Deep Dive Consultations	Subtotal	Additional capacity
Phase 2: Initial reporting	1 x 60-minute consultation	1 x 60-minute consultation	1 x 60-minute consultation	1 x 30-minute consultation if needed	1 x 60-minute consultation		4.5 hours of stakeholder engagement	Up to an additional 5.5 hours of targeted stakeholder consultation post survey review
Phase 3: Program monitoring	2 rounds of 6 – 8 x 30 – 60-minute focus group/individual interview sessions per round Total 13 hours of stakeholder engagement	2 rounds of 7 – 15 x 30 – 60-minute focus group/individual interview sessions per round Total 15 hours of stakeholder engagement	2 rounds of 9 – 30 x 15 – 90-minute focus group/individual interview sessions per round Total 27 hours of stakeholder engagement	2 rounds of 5 x 60-minute focus group sessions per round 10 hours of stakeholder engagement	2 rounds of 7 – 15 x 30 – 60-minute focus group/individual interview sessions per round Total 15 hours of stakeholder engagement		80 hours of stakeholder engagement	Up to an additional 10 hours of targeted stakeholder consultation post consultation review
Phase 4: Final reporting	4 – 6 x 30 – 60-minute focus group individual interview sessions Total 6 hours of stakeholder engagement	5 – 10 x 30 – 60-minute focus group/individual interview sessions Total 5 hours of stakeholder engagement	8 – 50 x 15 – 90-minute focus group/individual interview sessions Total 13 hours of stakeholder engagement	3 x 60-minute focus group sessions per round 3 hours of stakeholder engagement	5 – 10 x 30 – 60-minute focus group/individual interview sessions Total 5 hours of stakeholder engagement	Up to 10 site visits, up to 5 hours each Total up to 50 hours of deep dive consultations	82 hours of stakeholder engagement	Up to an additional 8 hours of targeted stakeholder consultation post survey review

Appendix F Data map and plan

To be provided as an attachment.

Appendix G Risk management plan

This appendix outlines the risk management plan for the evaluation, also included in the Detailed Project Plan (a separate evaluation deliverable). It sets out the risk assessment approach, and details key risks and mitigation strategies identified to date.

Overall risk assessment

Nous has adopted the best practices outlined in AS/NZS ISO 31000 – Risk Management Principles and Guidelines to ensure a systematic approach is used to identify and assess risks, and determine treatment plans to manage, transfer and/or avoid risks. This includes the elements of communication and consultation, establishing context, risk identification, risk analysis, risk evaluation, risk treatment and ongoing monitoring and review.

Nous assess risk using a risk matrix, displayed in Figure 7.

Figure 7 | Risk assessment matrix

CONSEQUENCE → LIKELIHOOD ↓	Low	Medium	High	Very High
Almost certain			EXTREME	
Likely				
Possible	MODERATE			
Rare	LOW			

Risk assessment and management

Table 13 outlines the initial risk management plan for the evaluation at a high level. The evaluation team will maintain and update a risk register.

Table 13 | Risk management plan

Risk	Mitigation strategy	Likelihood ³⁷	Consequence
Failure to understand the drivers of the Incentive uptake and effectiveness	The Monitoring and Evaluation Framework will set out a detailed and agreed methodology for understanding the drivers of the Incentive uptake and its effectiveness. Nous brings lessons from previous similar evaluations and technical expertise to design robust methods. Stakeholders will be involved in the design to further stress test methods and ensure feasibility.	LOW	HIGH
Differing views on the contribution/attribution of the Incentive to observed outcomes	Nous will use statistical and other methods to differentiate between outcomes from the Program and those from other initiatives, natural fluctuations, or external factors as much as possible. Nous will contextualise and weight all quantitative analysis with the qualitative and consultation based primary data collected through interviews and other stakeholder engagement.	LOW	MODERATE
Evaluation does not meet the Government's requirements	Nous will develop a comprehensive project plan, Monitoring and Evaluation Framework and consultation plan at the start of the project and use these tools to keep the Department informed on achievements, progress, key activities, issues, risks and suggested solutions through regular project meetings. This will ensure the processes and final products meet expectations (without compromising the independence of the evaluation).	LOW	HIGH

³⁷ After mitigation strategy is applied.

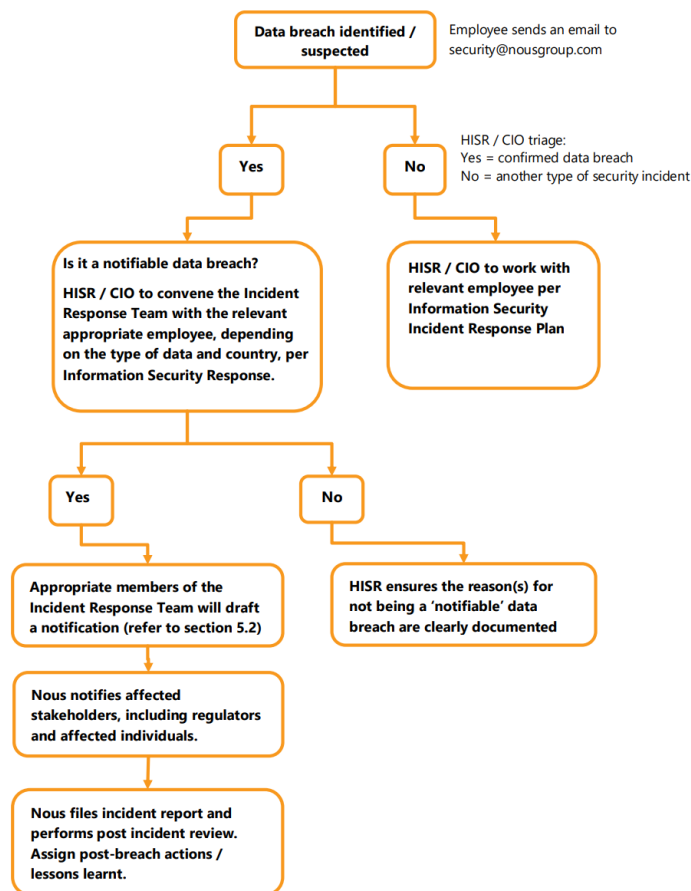
Risk	Mitigation strategy	Likelihood ³⁷	Consequence
Poor quality and/or limited data availability	Nous will identify and request the data and information required early to allow sufficient time for data to be supplied and where necessary, identify meaningful proxies or conducting targeted stakeholder engagements to impute qualitative data. Nous will escalate delays and discuss alternatives actions where required.	MODERATE	MODERATE
Lack of stakeholder engagement and/or representation from key groups	Nous will develop a comprehensive stakeholder engagement plan. Nous will establish relationships with key stakeholders early in the project, work through barriers and use stakeholder time effectively. Our engagement and data collection methods will be targeted, tested with users, and low burden. Nous will inform the Department of difficulties and will work collaboratively to devise alternative approaches.	LOW	HIGH
Mismanagement of confidential or sensitive data	Some data collected during the evaluation may be sensitive. Nous has strict privacy protocols and educates staff on how to manage sensitive information. The evaluation will have a range of technical and process controls in place to protect the information that the evaluation will hold, with a dedicated Information Security and Privacy Officer and a Head of Risk to support our operations. In the event of a data breach, Nous will follow the data breach response process presented in Figure 8.	LOW	HIGH

Risk	Mitigation strategy	Likelihood ³⁷	Consequence
Project delays due to ethics approval	The evaluation will have significant experience developing successful ethics applications and our experience informs our proposed approach. Nous will use Bellberry HREC to obtain ethics approvals and submit the request as early as possible to minimise risk of delays.	LOW	MODERATE
Lack of continuity in project staff over course of project	Nous will keep robust records and document handovers to ensure continuity in the team in the event of any staff changes and will communicate personnel changes to the Department in a timely manner. Nous acknowledges there may be change in personnel on the Department side and Nous will provide briefings to new team members and ensure meticulous record keeping ensuring handovers during and at the end of the project are robust and complete.	LOW	LOW
Failure to deliver on time	Nous will use project management tools to agree on a clear scope and prioritise activities. Nous will conduct regular risk assessments during the project and will escalate early and respond quickly if concerns are raised.	LOW	MODERATE
Reputational risk to the Department and Nous	Nous will keep the Department and key stakeholders fully informed of project process and findings. Nous will engage early and manage consultations sensitively, in a way that enables the Department's ongoing, constructive relationships. The evaluation will escalate early and respond quickly if concerns are raised. This will ensure that there are no surprises and that key views are heard.	LOW	HIGH

Risk	Mitigation strategy	Likelihood ³⁷	Consequence
Conflict of interest arising during the project	Nous provides Conflict of Interest training to Nous employees for their awareness of various types of Conflicts of Interest and to speak up as soon as one is identified so that it can be appropriately managed. Nous will manage conflicts of interest by logging it on the risk register and creating a conflict-of-interest management plan and disclosing the conflict to the Department. Nous will work collaboratively to develop recommendations on how to proceed.	LOW	HIGH

The data breach response process shown here in Figure 8 is part of a broader Nous Data Breach Response Plan.

Figure 8 | Data breach response process



Approach to ongoing risk monitoring

Nous will continue to assess and update risks and significant decisions during the evaluation using a risk register and decision register, described below. Nous will regularly share the risk register and decision register with the Department (e.g. at monthly or other progress meetings).

Risk register

This risk management plan is accompanied by a separate risk register, which will be a central, living document during the evaluation. Nous will promptly identify and raise all risks with the Department. Joshua Sidgwick, the project manager, will regularly consider the risk profile of the project and monitor known, existing risks, as well as considering emerging risks. Risks in the risk register will be accompanied by a mitigation strategy.

Any increase in the risk profile will be raised by the Nous project director and communicated to the Department within one business day, along with proposed mitigation strategies. The risks, actions and residual risk will be documented in the risk register.

Nous will share, discuss and update the risk register with the Department in progress meetings.

Decision register

The evaluation encompasses substantial work over three years, and it is anticipated that Nous and the Department will together make a range of decisions about the evaluation's scope, approach and management over that period.

To facilitate transparent evaluation management and to help both Nous and the Department track the project's evolution, Nous has set up a running decision register in which Nous and the Department will record all major decisions taken each year. The decision register will record the date, decision makers, the decision and rationale.

Nous will share, discuss and update the decision register with the Department in progress meetings.



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