AGED CARE GENERAL PRACTITIONER PANELS INITIATIVE HANDBOOK

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This book includes the guidelines for the Aged Care General Practitioner Panels Initiative, contact details for further information about the initiative and information and ideas about relevant work that has already been undertaken in residential aged care.

The guidelines included in this handbook explain the operation of the Aged Care General Practitioner Panels Initiative under the Enhanced Medicare Package (the Initiative) and may be cited as the *Aged Care GP Panels Initiative Guidelines*. The Guidelines have effect from 1 July 2004.

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PART 1

GUIDELINES FOR THE AGED CARE GP PANELS INITIATIVE

PART 1: GUIDELINES FOR THE AGED CARE GP PANELS INITIATIVE

1. SCOPE OF THE INITIATIVE

a) Government Funding and Directions

Aged care homes have been finding it increasingly difficult to keep the services of general practitioners (GPs) who can provide regular consultations for residents. This is especially the case where a resident does not have a regular doctor. The promise of incentives to attract and retain doctors into aged care homes and to reimburse those doctors who are providing services beyond the Medicare Benefits Schedule (MBS) is a timely strategy.

Evidence about the nature and extent of the difficulties surrounding the provision of GP services to residents of aged care homes is limited. However, MBS data does suggest that services are provided by a small proportion of GPs and that this proportion is shrinking. Without intervention it is possible that this trend would continue particularly given changing GP demographics and workforce patterns including increasing numbers of female GPs, younger doctors in the GP workforce, and lifestyle preferences.

The number of aged care homes and residents is increasing as the Australian population ages. There is also evidence that the proportion of aged care home residents with high care needs and complex conditions is increasing.

Furthermore, anecdotal evidence suggests that linkages between aged care homes and general practice are sub-optimal, and that the consequences include:

- ineffective management of chronic conditions leading to otherwise avoidable acute episodes
- poor access of aged care home residents to appropriate urgent and after hours medical care.

These issues signal the need for systemic improvement.

To address barriers to service provision, including coordination and support mechanisms to GPs providing services to residents in aged care homes, the Australian Government announced the Aged Care GP Panels Initiative (the Initiative) on 18 November 2003, as part of a broader set of changes being introduced to strengthen and protect Medicare.

The Initiative aims to improve access to medical care and to enable GPs to work in partnership with aged care homes. GPs who participate in the Panel arrangements can receive funding in addition to accessing relevant Medicare items for any services provided directly to residents.

The Initiative will also assist Divisions of General Practice (Divisions), GPs and aged care homes to work together to create an environment that is more attractive to GPs, thereby increasing GP service provision to residents of aged care homes.
The Department, in close consultation with key stakeholders has developed these guidelines to support the implementation of the Initiative. An Advisory Committee has provided valuable advice on program issues including implementation, funding formulae and

evaluation components. This Committee includes representatives from consumers, peak groups for aged care providers and general practitioners, GPs, Divisions, aged care nurses, aged care, medical specialists and pharmacists.

These guidelines outline the implementation and operational arrangements and criteria for the Aged Care GP Panel (Panel) arrangements and provide the basis for implementation and operation activity at the local level.

b) Related Initiatives

As noted above, this Initiative is being implemented as part of a broader set of changes being introduced to strengthen and protect Medicare. One of these changes that is of particular relevance is the introduction of a Medicare item to enable medical practitioners (including GPs but not including specialists or consultant physicians) to undertake Comprehensive Medical Assessments (CMAs) of new and existing residents (if required) of aged care homes. The CMA item is being implemented in conjunction with the Initiative. It is closely aligned with the Initiative and will assist in achieving better access and quality of care for residents of aged care homes.

Other aspects of the enhanced Medicare package will also help to address access issues as the medical workforce is increased over time.

As well as changes to Medicare, a range of Measures specific to aged care homes has been announced as part of the 2004-05 Federal Budget. These Measures will also support the Initiative in achieving its aims to improve access to and quality of, care for residents of aged care homes.

Some aged care homes, GPs and Divisions are already working together to address the issues of medical access for residents. The Initiative will complement and build on this work.

2. DESCRIPTION OF THE INITIATIVE

a) Aim

The Initiative aims to achieve the following:

i Improved access to appropriate medical care for all aged care residents including:
- provision of comprehensive assessment of medical needs for new and existing residents as required
- general practice consultations for residents of aged care homes
- medical care for residents whose usual GP arrangements have broken down
- access to emergency or after hours GP care.

ii Increased participation of GPs in aged care initiatives aimed at improving quality of care, including through:
- sourcing and adapting quality care protocols
- GP participation in quality care activities.

iii GPs and Divisions working more effectively with aged care homes to:
- identify key areas of concern
- implement measures to address concerns raised
- reduce barriers to GP involvement in aged care homes.

The Initiative has been designed to supplement, and not replace, existing arrangements. Where successful arrangements are already in place in aged care homes, this Initiative will provide an opportunity for aged care homes, GPs and Divisions to work together to enhance and further establish those arrangements. A paramount concern is not to compromise existing positive partnerships, but rather to support, promote and further such activity.

The Initiative is known at the National level as the Aged Care GP Panels Initiative, however local terminology may be used to describe the Panel arrangements (eg group, network, facilitators etc) where an alternative term is agreed between the Division, GPs and aged care homes in the area.

b) Panels

For the purposes of the Initiative the term Panel is used to describe a list, or group, of GPs who agree to undertake particular activities which have been identified as priorities for aged care homes in that Division (consistent with section *4e Panel Activities* of these guidelines). The work of GPs participating in the Panel arrangements should complement and build on successful activities already being undertaken in aged care homes in the Division, or assist with the development of new activities.

It is likely that GPs who participate in the Panel arrangements, within a region or Division, will meet from time to time to share learning and build on each others' experience (although in some areas, such as rural areas, this may involve meeting via teleconference). However, the Panel is not a committee and it is expected that such meetings will form only a small component of the work of Panel GPs. The majority of the work of participating GPs will involve collaboration with staff and residents of aged care homes on agreed activities to improve access and quality.

The Panel arrangements are intended to remunerate GPs for services that go beyond the normal Medicare payment arrangements. Medicare remains available for all direct patient-GP consultations.

The Panel arrangement will not necessarily include all GPs who provide services within aged care homes, but all GPs in the area, as well as residents and aged care homes, should benefit from the activities undertaken by GPs who are participating in the Panel arrangements.

GPs will be appointed to participate in the Panel arrangements by Divisions in collaboration with aged care homes (see section *5d Appointment of GPs to Panels* of these guidelines for further information on this aspect).

It is anticipated that one Panel, or list, of GPs will operate per Division. However, larger Divisions will have more GPs on their list than smaller Divisions, and may also choose to have subgroups of GPs on the list (eg to undertake activities in different geographic areas within the Division). Further information on the expected number of GPs who will participate in different areas is included at section *4d Size of Panels* of these guidelines.

The actual Panel arrangements put in place will vary across Divisions according to local need. Differences in Panel arrangements established in different areas might include, but will not be limited to:

i types of activities to be undertaken

The range of activities undertaken by GPs participating in the Panel arrangements will need to be consistent with those outlined at section *4e Panel Activities* of these guidelines, but will primarily depend on the needs of the area. For example, in one Division the highest priorities might include participating in a cooperative roster of GPs, and sourcing and adapting emergency care protocols. In another Division the top priorities might include encouraging GP participation in quality care activities, and sourcing and adapting mechanisms that coordinate/support GP work in aged care homes to overcome identified barriers.

The skills and interests of participating GPs and the level of funding available to the Division to support identified activities will also help to determine the activities that can be undertaken by participating GPs.

ii allocation of activities to participating GPs

In some areas GPs participating in the Panel arrangements may work closely together on all activities, in others GPs may work largely independently and communicate as the need arises and through regular but infrequent meetings or teleconferences (eg six-monthly).

The allocation of activities to participating GPs will vary depending on the degree to which it is possible for participating GPs to work together, the appropriateness of working together or independently on particular activities and the interests of participating GPs. Each Panel GP may work with one or a specified group of aged care homes or in a specialised role across all or most homes in the Division

iii payment methods

The payment method employed within the Division will be dependent upon the model developed collaboratively between the Division, the GPs and the aged care homes. In some Divisions GPs participating in the Panel arrangements may be paid a set retainer in return for agreeing to be available to undertake work for a number of aged care homes. For example, this work might involve agreeing to take on new residents as patients who do not have a usual GP, working with the home to source and adapt protocols and participating in relevant aged care home quality activities.

In other Divisions Panel GPs may be paid an hourly rate for their work with individual homes, or for their participation on quality care committees.

In yet another Division GP Panel activity funding might be linked to outcomes. For example, a participating GP might be paid to complete a discrete task such as development of a specific quality improvement tool that can be utilised by all aged care homes in the Division, without specification of the time required to complete the task.

A combination of payment methods (eg hourly and retainer) might also be utilised in some Divisions. It is important to emphasise that the payment method matches the model developed at the local level and the model addresses local priorities.

c) Participants

Key participants in the implementation and ongoing management of the Initiative include:

i GPs: Panels will consist of GPs who have been engaged to undertake locally identified activities aimed at improving access and quality of care for residents of aged care homes. GPs providing services as part of the Panels arrangements will be remunerated for relevant activities. Remuneration for panel activities is in addition to MBS payments for direct services provided to residents of aged care homes.

ii Aged Care Homes: The Initiative applies to all aged care homes subsidised by the Australian Government including both high and low care facilities and Multipurpose Services (MPSs). The Initiative will provide aged care homes with an opportunity to improve GP access for their residents, and to build on quality improvement activities.

iii Divisions: Divisions, in partnership with aged care homes, will play a key role in implementing and operating the Panels, and undertaking related activities to improve access to GP services for residents of aged care homes. Divisions will administer the payments to GPs for panel activities and will also receive funding to undertake local liaison, development and administrative work for this Initiative. Where a Division chooses not to be involved, other arrangements will be made for the implementation of Panel arrangements in the area.

iv Divisions' State-Based Organisations (SBOs): SBOs will be funded to work with Divisions and aged care homes to promote the Initiative and provide a coordination, advisory, development and management role. The SBOs are in a key position to encourage information sharing and collaboration between Divisions and to assist any Divisions who may have difficulty implementing and managing the Initiative. They will also play a role in liaising with State Government, aged care peak organisations and other professional organisations at the State level.

v Australian Divisions of General Practice (ADGP): The ADGP have been funded to provide national leadership, coordination and advice in developing, implementing and operating the Panels, and foster linkages between ADGP, aged care peaks and other relevant national organisations.

vi Department – (Central Office): The Department's Central Office has responsibility for establishing the policy framework, developing and maintaining these guidelines, and for monitoring and evaluating the Initiative. The Primary Care, and Ageing and Aged Care Divisions of the Department have worked closely together to develop these guidelines and will continue do so during all phases of the Initiative.

vii Department – (State/Territory Offices): The Department's State/Territory Offices will manage the contractual arrangements with Divisions, approve Divisions' plans to implement the Initiative, monitor the implementation of activities, analyse reports provided by Divisions and can assist Divisions with obtaining data to assist with planning, including advice on opening of new homes. The Department will ensure linkages between primary and aged care areas are established and maintained during this Initiative.

viii Other participants: Additional participants include medical deputising services or other locum providers, geriatricians and other health care providers, aged care assessment teams (ACAT) and education/training providers for up-skilling and the provision of specialist advice to assist with complex clinical problems.

3. FUNDING

a) General

The Initiative encompasses two distinct and separate funding streams to support the establishment of local Panels. These are:

i Funding for GPs for Panel activities (relevant activities are identified in section *4e Funding for Panel Activities* of these guidelines)

ii Funding for the Divisions network for their role in establishing, managing and supporting the Panels and working with aged care homes (relevant activities for Divisions, SBOs and the ADGP are identified in sections *5c Activities of Divisions, 6 Roles of SBOs* and *7 Role of ADGP* of these guidelines respectively).

This funding will supplement, and not replace, existing funding. GPs who receive funding for participating in Panel arrangements will also have access to Medicare items for any services provided directly to residents.

The models used to allocate funding under the Initiative are described below. Funding will be provided in accordance with these models for a three-year period subject to a review of the appropriateness of these models at the end of the first year. Any adjustment considered necessary as a result of this review will be transitioned into operation to ensure Panel arrangements are not disrupted.

b) Funding for Panel Activities

Approximately $18.2m is available from 2004-05 to 2006-07 for GPs participating in the Panel arrangements. Approximately $5.9m will be available in the first year. In the current budget estimates indexation would increase this amount to approximately $6.1m in the second year and to $6.2m in the third year. However, the exact indexation will be confirmed after each budget.

Funding will be provided to Divisions who will administer payments to Panel GPs. This funding is specifically for GP remuneration for Panel activities and should not be expended on other purposes without approval from the Department.

Funding for GP Panel activities will reflect relative workloads. The funding model will allocate 20% of the available funding evenly across Divisions (a “flagfall” amount). This will provide each Division with a standard level of funding to pay for Panel activities. The remaining 80% of the funding will be allocated based on the number of aged care homes and the number of operational beds (weighted equally in the model) in the Division as at 31 December 2003. This data includes MPSs within the Division, but does not include community services such as Community Aged Care Packages.

The maximum amount payable to any one GP for Panel activities undertaken within the Division is $8,000 per annum, unless agreement is obtained from the Department for an increase based on special circumstances.

Divisions will administer the Panel activity payments through contractual arrangements with Panel GPs. Funding for Panel activities will essentially enable Divisions to purchase the time of Panel GPs to undertake activities within the scope of these guidelines (described in section

4e Panel Activities of these guidelines). The activities to be undertaken by GPs as part of the Panel arrangements will need to be clearly specified by the Division and linked to outcomes.

It is envisaged that Divisions will remunerate GPs in one of the following ways under the Panel arrangements. A combination of these three basic payment types might also be appropriate in some circumstances:

i Remunerate GPs for time spent undertaking panel activities (eg on an hourly basis)

ii Remunerate GPs for GP Panel activities via a retainer payment/s (eg payments to the GP to act as a "lead GP" to be available to attend and contribute to network meetings, to liaise with staff of aged care homes, provide care to residents whose usual GP arrangements have broken down or to provide emergency after hours care, etc). It is expected that the retainer payment will be commensurate with the level of services expected.

iii Remunerate GPs based on outcomes achieved (eg on the completion of a discrete task, without specifying the time component of the task).

Payment rates for participating GPs will be determined by the Division, in consideration of the types of activities to be undertaken by GPs participating in that Panel arrangement and with a view to establishing the most effective arrangements possible within the allocated funding.

c) Funding for the Divisions Network for Support Work

Approximately $15.1m is available from 2004-05 to 2006-07 to support the work of the Divisions network (ie Divisions, SBOs and the ADGP). Approximately $7.4m is available in the first year. This amount is approximately twice that available in subsequent years in recognition of the additional workload in the first year to implement the Initiative. Funding available under the Initiative is approximately $3.8m in the second year and the current indexation would increase this amount to approximately $3.9m in the third year.

Of the total funding available in 2004-05, approximately $500,000 will be directed to SBOs and the ADGP to fund their work with Divisions to promote the Initiative and provide a coordination, advisory, development and management role. This is approximately twice the amount that will be made available to SBOs and the ADGP in subsequent years in recognition of the higher anticipated workload associated with establishing the Panels and identifying good models and protocols that can be adapted by Divisions.

It is anticipated that each aged care home will have a central liaison point that the Division can contact when undertaking consultation and liaison in relation to the Initiative, which means that workload will be linked to the number of aged care homes in the Division.

Funding for Divisions reflects comparative workload. The funding model allocates 33% of the available funding evenly across Divisions (a "flagfall" amount). This standard amount has been included in the model to reflect the need for every Division to undertake a certain level of development, implementation and liaison work to enable establishment and management of Panel arrangements. The remaining 67% of the funding has been allocated based on the number of aged care homes in the Division as at 31 December 2003. This data includes MPSs within the Division, but does not include community services such as Community Aged Care Packages.

Divisions may collaborate with neighbouring Divisions to set up regional models and Panels, where this is likely to improve ability to implement the Initiative more effectively and efficiently. Collaboration will provide a larger resource pool from which to fund implementation.

In addition to a project officer, funding for Divisions for support work for the Initiative may be used for costs such as:

i Costs associated with up-skilling and facilitating specialist advice (eg from a geriatrician)

ii Costs related to renting a location for education/training provision

iii Equipment and the development of resources to establish/enhance the Initiative

iv Payments to non-GP professionals and service providers, including aged care staff, to attend meetings

v Costs incurred by the Division for the administration of the Initiative (eg staff time for writing plans and reports associated with financial administration of Panel activity payments).

The above description is intended to provide guidance only as to what is permissible in relation to expenditure for the Initiative. In accordance with the general requirements for the Divisions of General Practice Program funding agreement, Divisions will be expected to submit a detailed annual plan and annual budget to their State/Territory Office of the Department for approval.

This funding is for activities outlined in section *5c Activities of Divisions* of these guidelines.

d) Unspent funds

The Department expects that the funding component provided to Divisions for support work will be fully, or nearly fully, expended in all years of operation of the Initiative. A significant level of work exists for Divisions to implement the Initiative in 2004-05 and it is anticipated that Divisions will remain actively engaged in managing and monitoring Panel arrangements in their Division in subsequent years of the Initiative.

The Department accepts, however, that some GP Panel activity funding may be underspent in the first year, particularly where unavoidable delays have prevented the early establishment of an effective Panel arrangement.

Where there are unspent or uncommitted funds at the end of any financial year during the operation of the Initiative, Divisions will be able to request approval from the Department to carry-over the unspent or uncommitted funds into the next financial year. There are many reasons as to why an underspend develops, especially for a new program. The Department will consider requests for a carry-over, taking into account the reasons for the underspend. If possible, the Department will work to gain this approval. However, it cannot guarantee that it will be possible to carry-over any funds.

The Department will notify Divisions in writing of the outcome of any requests to carry-over funds. Outcomes may include: Full or partial carry-over; the Division not being allowed to carry-over funding; the Division being allowed to carry-over funds only for use for specified purposes; or the Division being required to offset some or all of the unspent funds against a future payment.

e) Ongoing Funding

The Initiative is a lapsing program (similar to the rural Divisions More Allied Health Services Program). The Initiative will therefore need to be evaluated prior to the end of the current funding period to 2006-07 to determine whether the original objectives of the Initiative have been met and to consider the policy ground on which an extension is sought. The Minister for Finance will need to approve the terms of reference used for the evaluation of the Initiative and the continuation of funding for the Initiative will be considered in the Budget context.

4. ROLE OF GPs

a) General

The Initiative provides funding to support GPs participating in the Panel arrangements to work flexibly with staff of aged care homes to improve access to, and quality of, care for residents of aged care homes. Funding will be provided to GPs who agree to undertake specified activities which have been identified as local priorities (collaboratively by Divisions, aged care homes and GPs). Broadly, this will include agreeing to provide care to residents without a usual GP or whose usual GP arrangements have broken down, participation in quality improvement activities, advising on protocols such as those for emergency care, streamlining GP activities and addressing barriers to primary care service provision.

For example, Panel activities will include work aimed at reducing barriers to GP service provision in the Division's aged care homes. For a particular Division this might involve identifying and putting in place strategies for improved communication between GPs and staff of aged care homes. By working together to agree and implement these strategies, it may be possible to improve efficiency and effectiveness in the way that GPs and staff of aged care homes interact. Additional information about the types of activities which may be undertaken as part of this Initiative is provided at section *4e Panel Activities* of these guidelines.

b) Funding for GPs

Funding will be available for each Division to pay for GP panel activities. The funding model is discussed in section *3b Funding for Panel Activities* of these guidelines.

c) Appointment of GPs to Panels

GPs do NOT need to be a member of a Division to participate in the Panel arrangements, although Divisions will administer payments to GPs for Panel activities. Divisions will also, in collaboration with aged care homes, appoint GPs to Panels.

This Initiative has been designed to supplement, and not replace existing arrangements. Where GPs are already providing services in aged care homes or are working effectively with

aged care homes on quality improvement strategies, this Initiative should be used to support, strengthen and supplement those relationships and activities. Divisions are expected to work with aged care homes to identify the GPs providing services to residents in the aged care home and/or participating in quality initiatives.

A key consideration for Divisions in appointing GPs to the Panel arrangements will be to ensure that those GPs with a strong track record of working with aged care homes are supported to continue and expand this work. However, in order to increase the number and widen the profile of GPs in aged care, other GPs with an interest in working with aged care homes are also to be assisted.

There is flexibility for GPs to participate in Panel arrangements in other Divisions. For example, the aged care homes a GP would normally visit, or would prefer to visit, may form part of a neighbouring Division's Panel arrangements. In these situations it may be appropriate for the GP to participate in that Panel arrangement.

GPs may participate in more than one Panel arrangement. However, Divisions in partnership with aged care homes will be expected to consider the effectiveness of such arrangements.

A Panel might also include other health care providers such as geriatricians, although there is no specific funding available under the Initiative to support this type of arrangement. More information on the role of geriatricians and other health care providers is included in section *9 Role of Other Participants* of these guidelines.

GPs who are interested in participating in the Panel arrangements should approach the relevant Division to find out how to apply.

Information on appointment of GPs to Panels is also provided in section *5d Appointment of GPs to Panels* of these guidelines.

d) Size of Panels

The Panel arrangement established in each Division will consist of a list, or group, of GPs who have agreed to undertake activities aimed at improving access and quality of care for residents of aged care homes which have been identified as priorities at the local level.

There will be only one Panel (or list) of GPs participating per Division. However, given the large variation in the number of aged care homes and number of beds across Divisions, it is expected that number of participating GPs may vary widely from Division to Division. In general, it is expected that the number of participating GPs within a given Division will range from approximately 2-12. However, it is noted that 12 GPs may be inadequate for very large Divisions, or where Divisions choose to work cooperatively with neighbouring Divisions to establish arrangements that cover larger areas. For this reason a maximum number of GPs per Panel will not be imposed. Divisions will need to work with GPs and aged care homes to determine an appropriate number of Panel GPs that can be supported within allocated funding.

Larger Divisions may also choose to have subgroups of GPs on the list (eg to undertake activities in different geographic areas within the Division).

e) Panel Activities

Divisions will work with GPs and aged care homes to identify relevant activities for Panel GPs to undertake. Activities agreed for Panel GPs will be aimed at improving both access to medical care and quality of care for residents of aged care homes.

Divisions in partnership with their GPs and aged care homes should develop approaches which fall within the scope of the Initiative. This should take into account the needs of residents and aged care homes, the range and location of aged care homes and the interests of practicing GPs.

Core activities that Panel arrangements will cover are:

i addressing issues of resident access to GPs, including for residents without a usual GP or whose usual GP arrangements have broken down

ii participating in aged care homes quality improvement activities

iii sourcing or adapting protocols that assist in improving medical care for residents and streamlining GP activities

iv addressing barriers to primary care service provision.

For example, if participating GPs were to agree to facilitate the provision of care for residents without a usual GP or whose usual GP arrangements have broken down, the GP providing the medical service (whether this is the Panel GP or another GP) would receive the usual MBS payment for the provision of the medical service to the patient. In addition, the Panel GP would receive Panel Activity funding for facilitating the provision of that service to the resident.

To cover core activities specified above, Panels may undertake a range of activities which includes, but is not limited to, the following:

i recruiting a cooperative roster of GPs

ii recruiting GPs prepared to provide care to residents without a usual GP or whose usual GP arrangements have broken down

iii sourcing or adapting emergency care protocols

iv sourcing or adapting protocols for medication management

v sourcing or adapting protocols for GP contact/communication with aged care homes

vi promoting the use of protocols

vii developing protocols where none exist

viii participating in medication advisory committees

ix participating in quality care committees

x sourcing or adapting mechanisms that coordinate/support GP work in aged care homes

xi sourcing or adapting preventive health activities or programs such as immunisation and falls prevention activities

xii providing education to staff, residents and carers

xiii working with aged care homes and Divisions to identify and implement solutions to barriers for integration and encourage a merging of the cultures of aged care homes and general practice

xiv sourcing or adapting continuity of care activities

xv sharing resources for improvement in care provision.

5. ROLE OF DIVISIONS

a) General

Divisions will be funded to undertake the local liaison, development, and administrative support work for the Initiative, and work with the homes in their area to develop local responses including promoting interest among GPs in providing services to residents of aged care homes under the Initiative.

Divisions will play a key role in facilitating the implementation and operation of the Initiative and will undertake related activities to improve access and assist with quality improvement strategies for the care of all residents.

Where a Division chooses not to be involved in the Initiative, the Department will make alternative arrangements for the implementation of Panel arrangements in the area. For example, the funding may be offered for that Division to implement and manage the Panel arrangements in the neighbouring area. Where another organisation is contracted to implement the Initiative in this way, it is expected that this organisation would continue in this role for the three year contract period.

b) Funding for Divisions

Funding will be available for each Division for support work associated with the Initiative. The funding model is discussed in section *3c Funding for the Divisions Network for Support Work* of these guidelines.

c) Activities of Divisions

In implementing the Initiative Divisions will need to be responsive to local needs.

To the extent possible, Divisions should involve a multi-disciplinary team in decision-making in relation to the Initiative. Such teams may include:

- GP education/training providers
- Directors of Nursing and/or staff of aged care homes
- Directors of Nursing and/or staff of Public and Private Hospitals
- Geriatricians and/or other health care providers
- Aged care assessment team manager or members.

Core activities Divisions will be expected to undertake as part of the Initiative are:

i Consulting with GPs and aged care homes to identify current service delivery arrangements (including which GPs are already providing services), service delivery gaps and pressures

ii Identifying key priorities within the Division boundaries to improve access to GP services for residents of aged care homes

iii Selecting and establishing appropriate models that best suit local needs and the expectations and preferences of GPs, residents and aged care homes

iv Liaising and communicating with GPs, aged care homes and other relevant stakeholders

v Engaging of GPs to participate on the Panels in collaboration/partnership with aged care homes

vi Establishing and managing contractual arrangements with GPs

vii Promoting interest among GPs in providing services to residents of aged care homes under the Initiative

viii Sharing resources and working with other Divisions to implement the Initiative

ix Monitoring, evaluating and reporting on the implementation and operation of the Initiative in their area

x Reviewing and adapting the model operating within the Division in light of experience

xi Working with GPs and aged care homes to establish or support quality activities.

Examples of other activities that Divisions may undertake as part of the Initiative include:

i Facilitating access to up-skilling and/or professional support to participating GPs

ii Working with aged care homes to establish regional, group or Division-wide medication advisory groups or quality care committees

iii Working with GPs and aged care homes to source or adapt protocols, tools and other arrangements to assist in streamlining GP activities and improved service delivery arrangements.

d) Appointment of GPs to Panels

Divisions will appoint GPs to participate in the Panel arrangements in partnership with aged care homes. In appointing GPs to Panels, Divisions should ensure that they are aware of the work already being undertaken by GPs in homes within the Division, and of the needs of aged care homes. Where GPs are already working effectively with aged care homes and would like to participate in the Panel arrangements, this Initiative can be used to support, strengthen and supplement those relationships and activities.

A key consideration for Divisions in appointing GPs to the Panel arrangements will be to ensure that those GPs with a strong track record of working with aged care homes are supported to continue and expand this work, and that other GPs with an interest in working with aged care homes are supported to do so.

GPs do NOT need be a member of a Division to participate in the Panel arrangements, although Divisions will administer payments to GPs for Panel activities. Divisions will also, in collaboration with aged care homes, appoint GPs to Panels.

In appointing GPs to participate on Panels, Divisions should consider the skills and attributes required for the work to be undertaken.

Aspects Divisions should consider include:

i Demonstrated interest and skills in aged care, such as:
- high case load of patients in aged care homes
- training in geriatrics/aged care and/or willingness to undertake relevant additional training.

ii Demonstrated ability to work cooperatively with aged care homes and other health professionals in quality activities, such as:
- previous or current membership of medication advisory committees or quality care committees
- previous or current contributor to improving quality in aged care homes.

iii Demonstrated skills in liaising with other GPs to achieve agreed outcomes, such as:
- experience in coordination of roster arrangements
    - experience in working with others to develop agreed protocols.

Divisions may remunerate GPs who belong to a different Division under the Panel arrangements. This allows flexibility, for example, for GPs to participate in a Panel which covers homes in a different geographical area to the area in which they have their practice, where the homes they would normally visit, or would prefer to visit, are part of a neighbouring Division's Panel arrangements.

Contractual arrangements will need to be worked out between GPs participating in the Panel arrangement and the Division. The appointment of GPs to the Panel arrangements should be based on a range of criteria to ensure consistency and transparency.

The Division, in partnership with aged care homes in the Division, will have the final decision on the membership of the Panel. Where the Division, in partnership with aged care homes in the Division, determines that a GP already working in aged care should not participate in the Panel arrangements, despite an expressed desire from the GP to do so, care needs to be taken by the Division to avoid alienating the GP and potentially losing that GPs' services to aged care homes.

GPs may participate in more than one Division's Panel arrangement. However, Divisions should consider the effectiveness of such arrangements. In such circumstances it may be appropriate for Divisions to consider collaborating with neighbouring Divisions to streamline Panel arrangements.

Divisions may also need to consider sustainability of the Panel arrangements in relation to the GP workforce. For example, if the GPs providing services in aged care homes in a particular area are close to retirement age, there may be a greater need in that area to attract younger GPs to the aged care environment.

Medical Deputising Service and Locum GPs may be consulted in establishing Panel arrangements and in ongoing work of the Panels in their area. These GPs are not eligible to

participate in the Panel arrangements in their own right, however GPs participating in the Panel arrangements may delegate panel activities to these GPs. For example, once the Panel arrangements have been established, participating GPs could delegate some of their Panel responsibilities such as after hours care to these doctors who work for an on behalf of the Panel GP.

e) Ensuring Accountability and Transparency

In undertaking the local liaison, development, and support work for the Initiative, Divisions will need to ensure their processes are accountable and transparent. For example, in appointing GPs to participate on Panels, Divisions will need to ensure that decisions are documented, justifiable and founded on fair play.

6. ROLE OF SBOS

The role of the SBOs in the Initiative is to undertake the following:

i Provide leadership at the state level by contributing to national policy development and program outcomes of the Initiative

ii Work with, assist and support Divisions to implement and manage the Initiative. This may also include any cooperative arrangements across Divisions or other participants, such as facilitating access to geriatricians or other resources, providing support to Divisions, particularly those with little or no experience in residential aged care, to implement and manage the Initiative and working with head offices of groups or chains of aged care homes to enable a coordinated approach

iii Work with Divisions to promote the Initiative and share information about successful Panel arrangements

iv Work to coordinate a national picture of the Initiative's progress and outcomes

v Negotiate with state governments to ensure appropriate linkages (eg acute care, aged care assessment teams and geriatrician support)

vi Work in partnership with key aged care and related stakeholders to establish linkages and improved outcomes

vii Facilitate opportunities that contribute to a stronger evidence based focus for the Divisions' network, including assisting Divisions in accessing and using data.

These roles are consistent with those developed in consultation with the Department/ Divisions' Business Management Advisory Group, and with the roles set out in the *Divisions of General Practice: Future Directions*.

A portion of the Divisions network funding for the Initiative identified in section *3c Funding for the Divisions Network for Support Work* of these guidelines is being directed to SBOs in recognition of the role they can play in coordinating the implementation and management of the Initiative and to support Divisions.

Funding for SBOs takes into account the roles and likely associated workload, including the number of Divisions with which each SBO will need to work.

7. ROLE OF ADGP

The role of the ADGP in the Initiative is to undertake the following:

i Provide national leadership, assistance and support for SBOs and Divisions in achieving the aims of the Initiative

ii Coordinate and synthesise the views of the Divisions network to contribute to the policy and program development of the Initiative

iii Establish and maintain relationships with relevant aged care peak bodies and other relevant peak bodies in order to promote and further develop the Initiative.

iv Contribute to the dissemination of information and resources throughout the Divisions network and other relevant organisations on the Initiative.

These roles are consistent with those developed in consultation with the Department/Divisions Business Management Advisory Group, and with the roles set out in the *Divisions of General Practice: Future Directions*.

A portion of the funding for the Divisions network identified in section *3c Funding for the Divisions Network* of these guidelines is being directed to the ADGP in recognition of the role they can play in coordinating the implementation and management of the Initiative and providing national leadership.

8. ROLE OF AGED CARE HOMES

Participation in the Initiative is voluntary for aged care homes. There is no funding for staff of aged care homes to assist in the implementation and ongoing work associated with this Initiative.

It is anticipated that most aged care homes will want to participate in the Initiative, however there are a number of possible barriers to participation including the lack of specific funding to support this work.

Promotion of the benefits of the Panel arrangements to the aged care sector may help to maximise participation of aged care homes in the Initiative. There are a number of potential benefits for both residents and staff of aged care homes associated with participation in the Initiative, including the opportunity for staff of aged care homes to work with Divisions and GPs to develop flexible solutions to improve access to high quality care for aged care home residents, and support and advice for staff.

Further potential benefits for residents and staff of aged care homes might include:

i more timely access to primary medical care for residents

ii improved quality medical care to residents

iii consistency in medical care/GPs providing care

iv improved clinical advice for staff in their caring role

v reduction in inappropriate emergency transfers to hospital

vi reduction in inefficiencies in interactions with GPs

vii improved understanding by GPs of pressures affecting aged care home staff

viii improved communication between GPs and aged care home staff

ix ability of homes to utilise the Initiative to make changes to local processes, networks and supports

x improvements in the ability of the home to deliver high quality care (eg through introduction of emergency care and other protocols) and give confidence to aged care home staff

xi assisting homes in meeting accreditation standards (eg may assist in obtaining a doctor for quality improvement committees, keeping medication charts up to date).

GPs and Divisions will need to work in close partnership with aged care homes if the potential value of the Initiative is to be realised. To do this, they will need to engage positively with the residential aged care sector as well as individual aged care homes.

Some possible mechanisms for Divisions to engage with the aged care sector include:

- a mailout and/or e-mail to all aged care homes with information on the Initiative including details of the Division's area in which they fall
- regional level workshops to be developed in partnership between Divisions and State aged care peak bodies
- local level general meetings and promotion of benefits and activities
- presentations at relevant conferences (eg on models which are working well.)
- provision of information by Divisions to State level aged care bodies (such as the Australian Nursing Homes and Extended Care Association, Aged and Community Services Australia and Geriaction) and large organisations that deliver care to the ageing to enable information to go out through those networks.

Divisions should work with staff of local homes and may also need to establish links with 'head offices' of groups or chains of homes. Collaborative work with other Divisions and/or SBOs may assist in this.

Aged care homes will be encouraged to work closely with Divisions to implement and manage the Initiative. It is envisaged that aged care homes will undertake some or all of the following activities:

i work with their Division and GPs to identify current service delivery arrangements (including which GPs currently provide services) and service delivery gaps and pressures. This will assist Divisions and GPs to better understand the needs of the aged care home and its residents.

ii work with the Division to select appropriate Panel arrangements and activities that best suit the expectations and preferences of all stakeholders.

iii identify the key priorities to improve access to GP services for residents of aged care homes.

iv work with their Division to appoint appropriate GPs to participate in the Panel arrangements (eg by identifying those GPs that already have significant resident patient load and/or contribute to existing quality arrangements).

v work cooperatively with Panel GPs to facilitate panel activities for the benefit of aged care home residents.

vi work with their Division and Panel GPs to source and adapt protocols and tools to streamline GP involvement.

It is not appropriate for GPs and Divisions to impose perceived 'solutions' within aged care homes that have not been developed in close consultation with staff from the aged care sector.

9. ROLE OF OTHER PARTICIPANTS

a) Geriatricians

The Initiative is focused on improving access to medical care for residents of aged care homes and enabling GPs to work with aged care homes to assist with quality improvement strategies for the care of all residents. While the focus under this Initiative is on GP services, it is recognised that geriatricians may provide a source of support to GPs.

There is no specific funding for geriatricians under this Initiative. However, as part of this Initiative Divisions will be encouraged to develop or strengthen links with geriatricians within their Division. The funding stream provided to Divisions for support work associated with the Initiative may be used to encourage geriatricians to provide support to the Initiative, such as provision of expert advice to the Division.

Should a Division be unable to expend the funding stream allocated to GPs for Panel activities, with Departmental approval, the Division may provide funding to a geriatrician to participate in Panel activities, such as participation on relevant committees or advice on the development of protocols that will meet the local needs of the GPs and the residents of aged care homes. Such protocols may meet educational and professional development needs of GPs involved in providing services in aged care homes. Funding for these activites will be within the Division's existing allocations.

The normal referral process for a resident to see a geriatrician will remain unchanged and any links already established with geriatricians, especially those within the public system, should not be affected by this Initiative.

It is anticipated that the work of geriatricians may support the aims of the Initiative in a number of ways, including through:

- Contributing to facilitating up-skilling and education for Panel GPs and/or aged care homes in the Divisions' region
- Providing specialist advice as necessary to assist with complex clinical conditions
- Assisting to improve continuity of care and access to medical records and assessments that are undertaken by a geriatrician
- Providing vital links with regional specialised aged care services (eg ACATs, domicilliary therapy, in-patient rehabilitation)

Given the scarcity of geriatricians, it may be appropriate for Divisions to work collaboratively to access this support.

The role of geriatricians in the Initiative will be reviewed 12 months following implementation to consider the appropriateness of the role of geriatricians as outlined above, and whether it is possible and appropriate to expand the role of geriatricians in the Initiative.

b) Other Health Care Providers

As for Geriatricians, there is no specific funding to engage other expertise, such as that of other health care providers, ACATs or education/training providers. However, it is recognised that these groups may provide a source of support to GPs. In particular, the enhancement or development of partnerships between Panel GPs and other health care providers will enable a sharing of ideas and valuable input to local level planning.

10. ROLE OF THE DEPARTMENT

The Department's Central Office in Canberra, and each of the Department's State/Territory Offices will have roles in implementing and managing the Initiative.

The Central Office has responsibility for:

i Establishing the policy framework

ii Developing and maintaining these guidelines

iii Publicising the Initiative and communicating requirements

iv Articulating relationships with other programs

v Determining and putting in place funding models and arrangements

vi Setting up reporting requirements

vii Setting up contracts

viii Monitoring and managing the Initiative (including adjustment where needed)

ix Evaluating and reporting on the Initiative.

The State Offices of the Department have responsibility for:

i Publicising the Initiative and communicating requirements

ii Establishing and managing contractual arrangements with Divisions

iii Making payments to Divisions in accordance with contractual arrangements

iv Approving Divisions' plans to implement the Initiative

v Monitoring the implementation of activities

vi Analysing reports provided by Divisions

vii Assisting Divisions with obtaining data to assist with planning, including advice on opening of new aged care homes.

Communication with the Department in relation to the Initiative should be with the relevant State/Territory Office in the first instance.

11. ESTABLISHING A PANEL

Panels will consist of a number of GPs who have agreed to undertake priority activities that have been locally determined by the Division in partnership with aged care homes and GPs and are consistent with section *4e Panel Activities* of these guidelines.

There is flexibility for different arrangements to operate in different Divisions to ensure that local needs are addressed. The Panel arrangement that is established should take into account the needs of residents as well as the needs of aged care homes.

In establishing Panel arrangements, Divisions should take care to ensure that the principles of patient choice are upheld. That is, to the extent possible, residents of aged care homes should have access to the GP of their choosing.

As successful Panel arrangements are identified, information on their operation will be made available.

Over time, it will be appropriate for Divisions, in partnership with GPs and aged care homes to review the Panel arrangements in place to determine if adjustments are needed to more effectively meet objectives.

The process for establishing a Panel is expected to vary depending on the local circumstances of the Division such as the number and distribution of GPs in the Division, the level of GP interest in participating in Panel arrangements, the needs of the residents of aged care homes in the Division and arrangements already in place in aged care homes within the Division.

The following outlines some of the steps that Divisions might take to implement a Panel. These are not intended to be prescriptive – it will be appropriate for different processes to operate in different Divisions.

i The Division provides all aged care homes and GPs in the Division with information on the Initiative and invites them to a meeting/workshop.

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

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

iv The Division circulates this Charter of Priorities to all aged care homes and GPs for comments and/or holds a second meeting to finalise priority actions for the Panel that will be established in the Division.

v The Division contacts/writes to all aged care homes to identify which GPs are involved in providing services to residents and/or participating in quality Initiatives.

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

vii The Division contacts/writes to all GPs in the Division (including GPs who are not members of the Division) and to GPs outside the Division who are providing services

to determine their interest in undertaking the activities identified in the Divisional Charter of Priorities.

viii A selection process is undertaken if necessary.

ix The Division notifies successful/unsuccessful GPs.

x The Division arranges a meeting for GPs on the Panel, Directors of nursing (or staff as appropriate) of aged care homes to agree how the Panel will operate.

xi A possible agenda for this meeting might include:
- Specification of the roles of Panel GPs, aged care homes and the Division
- How Panel GPs will be remunerated (eg hourly or using retainer payments)
- Scope of activities which can be achieved within allocated funding
- Which GPs will do what activities/timing of activities
- How the Panel GPs, aged care homes and Division will communicate and how often (eg may elect a liaison officer for the Panel who meets with/works with aged care homes and/or Division and then reports back to other Panel members)
- Next steps (eg agree actions, set up next meeting).

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

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

xiv The Panel begins operating in accordance with the agreed Action Plan.

12. DIVISIONS' PLANNING AND REPORTING REQUIREMENTS

a) Planning

Divisions are required to provide planning and reporting documentation (similar to those required under Division of General Practice Program arrangements), and have these approved, prior to commencement of each financial year. Divisions are to submit all plans and reports to the relevant State/Territory Office for approval. Once approved, the Division of General Practice may be asked to forward some information to the Primary Health Care Research and Information Service (PHCRIS).

b) Stakeholder Consultation

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

- Aged care homes
- GPs
- Consumers

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

- the State/Territory Health Department
- private medical services (eg private hospitals including bush nursing hospitals)
- pharmacies that supply medicines to aged care homes
- Aboriginal and Torres Strait Islander health services and advisory mechanisms
- Medical Deputising and Locum Services, who may be able to assist Divisions to determine workforce gaps and pressures and provide advice on how to best implement the Initiative in that area.

Divisions are required to periodically review their assessments of stakeholders' needs during the period of the Agreement Plan. Ongoing monitoring of the needs of aged care residents and other members of the local community within a Division will occur as part of this process.

The stakeholder consultation required as part of this Initiative is in addition to the needs assessment undertaken as part of the Division of General Practice Program. Divisions will need to report on the planning processes undertaken in the development of the Panel as part of the Implementation Plan.

The report will include a summary of identified priorities for the Initiative, based on the planning process undertaken by the Division. It will reflect the aims of the Initiative identified in section *2a Aim* of these guidelines and discussion may include:

i the range of stakeholders support for the proposed activities;

ii prioritisation of one identified need over another, which may be based on practical considerations; and

iii management of practical considerations and risk management.

c) Funding and Reporting Requirements

Divisions will be funded for both Panel Activities and the Division's Support Work through a Schedule to the new contracts between the Department and the Divisions being implemented from 1 July 2004, and will be asked to incorporate Panel activities into their normal business plans and reporting cycles.

The first payment covering both Panel activities and Divisions support work funding will be made to Divisions under this Initiative on 1 July 2004, where the Schedule to the new contracts has been completed on that date and a correctly rendered invoice received by the relevant Departmental officer. If the Schedule is not finalised at 1 July 2004, payment will be made within seven days following completion of the Schedule and receipt by the relevant Departmental officer of a correctly rendered invoice.

Subsequent payments will be made quarterly, subject to receipt and/or approval of relevant plans and reports.

d) Agreement Plans

Divisions are required to submit new plans when Divisions of General Practice Program funding agreements are due for renewal.

The Agreement Plan for the 2004-07 period will need to be amended to incorporate information on the activities to be undertaken under this Initiative. An amended Agreement Plan will need to be submitted for Departmental consideration by **31 August 2004**.

Divisions are able to update Agreement Plans during the three year funding period to acknowledge changing needs and strategic directions. Similarly, elements of the Agreement Plan relating to this Initiative may be updated as the need arises, then submitted to the relevant State/Territory Office of the Department for approval.

e) Annual Plans

As part of the Divisions of General Practice Program funding arrangements, Divisions are required to submit new Annual Plans to the Department by 15 March each year for approval.

Divisions' 2004-2005 Annual Plans will need to be amended to include information on the activities to be undertaken under this Initiative. The amended Annual Plan will need to be submitted for Departmental consideration **31 August 2004**.

f) Annual Budgets

As part of the Divisions of General Practice Program funding arrangements, Divisions are required to submit a new Annual Budgets to the Department by 15 March each year for approval.

A separate approved budget will be required for this Initiative for each financial year, at the same time as the Annual Budget for the Divisions of General Practice Program. This will be additional to the Division of General Practice Program Annual Budget. The Aged Care GP Panels Initiative Annual Budget must be provided in the format required by the Department. Once approved, the Division network member must not deviate from the line items and amounts specified and approved therein without the agreement of the Department.

The budget may only include amounts sought for expenditure within the scope of these guidelines, as negotiated with the Department.

For the financial year 2004-05, the Annual Budget will need to be submitted to the Department for consideration and approval by **31 August 2004**.

g) Aged Care GP Panel Implementation Report

Divisions are to provide the Department with a brief report (approximately three pages in length) before the Panel is established. The Implementation Report is a once-off report that is separate from the Divisions of General Practice Program reporting arrangements.

The Implementation Report will allow the Government to receive advice on how quickly the Initiative is likely to be implemented. It will also assist the Department to gauge and provide additional necessary support to Divisions in establishing Panel arrangements.

The Implementation Report will briefly the outline the following:

- What residential aged care arrangements were in place as at 1 July 2004 within the Division including any partnership arrangements between aged care homes and general practice
- Whether the Division has undertaken any aged care programs in the past and if so whether this Initiative will build on arrangements already in place
- The nature of consultation that has been undertaken to develop the Implementation Report
- The priority needs identified by aged care homes, GPs, and other relevant professionals and stakeholders
- The different activities that are to be undertaken by the Panel GPs
- The approach to be undertaken in implementing the Initiative
- The intended process to be undertaken with respect to appointing general practitioners to participate on the Panel arrangements.

The Panel activity component of the second quarterly payment to Divisions will be linked to *receipt* of the Implementation Report. Divisions are therefore encouraged to submit their Implementation Reports as early as possible to ensure payment of the Panels activity component of the second quarterly payment on **15 October 2004**. The third quarterly Panel activity payment is linked to Departmental *approval* of the Implementation Report. Divisions will need to submit the Implementation Report prior to **6 December 2004** for approval.

h) Six Monthly Progress Report

As part of the Divisions of General Practice Program funding arrangements, Divisions are required to submit Six Monthly Progress Reports to the Department by 15 February each year for approval. The Six Monthly Progress Report will need to include information on this Initiative, as outlined below.

Because there are two separate areas of funding, the Six Monthly Progress Report will need to *clearly identify and separate* the activities and achievements of the Divisions in supporting the implementation of the Initiative and the Aged Care GP Panels. The Six Monthly Progress Reports will be provided to the Department as part of the standard Division of General Practice core funding reporting arrangements in February 2005.

The Six Monthly Progress Report should include:

a) a comprehensive report on progress made toward achieving program outcomes, outputs and performance indicators
b) the identification of barriers experienced and future challenges expected
c) actions taken or proposed to overcome those barriers and challenges
d) a succinct Executive Summary
e) operational information as a clearly identifiable section of the report
f) A description of outcomes, achievements and activities against each of the performance indicators
g) unaudited financial information, which clearly and separately identifies each stream of funding and associated expenditure.

A template will be provided to assist in this.

i) Twelve Month Report

As part of the Divisions of General Practice Program funding arrangements, Divisions are required to submit Twelve Month Reports to the Department by 31 August each year for approval. The Twelve Month Report will need to include information on this Initiative, as outlined below.

The Twelve Month Report must *clearly identify and separate* the activities and achievements of the Divisions and the Aged Care GP Panels. The Twelve Month Report will include information as outlined for the Six Monthly Progress Report above for items a) through f), but will require an Audited Financial Statement on expenditure during that financial year. The Twelve Month Progress Report will be provided to the Department as part of the standard Division of General Practice core funding reporting arrangements in August 2005.

The Six and Twelve monthly reports will provide an opportunity for Divisions to provide contextual information that will be taken into account when measuring performance against performances indicators. Divisions should provide contextual information, including challenges and obstacles their area faces to ensure that Divisions are not disadvantaged where unavoidable obstacles (eg workforce shortages in the area) have prevented or delayed implementation of the Panel arrangements.

A template will be provided to be used as part of the Twelve Month Report.

j) Departmental Assessment

All plans, reports and budgets will require the approval of the Department. The Department will need to be convinced that the requirements of these guidelines have been met satisfactorily prior to granting approval.

Divisions are expected to adhere to similar reporting requirements for funding under this Initiative as those required for continuation of the Divisions of General Practice Program funding.

Divisions will be required to submit both Six Monthly Progress and Twelve Month reports.

k) Financial Reports

Divisions will be required to submit financial reports in accordance with the Divisions of General Practice Program funding agreement. In submitting their financial report, Divisions **must** clearly identify the Panel activity and Divisions stream of funds separately. Approval for each financial years budget must be sought from the Commonwealth's Liaison Officer prior to the commencement of that financial year.

Six Monthly Financial Report – Unaudited: The six monthly financial report will need to be completed on the Divisions reporting template. It should clearly identify, by approved line item, the expenditure for the current financial year, the total budget allocated to that line item and any uncommitted funds associated with the Initiative at the time of drafting the report.

The Twelve Month Financial Report – Audited: The Twelve Month Financial Report should include:

i a statement of income and expenditure

ii statement of assets and liabilities

iii a statement of cash flows for the Initiative.

The income and expenditure statement must account for all funds provided by the Initiative by line item of the approved budget. Uncommitted funds should be clearly identified.

The Twelve month financial report should be audited by a qualified auditor and must include an auditor's report that:

i is addressed to the Department

ii includes a statement that testing was undertaken to obtain a reasonable level of assurance that monies provided under the Initiative have been expended in accordance with the funding agreement.

l) Partnerships

Divisions which are undertaking Panel activities in partnership with other Divisions or other agencies must identify such partnerships in the "activity" section of their Annual Plans. Also, the jointly funded activity should be identified in the approved budget and then in the subsequent financial reports.

13. SBO AND ADGP PLANNING AND REPORTING REQUIREMENTS

SBOs and the ADGP will also be required to report to the Department on the progress and outcomes of the Initiative as part of the standard reporting arrangements in place for their core funding. The reports will be similar to those detailed for Divisions. However, the once-off implementation report detailed above is to be provided by Divisions only.

SBOs and the ADGP will need to establish or enhance and maintain relationships with aged care peak bodies, other professional bodies and State/Territory government. They will also need to communicate information about the Initiative including identifying and disseminating resources to Divisions and aged care peak bodies to assist in implementation and operation of the Panel arrangements.

An approved budget for the Initiative is required for each financial year and will be in addition to core funding provided to SBOs and the ADGP. The budget must be provided in the format required by the Department. Once approved, the SBOs and ADGP must not deviate from the line items and amounts specified and approved therein without the agreement of the Department.

The budget may only include amounts sought for expenditure within the scope of these guidelines, as negotiated with the Department.

All plans, reports and budgets provided by SBOs and the ADGP will require the approval of the Department. The Department will determine whether the requirements of these guidelines have been met satisfactorily in granting approval.

14. MONITORING AND PERFORMANCE INFORMATION

a) Types of Data

The Department will need to collect information to assist in monitoring the progress of the Initiative and determining the extent to which the Initiative is meeting it objectives.

The Department will collect a range of data including from Divisions Reports, MBS activity and surveys, some of which will be used to assess performance and some of which will assist the Department to obtain a better picture of the operation of the Initiative, to inform future policy advice.

A range of information will be provided to the Department in Divisions' Reports. These reports will provide Divisions with an opportunity to outline barriers and challenges they are facing in relation to implementation and management of the Initiative. They will also provide information such as when the Panel was established, information about participating GPs and the activities that are being undertaken by GPs as part of the Panel arrangements. Further information on Divisions' Reports is outlined above (section *12 Divisions' Planning and Reporting Requirements* of these guidelines).

The Department will collect MBS data to assess performance of the Initiative in terms of access and to provide information about broader changes that might impact on the Initiative, including monitoring changes in GP demographics, and access and service patterns for residents of aged care homes over time.

The Department will also use survey information to gauge the effectiveness of the Initiative, particularly in relation to identifying improvements in collaboration and partnerships that have been established, and aged care homes' perceptions of changes in access to GP services.

Aggregated data from the above sources will also be available to the Divisions network as a mechanism for sharing information about the implementation and management of the Initiative at a national level.

b) Establishing the Context

The Department recognises that in some Divisions, relationships between the Division, GPs and aged care homes may be undeveloped, or may be strained, and that it might take some time to build trust and good working relationships. The Department also recognises that in some situations, despite the best efforts of Divisions, participating GPs and aged care homes, there will be delays and difficulties in establishing effective Panel arrangements. Even where effective Panels are put in place, it may take some time for change to become evident. In collecting and using performance information, the Department will take into account the individual circumstances of the Division. Reports provided by Divisions will enable Divisions to explain their particular circumstances, including barriers and challenges to implementation and effectiveness of Panel arrangements.

The Department also recognises that the indicators it uses to monitor performance need to be considered in context. For example, the residential MBS indicators used to assess access may show no improvement because the main access activity of the Division has been to organise transport for low care residents to general practices where non-residential MBS items are used, allowing GPs to concentrate visits to high care residents.

c) Indicators

There are overarching national indicators covering the three key aims of the Initiative. They are:

- Improved access to appropriate medical care for all aged care residents
- Increased participation of GPs in aged care initiatives aimed at improving quality of care
- Undertaking this work in a collaborative way with staff of aged care homes.

i Improved access

A range of information will be used to determine whether access has improved. These include:

- Aged care homes' advice that access to GP services has improved
- Increase in number of GP services provided to residents of aged care homes
- Increase in number of GP services provided to residents as a proportion of aged care beds
- Increase in the number of residential aged care GP services as a ratio to Full Time Equivalent (FTE) GPs
- The age and gender of GPs providing residential aged care services in the Division's region is more comparable with the national average.

The number of aged care homes is increasing in line with the ageing of the population. GP services will need to increase accordingly, in order for access to GP services to be maintained for residents of aged care homes.

In using this data the Department recognises that a number of factors may impact on the ability of the Panel arrangements to deliver change in this area and will take into account contextual information provided in Divisions' reports in assessing performance of the Initiative using MBS data. For example, it is recognised that these indicators will be influenced not only by efforts under the Initiative but also by workforce supply. Account will therefore be taken of movements (either increases or decreases) in workforce, as measured by FTE GPs in the Division. Account will also be taken of factors identified in Divisions reports where these have impacted on performance against these indicators.

Baseline and trend data will be provided to each Division.

ii Increased involvement in aged care homes' quality activities

Key performance measures will be:

- Increase in the proportion of aged care homes that have general practitioner involvement in their quality improvement activities
- Increase in aged care homes' satisfaction with the outcomes of general practitioner involvement in their quality improvement activities.

It is not expected that all aged care homes will show an increase (as a home may not choose to have GP involvement in their quality activities), but the proportion should increase as a result of the Initiative. Account will also be taken of factors identified in Divisions reports where these have impacted on performance against this indicator.

Quality initiatives may be more than quality advisory committees (which are not a requirement for the aged care sector). Where there are quality care committees these may be on a regional or group level.

iii Effective partnerships and collaboration

It is important that the Initiative is implemented and managed in a collaborative way with aged care homes if it is to have maximum effect.

Performance measurement on this dimension will consider:

- Establishment and maintenance of communication and partnerships between general practitioners and aged care homes
- Aged care homes and general practitioners working effectively together to improve access to medical care for residents of aged care homes
- Advice of aged care homes that the Panel is undertaking work to address key concerns.

Divisions will be required to provide information in their reports on establishment and maintenance of communications and partnerships with aged care homes and relevant professionals.

Divisions may establish additional indicators in order to ensure local needs and priorities are also reflected.

iv Other Information

Apart from the above performance information the Department will need to collect information relating to:

- The establishment and management of the Panels by Divisions including:
  - identification of key priorities to address needs within the Division's boundaries
  - an operational Panel
  - transparent and accountable processes for appointment of Panel GPs are established and maintained.
  - the Panel model is built on and amended in light of the Initiative's development.
  - appropriate expenditure of funds has occurred.
- The performance of the ADGP and SBOs
- Its own performance
- The scope and achievements of the Initiative overall
- How well accountability requirements have been met
- Broader policy questions about workforce, access, quality in the residential aged care sector.

15. EVALUATION OF THE INITIATIVE

Evaluation of the Initiative will include assessment of the performance of the Initiative, based on reports provided by Divisions, and ongoing internal Departmental monitoring.

There will be a review by the Department after 12 months of operation to examine:

- the appropriateness of funding models for GP Panel activities and Divisions support activities
- the role of geriatricians
- the general progress of the Initiative.

Further details about this review will be provided closer to the 12 month period.

A formal evaluation will inform Australian Government 2007 Budget considerations specifically with regard to the Initiative. This formal evaluation is likely to be undertaken in the second half of 2006 in order to feed into the May 2007 Budget.

16. ONGOING CONSULTATION PROCESSES

An Advisory Committee was established by the Department to provide advice on implementation of the Initiative. The Committee includes representation from GPs and general practice representative groups, Divisions, consumers, peak groups for aged care providers, aged care nurses and pharmacists. The Advisory Committee provided advice on issues including program scope, performance and funding arrangements.

It is anticipated that the Advisory Committee will have an ongoing role in 2006-07, which may include annual meetings to advise on the resolution or review of relevant aspects of the Initiative.

17. MEDICAL INDEMNITY

The Core Contract under Schedule 1 item E provides the minimum requirements for professional indemnity and vicarious liability cover and should be referred to for clarification.

It is recommended that the **minimum** professional indemnity insurance for Divisions of General Practice, for programs involving clinical work of medical practitioners who are carrying out medical procedures or providing medical advice, is $1million vicarious liability cover. In addition, there are other insurance policies that Divisions are required to hold, as set out in the Transitional Funding Agreement.

As the level of insurance required will depend on the level and coverage of the insurance of participating GPs, Divisions are advised to seek authoritative advice for their individual circumstances.

18. ACCREDITATION

The Initiative will provide an opportunity for aged care homes and GPs to become more familiar with the other's operational environments. For GPs this will include gaining a stronger appreciation of aged care homes' accreditation requirements. For staff of aged care homes this may involve obtaining an increased understanding of professional and service requirements in place for GPs. Divisions will be well placed to assist both GPs and aged care homes to better understand the others working environment.

The accreditation of an aged care home and the Initiative are completely separate. This Initiative does not affect aged care home accreditation.

The current accreditation system is a comprehensive assessment of each residential aged care home against 44 outcomes contained within 4 Accreditation Standards. The Aged Care Standards and Accreditation Agency is the independent body responsible for managing the accreditation and ongoing monitoring of Commonwealth-funded aged care homes. Homes must be accredited by the Aged Care Standards and Accreditation Agency in order to be

eligible to receive Australian Government funding. To meet accreditation standards, services must:

- Provide high quality of care to every resident
- Have a safe physical environment and building
- Be committed to protecting their resident's rights

Service providers must also ensure that they have an adequate number of appropriately qualified staff to residents' needs are met. The standards cover all aspects of residents' needs from health and personal care and safety to a range of lifestyle matters including independence, privacy and dignity. Aged care homes that meet these standards are accredited. Service providers that do not meet these standards may be subject to sanctions. The responsibilities of the providers, including the standards, are set out in the *Aged Care Act 1997*.

The accreditation responsibilities of aged care homes under the current accreditation system will continue under this Initiative. The Panel arrangements will not alter the responsibilities of aged care homes with regard to accreditation.

It is neither the role, nor the intention of the Initiative, for participating GPs to oversee the operation of the aged care home.

GPs working in aged care homes are also required to meet normal professional and services standards.

19. COMPLAINTS MECHANISMS

In the event of a grievance related to the Panel arrangements, the Division, GP and facility manager, as appropriate, might discuss the issues with the parties invovled as a first step. Where the grievance cannot be resolved in this manner, the aggrieved party may make a complaint in writing to a relevant officer within the Division. An independent decision might then be sought from the Division's Board. If the party still considers that the grievance has not been resolved, they may apply in writing to the relevant SBO to have the decision reconsidered. The SBO will work with the Division to identify a solution or independent arbitrator. Where the SBO is unable to identify a solution or independent arbitrator, the SBO may refer the appeal to the Department for advice or resolution.

For complaints which are outside the scope of the Initiative, normal complaints procedures will continue to apply. Broader complaints mechanisms include:

i Aged Care Complaints Resolution Scheme: The *Aged Care Act 1997* sets out what Commonwealth funded aged care facilities must do to receive Government funding. Where a service provider may not be providing the services that they are funded to provide, complaints may be made to the Complaints Resolution Scheme. A complaint may be about any aspect of a Commonwealth funded aged care service that should be provided or made available to people receiving care, such as care, catering, financial matters, hygiene, security, activities, choice, comfort and safety.

ii State/Territory Health Complaints Commissions: These services receive, review and investigate complaints about health care, including those relating to care and treatment provided by GPs and health services and the professional conduct of GPs.

20. ABBREVIATIONS AND DEFINED TERMS

ADGP means Australian Divisions of General Practice.

ACH or Aged care home includes both high care facilities (nursing homes) and low care facilities (hostels) subsidised by the Australian Government. It also includes Multipurpose Services (MPSs) that exist in some rural areas.

CMA means comprehensive medical assessment.

Department means the Australian Government Department of Health and Ageing.

Division means Division of General Practice.

GP means general practitioner

Guidelines means these Guidelines.

HIC means the Health Insurance Commission.

Initiative refers to the MedicarePlus Aged Care GP Panels Initiative.

Initiative address means the address(es) to which all communications to the Department regarding the Initiative are to be addressed as detailed in section 12 of these Guidelines.

MBS means the Medicare Benefits Schedule.

MPS means Multipurpose Service. These services are part of the joint Commonwealth/State Multipurpose Services (MPS) Program which aims to provide a flexible and integrated approach to health and aged care service delivery to small rural communities.

Panels means Aged Care GP Panels described in section 3 of these guidelines.

SBO means the Divisions' State Based Organisation.

PART 2
CONTACT INFORMATION

PART 2: CONTACT INFORMATION

a) The Department

Communications relating to the Initiative should be directed to the relevant State/Territory Office of the Department as identified in the table below.

New South Wales
NSW Manager
Aged Care GP Panels Initiative
GPO Box 9848
SYDNEY NSW 2001
Phone: (02) 9263 3564

Northern Territory
NT Project Manager
Aged Care GP Panels Initiative
GPO Box 9848
DARWIN NT 0801
Phone: (08) 8946 3442

Queensland
QLD Primary Health Care Manager
Aged Care GP Panels Initiative
GPO Box 9848
BRISBANE QLD 4001
Phone: (07) 3360 2956

South Australia
SA Primary Health Care Manager
Aged Care GP Panels Initiative
GPO Box 9848
ADELAIDE SA 5001
Phone: (08) 8237 8050

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

Western Australia
WA Primary Health Manager
Aged Care GP Panels Initiative
GPO Box 9848
PERTH WA 6848
Phone: (08) 9346 5406

Tasmania
Tasmanian Primary Care Program Manager
Aged Care GP Panels Initiative
GPO Box 9848
HOBART TAS 7001
Phone: (03) 6221 1477

ACT
ACT Program Manager
Aged Care GP Panels Initiative
GPO Box 9848
CANBERRA ACT 2601
Phone: (02) 6274 5153

b) SBO and ADGP Contacts

Information and support relating to implementation and management of the Initiative may also be obtained from the Divisional organisations listed below.

Australian Division of General Practice
PO Box 4308
MANUKA ACT 2603
Phone: (02) 6228 0821

Alliance of NSW Divisions of General Practice
GPO Box 5433
SYDNEY NSW 2001
Phone: (02) 9263 3564

Queensland Divisions of General Practice
PO Box 85
KELVIN GROVE QLD 4056
Phone: (07) 3360 2956

General Practice Divisions Victoria
Level 1
458 Swanston Street
CARLTON VIC 3053
Phone: (03) 9665 8906

General Practice and Primary Health Care Northern Territory
GPO Box 2562
DARWIN NT 0801
Phone: (08) 8946 3435

General Practice Divisions Western Australia Ltd
PO Box 6115
EAST PERTH WA 6892
Phone: (08) 9346 5430

SA Divisions of General Practice
1st Floor
66 Greenhill Road
WAYVILLE SA 5034
Phone: (08) 8237 8319

ACT Division of General Practice
PO Box 3571
WESTON ACT 2611
Phone: (02) 6287 8099

Tasmanian General Practice Divisions Ltd.
GPO Box 1827
HOBART TAS 7001
Phone: (03) 6221 1500

c) Aged Care Contacts

Information and support relating to implementation and management of the Initiative may be obtained from the aged care sector organisations listed below.

National Level Organisations

GERIACTION Inc.
Suite 308, 282 Victoria Avenue
Chatswood NSW 2067
Phone: (02) 9412 2145

Australian Nursing Homes and Extended Care Association (ANHECA)
PO Box 335
Curtin ACT 2605
Phone: (02) 6285 2615

Aged and Community Services Australia (ACSA)
Level One, 36 Albert Road
South Melbourne VIC 3205
Phone: (03) 9686 3460

State Offices of Australian Nursing Homes and Extended Care Association (ANHECA)

ANHECA NSW
PO Box 7
STRAWBERRY HILLS NSW 2012
Phone: (02) 9212 6922
Fax: (02) 9212 3488
Email: admin@anheca.com.au

Aged Care Association of Victoria
2/1949 Malvern Road,
MALVERN EAST VIC 3145
Phone: (03) 9885 0388
Fax: (03) 9885 0347
Email: agedcare@agedcarevic.com.au

ANHECA SA
Unit 5,
259 Glen Osmond Road
FREWVILLE SA 5063
Phone: (08) 8338 6500
Fax: (08) 8338 6511
Email: anhecasa@senet.com.au

ANHECA WA
PO Box 8209, Angelo Street
SOUTH PERTH WA 6151
Phone: (08) 9474 9200
Fax: (08) 9474 9300
Email: anhecawa@iinet.net.au

ANHECA Tasmania
Cosgrove Park Nursing Home
PO Box 198
KINGS MEADOW TAS 7249
Phone: (03) 6344 5701
Fax: (03) 6343 1035
Email: rarcher@parkgroup.com.au

Aged Care Queensland
PO Box 995
INDOOROOPILLY QLD 4068
Phone: (07) 3715 8177
Fax: (07) 3715 8166
Email: acqi@acqi.org.au

State Offices of Aged and Community Services Australia (ACSA)

Victorian Association of Health & Extend Care (VAHEC)
Level 3, 450 St Kilda Road
MELBOURNE VIC 3004
Phone: (03) 9820 0888
Fax (03) 9804 5133
Email: karenL@vahec.com.au

Aged and Community Services Association NSW/ACT
Level 1, 391 Liverpool Road
ASHFIELD NSE 2131
Phone: (02) 9799 0900
Fax: (02) 9799 0800
Email: jillp@agedservices.asn.au

Aged and Community Services Tasmania
Thirza Cottage
27 Kirksway Place
BATTERY POINT TAS 7004
Phone: (03) 6231 1788
Fax (03) 6223 3299
Email: graeme.a@beyondpr.com.au

Aged and Community Services SA/NT
246 Glen Osmond Road
FULLARTON SA 5063
Phone: (08) 8338 7111
Fax: (08) 8338 7077
Email: residential@agedcommunity.asn.au

Aged Care Queensland
PO Box 995
INDOOROOPILLY QLD 4074
Phone: (07) 3715 8177
Fax (07) 3715 8166
Email: PamB@acqi.org.au

Aged and Community Services WA
Suite 3, 59 Walters Drive
OSBOURNE PARK WA 6017
Phone: (08) 9443 8233
Fax: (08) 9443 8933
Email: helen@acwa.com.au

d) Complaints Mechanisms Contacts

Complaints outside the scope of this Initiative may be addressed to:

- Aged Care Complaints Resolution Scheme: Complaints about any aspect of a Commonwealth funded aged care service that should be provided or made available to people receiving care, such as care, catering, financial matters, hygiene, security, activities, choice, comfort and safety.
- State/Territory Health Complaints Commissions: Complaints about health care, including those relating to care and treatment provided by GPs and health services and the professional conduct of GPs.

Aged Care Complaints Resolution Scheme
C/- Department of Health and Ageing
GPO Box 9848
In your Capital City.
Freecall: 1800 550 552

State/Territory Complaints Organisations

Tasmania
Health Complaints Commissioner
Ground Floor, 99 Bathurst St
Hobart TAS 7000
Phone: (03) 6233 6348
Freecall: 1800 001 170
Email: health.complaints@justice.tas.gov.au

Australian Capital Territory
Community and Health Services Complaints Commissioner
1 Moore St
Canberra City 2601
Phone: (02) 6205 2222

Victoria
Health Services Commissioner
30th Floor/ 570 Bourke St
Melbourne VIC 3000
Phone: (03) 8601 5200
Freecall: 1800 136 066
Internet: www.health.vic.gov.au/hsc

New South Wales
Health Care Complaints Commission
LMB 18, Strawberry Hills NSW 2010
Phone: (02) 9219 7444
Free: 1800 043 159
Internet: www.hccc.nsw.gov.au
Email: hccc@hccc.nsw.gov.au

Western Australia
Office of Health Review
St Martins Tower Level 17,
44 St Georges Terrace
Perth WA 6000
Phone: (08) 9323 0600
Freecall: 1800 813 583
Internet: www.healthreview.wa.gov.au

Northern Territory
Health and Community Services Complaints Commission
GPO Box 1344
Darwin NT 0801
Phone: (08) 8999 1969
Internet: www.omb-hcscc.nt.gov.au

South Australia
Ombudsman (STATE)
East Wing, 5th Floor, 50 Grenfell St
Adelaide SA 5000
Phone: (08) 8226 8699
Freecall: 1800 182 150
Email: ombudsman@agd.sa.gov.au
Internet: www.tio.com.au

Queensland
Health Rights Commission
Level 19, 288 Edward St
Brisbane QLD 4000
Phone: (07) 3234 0272
Freecall: 1800 077 308

PART 3

RELATED INITIATIVES

PART 3: RELATED INITIATIVES

The following information on related initiatives is current as at June 2004.

a) Related Medicare Initiatives

i Comprehensive Medical Assessment

The CMA, which is being implemented in conjunction with the Initiative, complements the Initiative. Both Initiatives will be funded from 1 July 2004.

The aims of the CMA are very closely aligned with those of the Initiative. The CMA aims to improve access to medical care and also improve the quality of care provided to residents by enabling doctors to better assess a resident's health care needs and provide important information for their care planning and medication management.

The CMA involves the introduction of a Medicare Benefits Schedule (MBS) item to enable medical practitioners (including GPs but not including specialists or consultant physicians) to undertake Comprehensive Medical Assessments (CMAs) of new and existing residents (if required) of aged care homes.

The CMA does this by encouraging medical practitioners, through access to a new Medicare Benefits Schedule item, to undertake a comprehensive medical assessment of a patient in an aged care home.

The CMA will be voluntary services available to:
- New residents on admission to an aged care home; and
- Existing residents on an 'as required' basis, where it is required in the opinion of the resident's medical practitioner, for instance, because of a significant change in medical condition, physical and/or psychological function requiring a CMA.

The CMA will involve a personal attendance by the resident's usual GP to undertake a full systems review that includes an assessment of the resident's current health and physical and psychological function. Medicare Benefits will be payable for a maximum of one CMA per resident in any twelve-month period.

ii Enhanced Primary Care

In November 1999 the Federal Government introduced a range of Medicare items intended to:
- provide more preventive care for older Australians; and
- improve care coordination between general practitioners and health and other professionals providing care for people of any age with chronic conditions and complex care needs.

The Enhanced Primary Care (EPC) Medicare Items provide a framework for a multidisciplinary approach to health care through a more flexible, efficient and responsive match between care recipients' needs and services.
There are 28 EPC Items on the MBS. These items cover:

- Health Assessments for people aged 75 + over
- (55 + over for Aboriginal and Torres Strait Islander people in recognition of their specific health needs);
- Multidisciplinary care planning; and
- Multidisciplinary case conferencing.

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

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

iii More doctors and practice nurses

There is also a commitment under Medicare to add the equivalent of more than 1,500 doctors to the medical workforce and support about 1,600 nurses to work in general practice. This will complement the Initiative by assisting to improve access to GPs for all Australians, including residents of aged care homes.

The Australian Government has also introduced programs and incentives to encourage the redistribution of GPs to areas of workforce shortage, particularly to rural and outer metropolitan areas, to improve overall access to GPs.

Further information on related Medicare initiatives can be found on the Department's website at www.health.gov.au or by calling the hotline on 1800 011 163 (free call).

b) Department of Health and Ageing Initiatives

i Investing in Australia's Aged Care: More Places, Better Care

The Initiative will also be supported by a number of aged care measures, including the introduction, as part of the 2004-05 Budget, a $2.2 billion package, *Investing in Australia's Aged Care: More Places, Better Care*, which builds on previous reforms by providing further support for older Australians needing care, while encouraging aged care providers to become more flexible, accountable and innovative in the delivery of care.

The package improves significantly the capacity of aged care providers to deliver high quality care. The Initiatives also encourage improvements in management practices and increased efficiencies.

Further information on the Investing in Australia's Aged Care: More Places, Better Care measures can be found on the Department's website at www.health.gov.au or by calling the hotline on 1800 500 853 (free call).

ii Documentation Working Group

A Documentation Working Group has been established by the Department of Health and Ageing to undertake the work required to develop a national model of care document with an evidence-based assessment component. This Working Group is chaired by Professor Alan

Pearson, with representation from industry stakeholders and the Department. The documentation system developed will be voluntary and access will be available to any aged care home. Draft documentation was developed and trialed for a period of 3 months from June 2003. Feed back from the pilot sites has been considered by the Working Group. A report of the trial is available on the website at www.ageing.health.gov.au/reports/framework.htm

iii Clinical IT in Aged Care Project

The Clinical IT in Aged Care Project has been initiated by the Department to investigate how clinical IT applications or tools can support and improve quality and effectiveness of care in residential aged care. The first stage of the project has been completed. An interim report is on the Department's website http://www.ageing.health.gov.au/rescare/clinitrep.htm. The second stage will consist of further identification and research into IT applications and other relevant projects with potential to improve the quality of care in aged care homes. It will involve evaluation of IT applications for trial. The Product Trials Guidelines have been available on the website http://www.ageing.health.gov.au/rescare/clinitfly.htm since early December 2003. Applications closed on 6 February 2004.

iv Guidelines for a Palliative Approach in Residential Aged Care

The Department of Health and Ageing commissioned the development of *Guidelines for a Palliative Approach in Residential Aged Care* under the National Palliative Care Program. These guidelines are intended to help all practitioners of the aged care team in applying a palliative approach in the residential aged care setting for older people with a life-limiting illness or who are dying as a consequence of the ageing process. The guidelines cover all aspects of providing a palliative approach for a resident , from physical symptoms, through spiritual needs to the reactions of family members. They are designed to prompt creative solutions that will be appropriate in an aged care home. They may also be used to identify strengths and weaknesses of the approach being taken and provide a mechanism for change and evaluation over time. The guidelines are evidence-based and were developed on the principles for guideline development as outlined by the NHMRC. The Guidelines will be available from July 2004.

v Post-Graduate Applied Gerontology and Palliative Care Education Project

The Department of Health and Ageing contracted Flinders University (FU) to develop a new web-based postgraduate education program in combined Gerontology and Palliative Care. The new courses are designed for nurses, allied health professionals and general practitioners. They consist of a web based Graduate Certificate and Graduate Diploma available on a part-time or full-time study basis. The first course commenced in Semester 1 (Feb-March) 2004.

vi Australian Pharmaceutical Advisory Council Medication Management Guidelines

The Australian Pharmaceutical Advisory Council have developed *Guidelines For Medication Management In Residential Aged Care Facilities.* These guidelines are not intended to prescribe general professional standards, nor processes relating to those outcome standards concerned with medication management in residential aged care facilities. They aim to ensure that implementation of individual professional standards is encouraged in a multidisciplinary manner which will facilitate quality outcomes for residents. This requires a closer interaction between all stakeholders and the guidelines recommend ways in which this will be achieved. These guidelines are available on the Department's website at www.nmp.health.gov.au

vii Royal Australian College of General Practitioners (RACGP) Guide for Care of Older Persons

The RACGPs *Medical Care of Older Persons in Residential Aged Care Facilities (the Silver Book)* publication provides a guide for GPs on how to care for residents of aged care homes.

The Department is negotiating with the RACGP to update the Silver Book to reflect recent development, including this Initiative.

A number of the RACGPs publications are available on its website at www.racgp.org.au/publications

c) Aged Care Homes Initiatives

i Royal Freemason Homes (Victoria)

Freemason Homes have established a panel of visiting medical officers (VMO) to provide appropriate services for their aged care homes, within specific agreed guidelines. These arrangements have led to improved coordination and support for GPs. Key features include:

- VMOs accompanied and assisted by a carer/nurse to the residents room;
- medical notes and medications charts kept in a cental and accessible location;
- coinciding VMO visits with pharmacist visits;
- residents given the choice of doctor from the panel;
- all health professionals use the same file; and
- regular meetings and medication audits.

ii Montefiore Homes (Victoria)

Have also established GP Panels.

iii Mary Ogilvie House (Tasmania)

Has engaged a geriatrician for a session/week to improve clinical governance and clinical care for residents. This has included up-skilling sessions for staff members and advisory input to specific areas, for example falls prevention and pain management.

PART 4

POSSIBLE MODELS AND DIVISIONAL EXAMPLES

PART 4: POSSIBLE MODELS AND DIVISIONAL EXAMPLES

The following models and Divisional examples have been provided by the ADGP. Links to further information on aged care initiatives and updates are available on the ADGP's website at www.adgp.com.au

a) Possible Models

The following provides possible models that Divisions, in consultation with their aged care homes and GPs, might consider adapting for the purposes of this Initiative. These models are not intended to be an exhaustive list, and the models included in this information are not mutually exclusive.

i Model One – The GP Facility Adviser Model

In this model, the individual GP member of the Aged Care GP Panel is assigned to an aged care facility to provide advice and services (including medical services to residents who do not have a usual GP), as agreed between the GP and the aged care facility. In this model, a patient's usual GP would continue to provide care to them where possible, to ensure choice of GP is available to all residents of the aged care facility. In this model, the individual GP member could participate in the aged care homes quality improvement activities, medication advisory committees or attend other meetings or provide other advice as required and agreed.

This model could remunerate the Aged Care GP Panel member through a retainer payment for the advice and services. The remuneration is not for the direct provision of the clinical service as this will be claimable through the MBS as per the GPs usual arrangements.

ii Model Two – Regional Aged Care GP Panel Model.

In this model, rather than having the Aged Care GP Panel at the Divisional level, in some areas there may be value in considering a regional Aged Care GP Panel where Divisions agree to have joint arrangements. This regional panel could be comprised of GPs selected by individual Divisions. The coordination, liaison and work such as development of protocols would happen at a region level. This regional panel could elect to do any number of activities within the broad parameters of the Initiative, with this model overcoming potential disadvantages of operating in isolation.

iii Model Three – GP Liaison Officer Model.

In this model, each aged care home would have a nominated Aged Care GP Panel member who liaises with the aged care home. The Aged Care GP Panel member reports back to Aged Care GP Panel meetings where protocols and strategies could be developed. Following the development of Division wide protocols and strategies, (initially agreed in principle with the aged care homes in the Division), the nominated panel member would liaise and work with the aged care homes to implement the Division wide strategies and protocols.

In this model, the Division could be responsible for coordinating and providing support to the panel in the development of these protocols and strategies.

iv Model Four – Aged Care GP Panel Network Model.

In this model, the Aged Care GP Panel members participate in a quarterly meeting with the Directors of Nursing of aged care homes and other interested stakeholders to provide feedback and discuss resolutions to barriers to accessing GP services in aged care facilities. Following these network meetings, the Aged Care GP Panel could be asked to develop and implement solutions to the identified issues within their sphere of influence.

GPs that participate in these meeting could be paid either an hourly or daily rate for their attendance. To complement this model, a retainer payment could be paid to some GPs who also elect to make themselves available to take on new patients where that resident does not have a usual GP.

b) Divisional Examples

The following provides information on work being undertaken by Divisions, including examples of models already in use in Divisions. This information is intended to provide some guidance to possible issues and arrangements which might be considered under this Initiative.

New South Wales

i Hastings Macleay Division of General Practice

Catholic Care of the Aged Project (CCA)
CCA was an innovative project that utilised the services of a GP to approximately 500 patients in the Port Macquarie area in residential aged care homes. The GP was paid a retainer to visit patients without a full time or usual GP. The GP was also invited to be a member of the patient care review committee, the medication review committee and act as a liaison officer to the Division of General Practice and other GP colleagues.

Nursing Home Liaison Project
This project was funded under the National Innovations Funding Pool program in 1999 and sought to address an ongoing problem of the breakdown in communication between GPs and aged care homes to improve the care of residents. The project worked with seven aged care homes in the Division catchment area on issues of uniformity in documentation, establishment of a clinical service agreement, medication reviews and establishment of a continuation program called "Link"

For more details: Hastings Macleay Division of General Practice
Tel: 02 6583 3600
http://www.hmdgp.org.au

ii Macarthur Division of General Practice

The Macarthur Division of General Practice instituted a collaborative approach to Aged Care early in 2003. The main aim was to enable relevant parties to share information and where possible address issues effecting the care of older people. To date this forum has achieved

- Single referral process to the Aged Care Psychologists in Macarthur
- Provided education on dementia/delirium screening including base line tests and
- Reviewed data of Nursing Home presentations to Emergency Departments in Macarthur.

The next phase of this group is to address patient flow between Nursing Homes and Hospitals and to develop strategies that will address the issue of consistent documentation in Nursing Homes.

For more details: Macarthur Division of General Practice
Tel: (02) 4625 9522
www.shiregps.org.au

iii Sutherland Division of General Practice

The Sutherland Division of General Practice's Aged Care Program commenced in July 2002 in response to a need identified by GPs during a consultative meeting in early 2002. The goal of the program is to enhance resident care outcomes by improving the interface between General Practitioners (GPs) and Residential Aged Care Facilities (RACFs), specialists, consumers and other community aged care service providers.

The program's first year focused on building relationships with key partners. An Aged Care Advisory Committee (ACAC) was established to enable the development of partnerships. This provided the opportunity to work collaboratively on issue identification with an integrated approach to implementation and evaluation of strategies.

Program Achievements
- Networks established key groups e.g. other Divisions, ADGP, SESAHS, NSW Health, ANHECA, ACSA and DHAC
- Comprehensive needs analysis conducted including a literature review, focus groups and data from annual GP survey which identified 29 areas for action
- 10 key recommendations identified with work commenced on 6
- The ongoing commitment of the ACAC
- 22 GPs have also taken up the Dementia for GPs CD-Rom
- Successful combined education forum
- Formal communication strategy between Divisions and RACFs
- Presentation at Alliance Conference

Future Directions
The Division's Aged Care Program's future direction is about making further inroads by:

- *Medical Director Pilot*. The six month MD pilot will commence in the near future in four RACFs with 27 GPs registered to participate. Formal agreements have been established between HCN, the Division and the RACFs. Modifications to the MD software for RACFs are expected to improve efficiencies for both the visiting GPs and RACF providers.
- *Memorandum of Understanding.* Development of a generic MoU between GPs and RACFs that will clearly outlines roles and responsibilities of both partners to assist them to work better together.
- *Sectorising* will provide an opportunity for GPs to streamline service provision. GPs will nominate the RACFs in which they wish to service in their area which will reduce the number of facilities that the GPs visit, thus reducing travel time, and provide opportunity for the GPs and RACFs to build better relations and develop efficient and effective systems and processes.

For more details: Sutherland Division of General Practice
Tel: (02) 9525 4011
www.shiregps.org.au

Queensland

i Brisbane North Division of General Practice

The Brisbane North Division of General Practice was funded under the Department of Health and Ageing National Innovations Funding Pool to carry out a project titled "The involvement of GPs in multi-disciplinary care planning and case conferencing in nursing homes". The Division was funded in June 2000. In November 2000 MBS introduced several new items in relation to case conferencing and care planning in residential aged care facilities. The project took a new focus to increase the number of GPs working in residential facilities by testing a GP Assessment of Resident's Health Form. The project concluded in December 2002 with the final report completed in February 2003. While the results did not demonstrate a significant increase in the quality of care for residents who received a comprehensive health assessment, the project resulted in the development of health assessment forms and has led to further consideration of quality care issues in aged care for the Division.

For more details: Brisbane North Division of General Practice
Tel: (07) 3630 7300
www.gndgp.com.au

ii Brisbane South Division of General Practice

Brisbane South Division of General Practice is working on improving the communication and information sharing links between all service providers i.e., GPs, nursing homes and respite care. They are using the government preferred encryption and encoding technology public key infrastructure (PKI) in order to improve the communication and information sharing links between all service providers including GPs, hospitals, nursing homes and respite care.

For more details: Brisbane South Division of General Practice
Tel: (07) 3274 1886
www.bsdgp.com.au

iii Gold Coast Division of General Practice

Is currently developing models/approaches to integrating GPs into hospital discharge processes.

For more details: Gold Coast Division of General Practice
Tel: (07) 5526 2966
www.gcdgp.com.au

iv Toowoomba and District Division of General Practice

The Toowoomba Division has been active in aged care programs for several years and assists and supports the Older Person's Interest Group (OPIG). OPIG aims to bring together individuals and services who have a common interest in the well-being and care of older person's in our community.

The Division has surveyed GPs and information suggests that a focus on streamlining the number of GPs visiting each home may be most beneficial. The Division has undertaken work to further develop a possible model.

For more details: Toowoomba and District Division of General Practice
Tel: (07) 4633 0131
www.tddgp.com.au

v Townsville Division of General Practice

Has a focus on integration, including a general practice liaison officer (GPLO) position and GPLO committee to support ongoing liaison with aged care services.

For more details: Townsville Division of General Practice
Tel: (07) 4725 8915
www.tdgp.com.au

vi Wide Bay Division of General Practice

The Wide Bay Division of General Practice has had a specific aged care program since 2002 and has pursued a range of activities under this program. Some of the key activities are listed below.

Inter-facility Aged Care Forums
Forums have been established in Hervey Bay, Maryborough and Bundaberg to address issues related to GPs and provision of high quality health services to older people. The membership of these forums changes according to the issue being addressed at any given time. Issues addressed so far have centred around residential aged care facilities and in particular the timely provision of regular medications. As a result of discussion and negotiation between GPs, RACFs and Pharmacists a standardised system for prescription requests has been developed and implemented in Hervey Bay and Maryborough. It is anticipated that a similar system will be adopted in Bundaberg as well in the coming months.

Regional Dementia Forum
The Division is an active member of the Regional Dementia Forum and we are currently working with this group in the final stages of development of a document that can be integrated into medical software to be printed out by GPs and given to patients or carers of patients who have been diagnosed with dementia. The document contains local information and contact details as well as general information and aims to encourage early contact with service providers so that support structures can be prepared rather than contact only during crisis.

GP Call Out form for Residential Aged Care Facilities
In cooperation with GPs and RACFs a standardised call out form has been developed for RACFs to complete prior to calling out a GP to attend a patient. The form provides the basic information that GPs identified that they wanted to know and allows for recording of GP response/instructions. Originally designed to be used for after hours call outs, the form has been found to be useful during GP surgery hours as well. The form is also used as a communication tool as a copy of the completed form is forwarded to the patient's regular GP where another "on call" GP has attended.

For more details: Wide Bay Division of General Practice
Ph: (07) 4151 0814
www.widebaydgp.org.au

South Australia

i Adelaide North Eastern Division of General Practice

The Adelaide North Eastern Division of General Practice has been active in working with aged care homes for some time, including: establishing an Aged Care Subcommittee; holding aged care forums; funding GPs to participate in Medication Advisory Committees and providing education for GPs and practice staff about aged care issues. A recent project, undertaken with the University of South Australia and the Helping Hand Ingle Farm aged care home, has implemented computerised medication management with a number of positive outcomes including a 30% reduction in medication incidents in the first 12 months.

For more details: Adelaide North East Division
Tel: (08) 8396 4511
www.anedgp.com.au

Tasmania

i GP North Division of General Practice

A Forum of stakeholders, including residential care facilities, GPs and Pharmacists was held in March 2002. Priority issues were identified and the outcomes to date are as follows:

- GP participation on Medications Advisory Committees. GPs may claim remuneration for attendances from GP North.
- Introduction of single long-term medication chart throughout divisional Aged Community ie. RCFs, Community Health, Veteran's Affairs, discharge from hospitals to the community and Group Homes – **Currently being implemented.** Divisional support in reduction of costs for facilities in purchase of charts (purchased in bulk) and in the provision of technical support.
- Exploring successful systems for obtaining repeat prescription requests from pharmacist to GPs and the subsequent distribution of successful form development to all pharmacists in divisional area.

For more details: GP North Division (Tasmania)
Tel: (03) 6331 9296
www.gpnorth.com.au

ii North West Tasmania Division of General Practice

The North West Tasmania Division of General Practice uses a model that allows contributing GPs to engage with Aged Care Facility (ACF) governance to improve service delivery processes and health outcomes for residents in ACFs.

A regular collaborative meeting between Ulverstone GPs and senior staff from aged care homes has been established. It provides a platform from which to address systemic issues and is comprised of*:* DONs and section heads of the 4 Ulverstone ACFs, GPs attending ACFs,

Pharmacists, invited guests (dementia support worker, ACAT , psychogeriatrician, acute care in the home program). Bi-monthly breakfast meetings are conducted lasting about 1 hour.

Some of the Issues Addressed include:

- Drug chart format, including transition to electronic format
- Drug chart renewal protocol
- Accessing authority scripts
- Electronic communication with practices to access database remotely
- Protocol for nurse initiated medications
- Assessment of the confused patient
- Admission procedures
  - Timelines for admission
  - Assessment protocol based on bests practice models
  - Surgery based assessment of new patients with their families wherever possible
- Death certification procedures
- Emergency drug availability
- Acute care in the home program (IV antibiotics and transfusions in the NH)
- Improving care for patients with dementia
  - Assessment protocol in accordance with evidence based best practice care
  - Involvement of dementia support worker in training of staff, management of patients through case conferencing
  - Lobby ACF executives for increased staffing levels
  - Regular MMSE on patients to assist in RCF classification
- Trouble shooting any issues

Building relationships has been an important part of the success of this Initiative, allowing a true *partnership* approach. The vision of the Division has allowed this Initiative to progress. This model provides a platform for the coordination of other initiatives such as DMMR, EPC.

For more details: North West Tasmania Division of General Practice Inc.
Tel: (03) 6432 1440
www.nwtasdgp.com.au

Victoria

i Bendigo Division of General Practice

Bendigo Division of General Practice is working to improve medication management through consultation with aged care homes.

For more details: Bendigo Division of General Practice
Tel: (03) 5441 7806
www.bgodivgp.org.au

ii Dandenong & District Division of General Practice

The Dandenong Division has developed an Aged Care committee to examine pertinent issues affecting GPs, Aged Care Homes and specialists integration/interface in the Aged Care Sector.

Outcome

- A formalised relationship between local aged care facilities and the Division.
- Improved quality of documentation, communication and medication prescribing between GPs and the aged care facilities.
- Appropriate and supported GP involvement in Residential Aged Care facilities.
- More efficient processes concerning GP/Aged Care integration.

Activity

- Establish collaborative linkages with the Aged Care sector to pursue a range of issues relating to GP/Aged Care integration.
- Establish a working group with representation from GPs, RACF's, Pharmacists, Consumer and relevant Divisional staff.
- Investigate and pilot electronic models for use by GPs in aged care facilities.
- Facilitate processes around care planning & case conferencing to both GPs and RACF's.

Indicators

- Relationships with Aged Care facilities established.
- Increased formal care planning & case conferencing. (EPC utilisation).
- Working group meets monthly with 90% attendance rate.
- Electronic model/s implemented and tried.

For more details: Dandenong & District Division of General Practice
Tel: (03) 9706 7311
www.dddgp.com.au

iii Greater South Eastern Division of General Practice

The Greater South Eastern Division of General Practice (GSED) has been running an Aged Care Program for five years. Initial planning meetings raised many and varying problems in aged care in our local area.

As a result of these meetings GSED established a Regional Medical Advisory Committee (RMAC) and a Regional Medication Advisory Committee (ReMAC), in order to liaise, address and solve many of the problems, which were identified.

At our last GSED Aged Care Committee meeting, and as announced at the recent *Advances in Wound Management* CPD session, we had intended to schedule two such meetings in 2004, but now there may well be more.

For more details: Greater South Eastern Division of General Practice
Tel: (03) 9569 5077
www.gsedgp.com.au

iv North West Melbourne Division of General Practice

This project is being undertaken as part of the After Hours Primary Medical Care Trials and is due for completion in December 2004. The Project will develop and implement four key strategies for improving after hours care to residents of aged care homes in the area:

- an aged care home/Service Provider Partnership Strategy to provide more effective communication, consensus and sustainable working arrangements;
- a standardised Patient Information Sheet;

- Acute Care Plans, aiming to facilitate decision making for residents requiring care after hours; and
- standard protocols to guide staff and service providers in aged care home initiated assessment, triage and referral and local symptom and disease management after hours.

The Project is developing a GP Residential Care Kit, an Aged Care Home After Hours Kit and tools including: a Patient Summary & Care Plan,; a Quick Guide for installing the Patient Summary onto Medical Director; and a Guide to EPC Item Numbers.

More information, including after hours primary medical care kits, is available on the North West Melbourne Division of General Practice website under resources and information

For more details: North West Melbourne Division of General Practice
Tel: (03) 8345 5600
www.nwmdgp.org.au

v West Victoria Division of General Practice

This project is part of a larger joint venture, which seeks to improve the quality of care to residents through the active engagement of health professionals, aged care providers and staff in quality improvement activities.

In March 2001 the Department of Veterans' Affairs (DVA) and the Department of Health and Ageing (DoHA) agreed to jointly fund a consultant to research and advise on an appropriate strategy for piloting quality committees in aged care facilities.

The Objectives were to:
1. Develop a system to assist aged care facilities to minimize the risk of adverse events and improve safety and quality of care. This may involve an incident monitoring system that identified and reports incidents and implements appropriate processes with a view to preventing their re-occurrence.
2. Research and develop strategies that assist aged care facilities to meet accreditation processes through participation in incident reporting and quality committee programs.
3. Research and develop a multidisciplinary quality of care committee (RQCC) to discuss and develop recommendations.
4. Develop appropriate systems for dissemination of recommendations to participating aged high care facilities, including protocols and pathways for best practice.

The project outcomes
1. A regional quality committee was established that included representatives from three aged care facilities, a local GP and a consumer representative.

2. The quality committee has met 5 times. The main focus being dementia management and medication management with case studies concentrating on these issues.

3. Sharing case studies and brain storming strategies. Members were encouraged to present written case studies on quality issues and these were presented and the committee offered advice and links to expert knowledge.

4. Setting up a regional network for unit/middle managers. Peer managerial support emerged as an immediate need as many managers work in profession isolation and used their peers in the group to discuss issues around documentation, accreditation and staff management.

5. Provision of expert advice, for example pharmacists, GP and psychiatric services. The Division was able seek expert advice through email and resource and facilitate allied health, GP or consultant attendance at the meetings. This allowed local facilities to establish networking opportunities and discussions on quality free of the workplace and the sometimes complex relationships of local relationships. As a result the agencies reported improved health care for 3 residents following medication advice.

6. Trial of a quality assurance model for residents with dementia (ReBOC), as dementia was an area discussed. Agencies trialed ReBOC which promoted the quality improvement cycle.

The simplicity of the model acknowledges that the most important needs of these agencies is a network that can respond to immediate needs and one that provides a growing sense of a regional approach and is developing a culture of openly sharing areas that need addressing under a quality framework.

The challenge for the Division, throughout this project, was to provide
- a professional environment that encourages the disclosure of concerns around patient care and
- support to facilitate practical and relevant interventions.

Proposal
At the current proposed level of funding the project is expected to deliver the following;
- A regional quality committee,
- Broad based stakeholder input
- Specific case based issue analysis
- A platform for the sharing of common concerns and suggested solutions

Further consideration is required for the refinement of the quality process, this includes;
- incident and event detection,
- data management,
- process analysis,
- intervention design and implementation.

Evaluation
Information was collected from each participating facility as in line with the work conducted by Elizabeth Percival. The methods of collection included an interview and pre- RQCC establishment questionnaire.

For more details: West Victoria Division of General Practice Inc
Tel: (03) 5381 1756
www.westvicdiv.asn.au

Western Australia

i Canning Division of General Practice

Canning Division in association with the Perth & Hills Division of General Practice, and the Western Australian Government Department of Health has developed a training program for General Practitioners and aged care industry workers.

The program "Managing Care in the Elderly: A Training Program for General Practitioners" has been developed as one of a range of strategies to support GPs providing care to the elderly and/or working in Aged Care Facilities. The program provides a focus is on multidisciplinary, holistic care and a pro-active approach to maintaining the independence of elderly people in the community. General Practitioners will further their skills in the management of elderly patients with complex care needs including those whose health may warrant a palliative approach to care.

Division coordination
Divisions will be funded to appoint a dedicated staff member to provide coordination and support to GPs working in Residential Aged Care.

The Division Aged Care Coordinator will:
- provide support to the Aged Care Liaison GPs;
- establish a local Aged Care GP Network;
- co-ordinate local Network meetings, professional development for GPs and multidisciplinary case study meetings;
- liaise with Aged Care Facilities (ACFs), area health services and relevant agencies;
- map current service delivery arrangements and gaps in services;
- map the GP workforce attending ACFs and monitor access to primary medical care by residents in ACFs;
- develop processes to facilitate the uptake of Comprehensive Medical Assessments (CMAs) by GPs;
- assist in the development of quality improvement initiatives to optimise the delivery of primary medical care in ACFs; and
- provide the secretariat to the Aged Care Panel.

Aged Care Liaison GPs
Aged Care Liaison GPs would be contracted by the Division on a sessional or hourly basis and attached to groups of geographically located Aged Care Facilities.

The selection criteria for an Aged Care Liaison GP would include:
- Registered medical practitioner with RACGP fellowship in general practice;
- Currently working in an Aged Care Facility (or recent experience);
- High level communication skills with demonstrated ability to communicate with GPs, geriatricians, a range of health professionals and ACF administrators;
- Ability to facilitate GP and multidisciplinary meetings;
- High level organisational skills

A pool of hours would be allocated to each Division based on the number of ACFs and attending GPs in the region. Remuneration would be at Division rates of $120 per hour indexed to CPI. The funding allocation would determine the number of Liaison GPs appointed and the number of sessions.

The role of the Aged Care Liaison GPs would be non-clinical and include to:

- Liaise with GPs and clinical staff working in ACFs;
- Assist the Division to establish a local Aged Care GP network of GPs working in ACFs and coordinate network meetings;
- Assist the Division to identify the educational and professional needs of GPs in ACFs and coordinate a professional development program including multidisciplinary case study meetings;
- In conjunction with the local Aged Care GP network assist the Division to identify strategies to:
    - optimise the delivery of primary medical care in ACFs;
    - enhance communication processes between ACFs and attending GPs;
- In consultation with GPs provide advice to ACFs on the development of protocols of care and quality improvement initiatives;
- Promote working in Aged Care including Residential Aged Care to GPs;
- Represent GPs attending ACFs and the Division on the Aged Care Panel.

Aged Care Panel
A multidisciplinary Aged Care Panel would be established for the region with membership consisting of Aged Care Liaison GPs, a Geriatrician nominated by the area health service, 2 Directors of Nursing nominated by the ACF network, a representative from the Carers Association, local representatives from both Aged and Community Care Services WA (ACCSWA) and Australian Nursing Home and Extended Care Association of WA (ANHECA).

The role of the Aged Care Panel would include to ***provide strategic advice:***

- to enhance access to primary medical care for residents of aged care facilities;
- identify gaps in clinical care and make recommendations to -address these;
- contribute to a regional plan for primary medical care for residents in Aged Care Facilities.

The Division Aged Care Coordinator will provide the secretariat to the Aged Care Panel.

For more details: Canning Division of General Practice
Tel: (08) 9458 0505
www.canningdivision.com.au

ii Osbourne Division of General Practice

With funding through the WA Department of Health, Osbourne Division has undertaken a needs assessment in consultation with GPs, aged care providers and allied health professionals and developed a model for enhanced primary care in aged care homes. The model is based on enhancing existing service provision, coordinating the service providers into a multidisciplinary team and enhancing communication with the other sectors/agencies working in the industry.

For more details: Osborne Division of General Practice
Tel: (08) 9376 9200
www.odgp.com.au

iii Perth and Hills Division of General Practic

The Perth and Hills Division of General Practice has recently employed a Program Officer Aged Care and has been working with geriatricians to develop an educational program for GPs. The primary objectives of the program are to upskill GPs in disease management, identify available resources for managing elderly patients and to build a relationship between GPs and geriatricians in the area.

For more details: Perth and Hills Division of General Practice
Tel: (08) 9201 0044
www.phdgp.com.au