Primary Health Care

Strengthening Medicare General Practice in Aged Care

Quality Improvement Toolkit

phn NATIONAL IMPROVEMENT NETWORK COLLABORATIVE
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National MyMedicare PHN Implementation Program

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The aim of the General Practice in Aged Care Incentive (GP ACI) Quality Improvement (QI) toolkit is to provide a simple and practical guide for implementing GP ACI through continuous Quality Improvement (QI) activities. It focuses on enhancing continuity of care, improving patient outcomes, and increasing practice efficiency by shifting from volume-based care towards structured, regular care planning and preventative care model.

The QI toolkit also links to existing resources related to MyMedicare and the General Practice in Aged Care Inventive.

This QI toolkit seeks to enable general practice to determine readiness for participation in the General Practice in Aged Care Incentive, complete the registration process (if needed), and sets out actionable steps to assess and improve your practice's model of care for residents in aged care homes.

This toolkit has been developed by Primary Health Networks through the PHN Cooperative, National Improvement Network Collaborative, and the National PHN MyMedicare Implementation Program.

Acknowledgement

This QI toolkit has been developed by PHNs nationally through the PHN Cooperative, the National Improvement Network Collaborative (NINCo), and the National MyMedicare PHN Implementation Program. We acknowledge that some resources used or referenced within this toolkit are from organisations including the Department of Health and Aged Care, Services Australia, Royal Australian College of General Practitioners (RACGP); Best Practice; and Medical Director. These organisations retain copyright over their original work. Referencing of material is provided throughout.

Disclaimer and recognition

Due to constant developments in research and health guidelines, the information in this document will need to be updated regularly. Please contact Murray PHN if you have any feedback regarding the content of this document.

Resources included in this QI toolkit not developed by Murray PHN have been referenced throughout, and these organisations retain copyright over their original work.

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Where to get help?

PHN name: Murray PHN

Contact your Quality Improvement Consultant:

gpsupport@murrayphn.org.au

Overview

This section provides an overview of the General Practice in Aged Care Incentive (GP ACI) QI Toolkit, outlining its purpose, key components, and expected outcomes. It includes the executive summary, background on the GP ACI initiative, incentive payments structure, and the toolkit's aim to support general practices in delivering proactive, high-quality care to aged care residents.

Executive summary

The General Practice in Aged Care Incentive (GP ACI) QI Toolkit is designed to support general practices in implementing the GP ACI to enhance care for aged care residents. This Quality Improvement (QI) toolkit provides practical resources and guidance to support planned, preventative care by outlining key steps for MyMedicare registration, care planning, coordination with multidisciplinary teams, accessing incentive payments, ensuring improved patient outcomes and continuity of care. Practices can use the toolkit to streamline their workflows, access relevant resources, and implement continuous Quality Improvement (QI) activities, ultimately fostering a patient-centred approach in aged care settings.

About this toolkit

This QI toolkit has been developed to support primary healthcare services in implementing quality improvement activities, offering practical tips, examples, and templates. The GP ACI QI toolkit provides ideas for healthcare providers on how to use GP ACI and MyMedicare Voluntary Patient Registration to enhance the quality of care for residents of Residential Aged Care Homes (RACHs) and strengthen care coordination between Residential Aged Care Homes, patients, and their primary care teams.

How to use this toolkit

The QI toolkit is organised into sections ordered to support your practice to get across the foundations before stepping into QI and care delivery. You are also encouraged to navigate forward to the section that is most relevant to your practice and work through activities in any order you prefer.

Outcomes of this QI toolkit

The QI toolkit provides a step-by-step approach to:

Provide practical instructions for understanding, implementing, and evaluating the GP ACI initiative within general practices and residential aged care homes (RACHs).

Improve coordination of care between general practice teams, RACHs, patients and their carers.

Successful implementation of GP ACI using Quality Improvement (QI) activities, leading to improved care delivery.

Make measurable and sustainable improvements to models of care

There are six steps to implement any successful QI activity.

STEP 1 - Planning and Preparation: Identify resources, define the scope, and set up the team to lead the QI activity.

STEP 2 - Use Data to Set Goals and Identify Suitable Patients: Leverage practice data to select eligible patients and establish clear care goals aligned with GP ACI objectives.

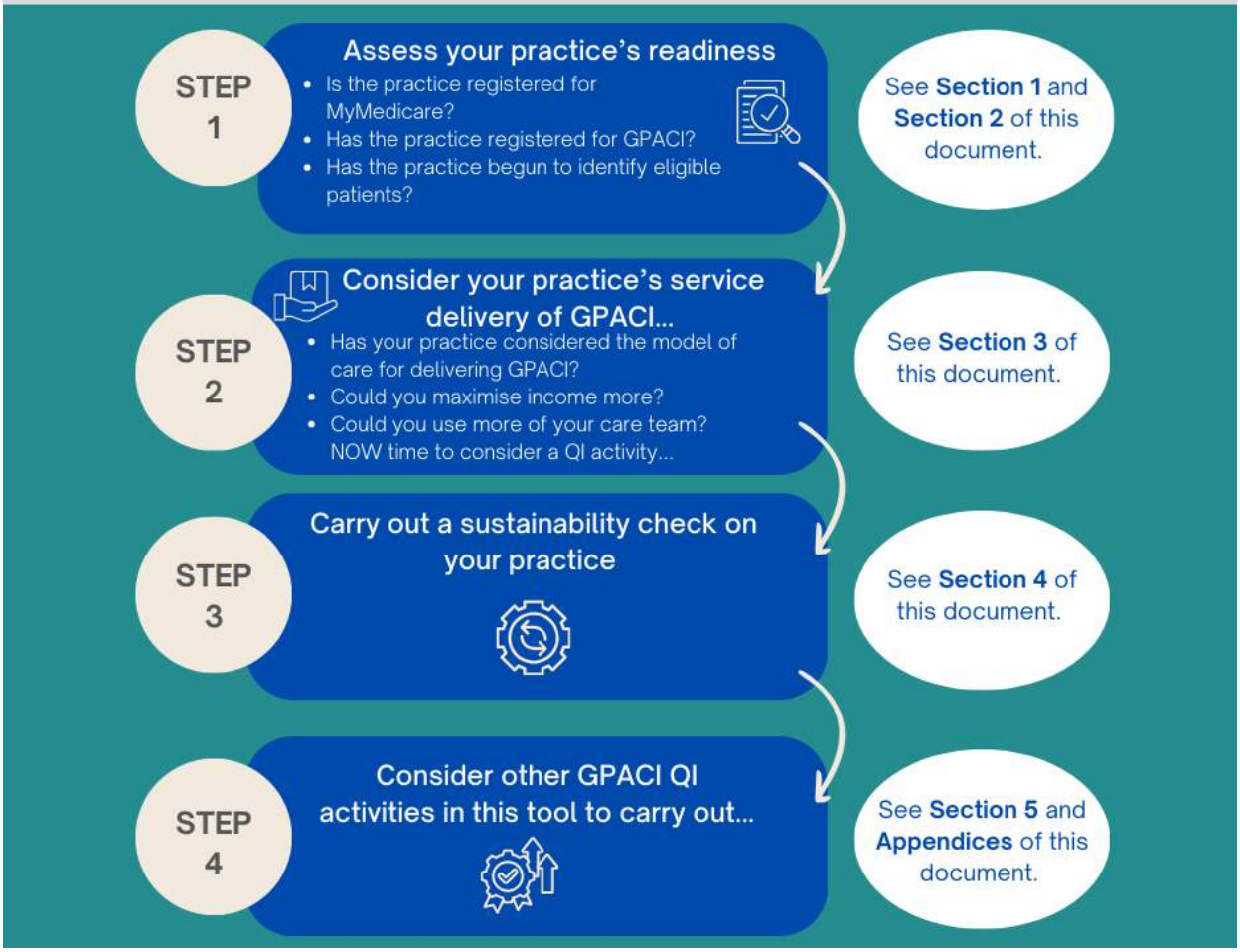
STEP 3 - Implement Improvement Actions: Initiate care interventions, such as developing care plans and conducting regular patient reviews, in line with GP ACI requirements.

STEP 4 - Regularly Review Your QI Activity: Continuously monitor progress against goals and adjust strategies as needed to ensure effectiveness.

STEP 5 - Sustain and Maintain Improvements: Develop a long-term plan to sustain the improvements made, ensuring continuous care and patient engagement.

STEP 6 - Document Your Activity: Keep detailed records of all steps and outcomes, ensuring compliance with GP ACI guidelines and supporting future QI activities.

HOW DO I DETERMINE A START POINT IN THIS TOOLKIT?



Section 1 - QI and GP ACI Foundations

1.1 MyMedicare, Person Centred Care and GP ACI

This section provides an overview of the General Practice in Aged Care Incentive (GP ACI), including its purpose and structure. It covers key topics such as the MyMedicare initiative, incentive payments, and the principles of person-centred care. Additionally, it explores the relevance of GP ACI within primary healthcare, detailing the roles and responsibilities of healthcare providers, practices, and aged care homes. Links to relevant resources are also provided to support implementation and understanding of the program.

Video links below provide a quick summary on GP ACI from the perspective of a GP.

- **MyMedicare and an overview of GP ACI** (2 minutes)- https://youtu.be/tFNUhZZpy9o
- **Details of GP ACI and service and eligibility requirements** (5 minutes) - https://youtu.be/jIFYDB5D4T8
- **Patient registration for GP ACI** (2 minutes) - https://youtu.be/xcPMx2jaRq8

1.1.1 MyMedicare

MyMedicare is a voluntary patient registration (VPR) model that aims to strengthen the relationship between patients, their general practice, GP, and primary care team. General practices can register through PRODA, and patients can register through Medicare Online or by completing a paper registration form. MyMedicare registration is voluntary for patients, practices, and providers, and supports practices to work to deliver more person-centred, comprehensive care.

Residents of aged care homes have simplified eligibility for MyMedicare registration. More detailed information about MyMedicare, what it is, its benefits, eligibility requirements and how to participate are available here.

MyMedicare registration is an essential preliminary step that must occur before a practice or a patient can participate the General Practice In Aged Care Incentive.

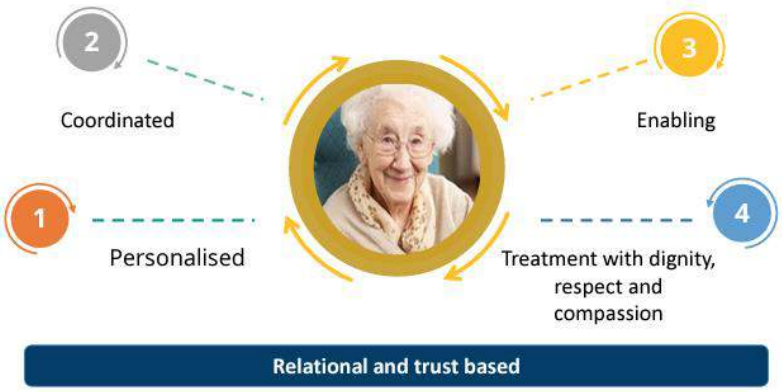
Relevant Resources

- MyMedicare GP Communication Toolkit
- MyMedicare Fact Sheet
- MyMedicare information for practices and providers
- MyMedicare Resources for patients; general practices, providers; and translated resources

1.1.2 Person Centred Care

The General Practice in Aged Care Incentive (GP ACI) emphasises a person-centred approach to care, defined by the Australian Commission on Safety and Quality in Health Care as *'healthcare that respects the individual, their family, and carers, and responds to their preferences, needs, and values'* which leads to improved health outcomes. The four core principles of person-centred care include:

1. treating individuals with dignity, compassion, and respect
2. providing coordinated care, support, and treatment
3. offering personalised care tailored to individual needs
4. empowering people to recognise and build on their strengths to lead more independent and fulfilling lives.

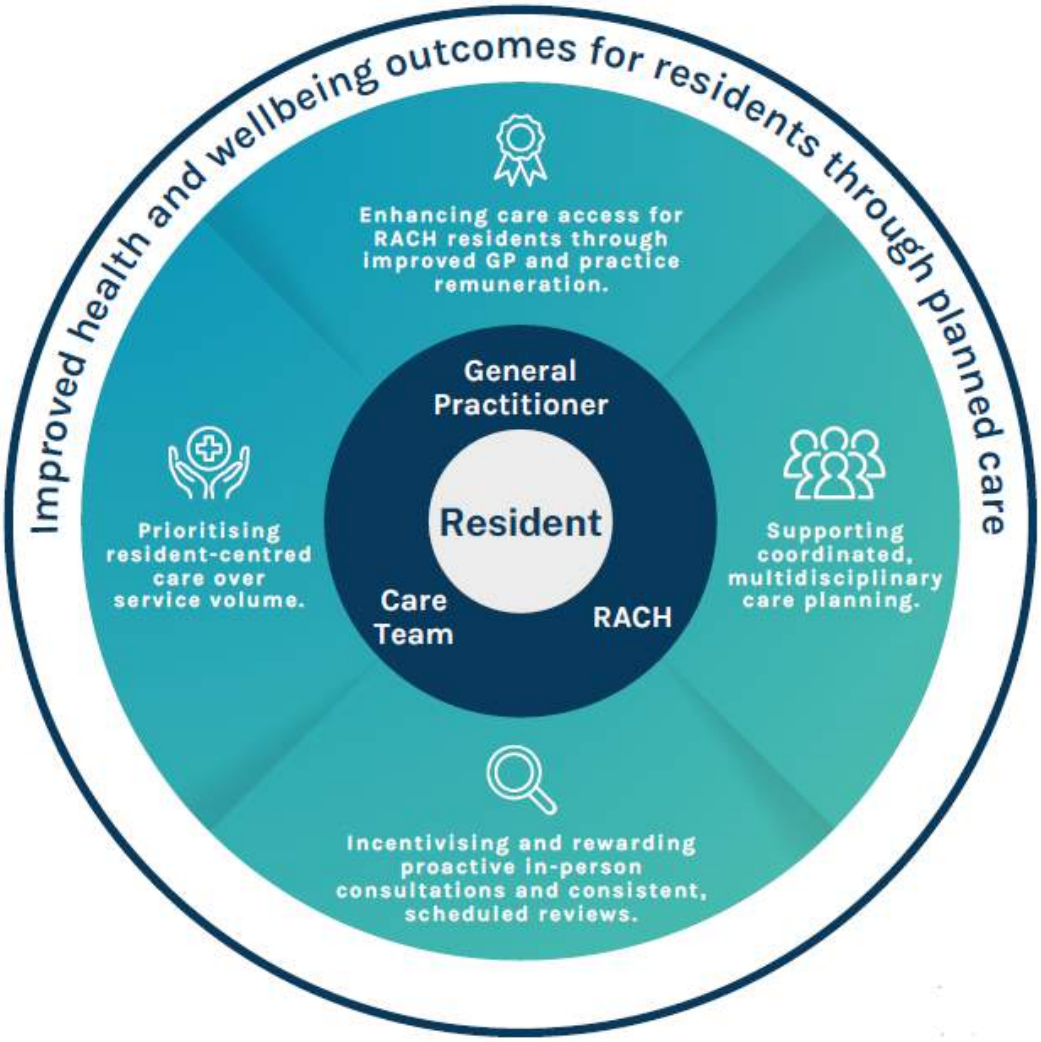


Reference: https://www.health.org.uk/sites/default/files/PersonCenteredCareMadeSimple.pdf

1.1.3 General Practice in Aged Care Incentive

For residents in residential aged care homes (RACHs), the General Practice in Aged Care Incentive (GP ACI) seeks to enhance access to high-quality, proactive, ongoing, and person-centred care. General practices can register to participate in GP ACI and register providers and patients in the incentive through PRODA.

The incentive incorporates a team-based approach with some services able to be delivered by other practice team members, with the GP nominated as the Responsible Provider delivering the majority of care and assuming ongoing responsibility for care delivered by the practice.



GP ACI Benefits. Source: Eastern Melbourne PHN

Incentive payments

General practitioners (GPs) and practices registered with MyMedicare and meeting the eligibility and service requirements will receive quarterly incentive payments (rural loadings apply for MMM 4-7), in addition to standard Medicare Benefits Scheme (MBS) and Department of Veterans Affairs (DVA) rebates.

The payments include:

- $300 per patient, per year, for the responsible GP or provider.
- $130 per patient, per year, for the practice managing the patient's care.

For more information on the General Practice in Aged Care Incentive please refer to the fact sheet provided by the Department of Health and Aged Care.

Factsheet: General Practice in Aged Care Incentive Fact sheet

GP ACI Stakeholder Benefits and Responsibilities

The General Practice in Aged Care Incentive (GP ACI) enhances primary care in aged care settings by improving coordination and continuity of care, benefiting residents, families, general practitioners, and aged care homes. Each stakeholder has an essential role in coordinated care to achieve better health outcomes and a more integrated approach to care in residential aged care settings.

Below is a summary of the key benefits and role for each stakeholder group.

Stakeholder	Benefits	Role
Residents, families and carers	Enhanced, continuous primary care within aged care homes. Improved care coordination involving family, friends, and carers.	Register for MyMedicare Collaborate in setting care goals Benefit from proactive and continuous care
Residential aged care homes	Collaboration with GPs and practices to enhance resident care and compliance with Aged Care Standards	Assist residents in registering for MyMedicare Support GPs in delivering proactive care
General practice	Payments for proactive care planning and regular care for registered aged care residents. Strengthened relationships between GP, practice, patient, and care team. Opportunities for practice team to deliver care directly to aged care residents. Access to resources that improve patient outcomes and satisfaction, expanding scope of practice. Develop specialised skills in aged care (e.g. dementia care, palliative care) while fulfilling Continuing Professional Development (CPD) requirements	Deliver eligible services to aged care residents Support planning, coordination, and administration Register residents in MyMedicare and GP ACI

A detailed illustration of the key implementation partners and their roles in the General Practice in Aged Care Incentive (GP ACI) is available here: GP ACI Roles and Contributions

Other GP ACI-relevant resources

Website: GP ACI Website

Videos: My Medicare and GP ACI overview

Practice resources:

- GP ACI FAQs for GPs and Practices
- MyMedicare Resources (available in 10 Languages)
- Social Media Tiles
- MyMedicare - Poster 1
- MyMedicare Poster 2
- MyMedicare Poster First Nations

Murray PHN GP ACI webpage: General practice in aged care incentive - Murray PHN

1.2 Preparing your practice team for GP ACI quality improvement activities

The actions outlined below are important steps to prepare your team and practice for participating in General Practice in Aged Care Incentive (GP ACI) Quality Improvement activities. A coordinated strategy incorporating team engagement, practice accreditation, and well-defined care delivery procedures is necessary for successful participation.

1.2.1 Quality Improvement Activity Summary

This QI toolkit uses the Model for Improvement (MFI) framework to plan the activity goal, activity measurement, and improvement ideas.

For more information on MFI: Weblink: How to Improve: Model for Improvement | Institute for Healthcare Improvement (ihi.org)

The improvement ideas in this toolkit are examples of practical steps to assist with the GP ACI initiative. It is recommended to review each activity and select what may be appropriate for your primary health care service to consider undertaking and test using Plan Do Study Act (PDSA) cycles to make sustainable changes and record key learnings for your team.

1.2.2 Goal of Quality Improvement Activity

Defining the goal of any activity provides your primary healthcare team with a statement of what you are trying to accomplish. Review the goal below and adjust according to your primary healthcare service starting point and requirements.

QI ACTIVITY GOAL EXAMPLE

Our team will aim to improve aged care residents' registration rates for GPACI by XX% within the next XX duration (months)

Measure – How will you measure the change for this activity?
Overall measure - Percentage increase in patients registered to GPACI in PRODA.

Baseline measures
Practice has 2 patients registered at the start of the activity. We are unsure of the number of patients that are residents of Residential Aged Care Homes (RACHs), but we estimate we are providing care to about 50 residents, at 3 RACH locations.

Data to collect
Data will be collected on the following on the first Tuesday of the month for 6 months.

- Number of new GPACI patients registered each month by the practice
- Number of GPACI patients removed from PRODA (e.g. deceased or withdrawn)
- Number of total patients registered to GPACI
- Number of total patients registered to GPACI in the previous month

Regular review of activity measurement enables your primary health care team to assess progress and track if change(s) are leading to an improvement. It is best to measure at the beginning of the activity (baseline) and at regular intervals. Use the Model for Improvement (MFI) framework to methodically work through identifying a clear problem, and to explore solutions and take action.

1.2.3 Quality Improvement Building Blocks

Step 1: Identify your QI team and establish QI activity communication processes
Refer to Appendix 1 for a checklist template to help you with this activity.

1. ☐ Identify your QI change team
2. ☐ Identify your 'why'
3. ☐ Allocate QI team protected time
4. ☐ Set up QI team meetings
5. ☐ Setup your QI team collaboration zone
6. ☐ Plan communication with the wider practice team
7. ☐ Plan communication with other important stakeholders

Section 2 – GP ACI Registration and Participation

This section provides information describing the requisites for your practice to participate in the General Practice in Aged Care Incentive (GP ACI). It includes essential information on practice accreditation requirements, the process for registering your practice and patients, and key system details from Services Australia.

2.1. Accreditation Requirements

A key requirement for participation in the General Practice in Aged Care Incentive (GP ACI) is for general practices, responsible providers, and patients to be registered with MyMedicare and linked to the GP ACI program in the Organisation Register.

To qualify for MyMedicare, general practices must be accredited under the National General Practice Accreditation Scheme. An exemption allowing non-accredited practices to participate in MyMedicare, and the General Practice in Aged Care Incentive is in effect until 30 June 2025.

The definition of a "general practice" was amended by the Royal Australian College of General Practitioners (RACGP) in April 2024 to include 'non-traditional practices'. As such general practices such as solo or mobile general practitioners providing essential visiting services to Residential Aged Care Homes are now eligible to participate in accreditation.

The RACGP Interpretative guide for non-traditional general practices for the purposes of accreditation provides general practices and accreditation assessors information to understand how the RACGP 5th Edition standards apply to non-traditional general practices. The interpretive guide outlines how indicators in the standards may apply differently to non-traditional practices and those without a physical clinic premises.

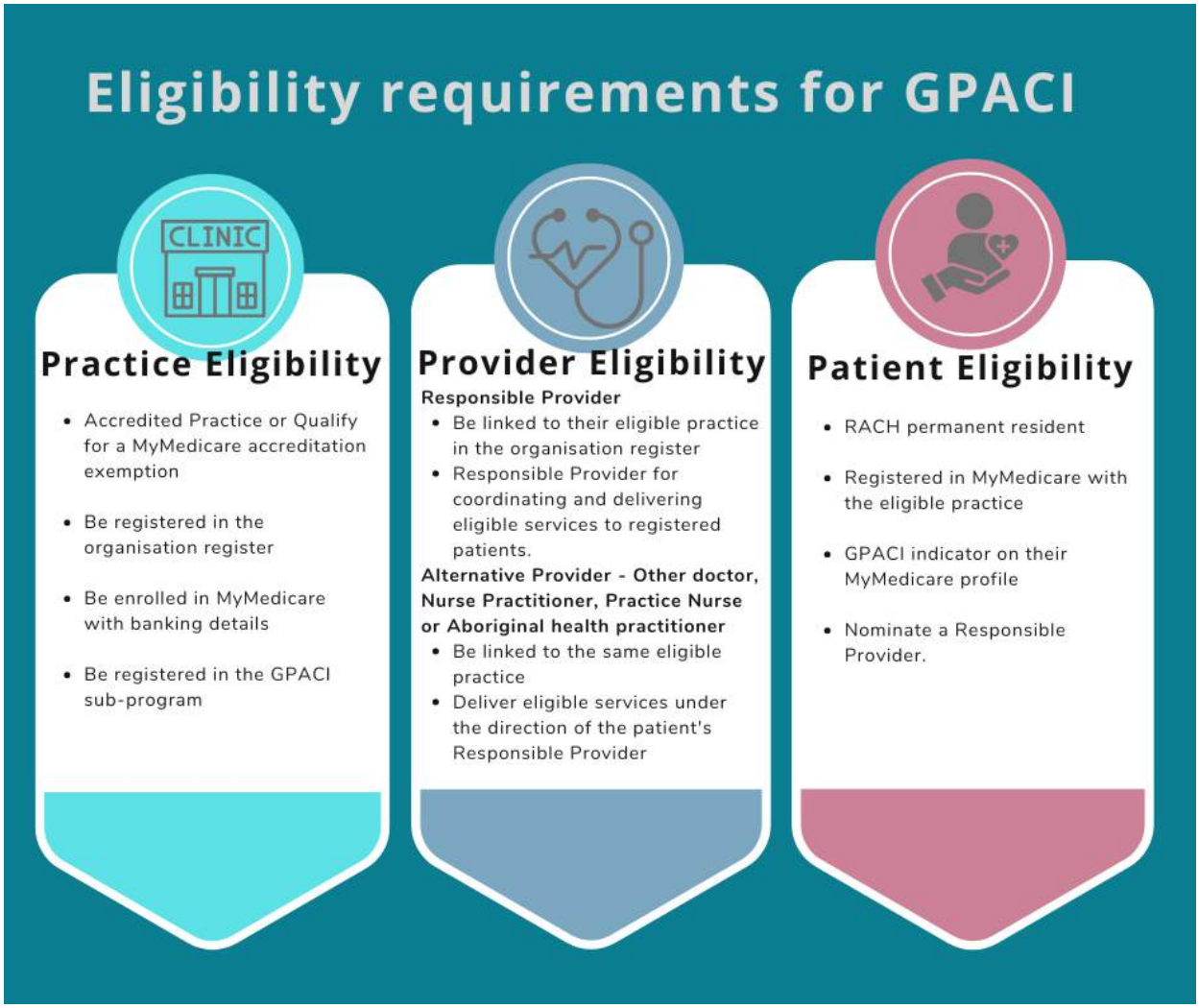
National General Practice Accreditation (NGPA) scheme
https://www.safetyandquality.gov.au/our-work/accreditation/national-general-practiceaccreditation-scheme

Approved accrediting agencies under the NGPA Scheme
https://www.safetyandquality.gov.au/our-work/accreditation/national-general-practiceaccreditation-scheme/approved-accrediting-agencies-under-ngpa-scheme

Murray PHN invites non-traditional practices, and non-accredited practices particularly those delivering essential visiting care services to residential aged care homes to contact us at gpsupport@murrayphn.org.au for information and to explore options for participating in accreditation and the General Practice in Aged Care Incentive.

2.2 Eligibility requirements for GP ACI

The eligibility requirements for practices, providers and patients for GP ACI are summarised below.



Resources: Services Australia Learning Module – MyMedicare and GP ACI

2.3 Develop accurate patient registers of people living in residential aged care

This activity aims to support your practice to develop an accurate list of all patients that you care for that are residents of a Residential Aged Care home. There are two options outlined below to develop a list of RACH patients for your practice.

Option 1 – Existing RACH patient lists

Existing lists of RACH patients may already be available including:

- Lists of RACH patients your practice has compiled, or
- A list of patients that residential aged care homes (RACH) have, which provide a summary of all patients you deliver care to at that RACH.

If these lists are readily available and reliable then you may not need to use other data to develop a list.

Option 2 – Use your practice system data to create a patient list

You can also use data from your practice software, or data extraction tools provided by Murray PHN to develop a patient list.

Either way, you'll need to use data to from these sources to track your progress and QI activities in a meaningful manner.

Baseline data provides a starting point of data that measures your current state. Having a baseline is essential to compare to in the future so that you can understand the impact of improvement activities. Baseline data for QI activities can be obtained from multiple sources, for example:

- Practice management software
- Data analytic tools, such as Primary Sense, PenCS CAT Plus or POLAR.

Data searches to identify Residential Aged Care Home (RACH) patients

Use your practice software to identify RACH MBS items billed by your practice.

Search your practice software for MBS items you have billed to develop a list of patients that have had these items claimed in the last 12 months. Review the list below and choose one or more MBS items you commonly bill and run searches for those items to develop patient lists. Document your approach using the Model For Improvement and PDSA template available at Appendix 2

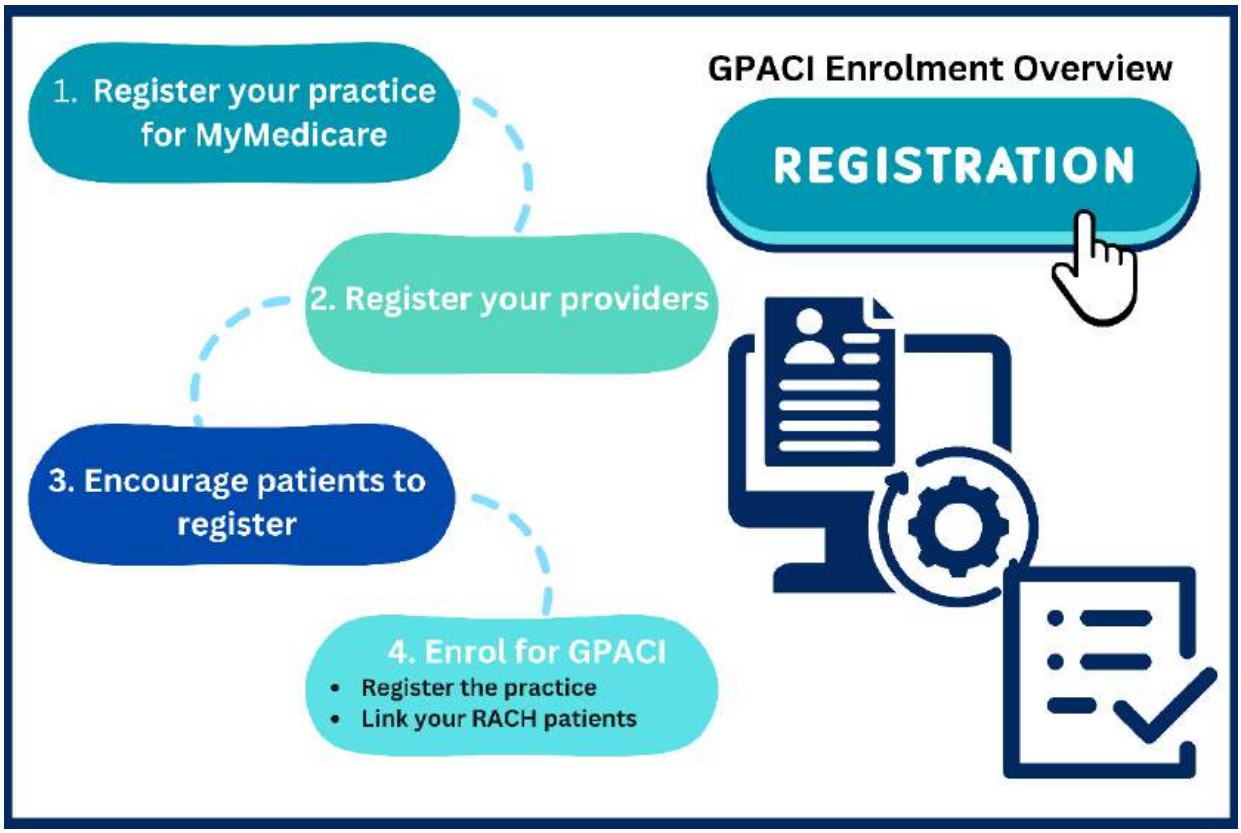
RACH Care Plan MBS Items	**Comprehensive medical assessments (701, 703, 705, 707)*** **Contribution to, or review of, multidisciplinary care plan (731)*** **Residential Medication Management Review (249, 903)** **Veteran Health Check (MT701, MT703, MT705, MT707)***
Other RACH MBS Items	Attendance at a residential aged care home [B-E Consultation] (90035, 90043, 90051, 90054, 90093, 90095, 90096, 90098, 90188, 90202, 90212, 90215) Non-Urgent After-Hours Attendance (772, 776, 788, 789, 2200, 5028, 5049, 5067, 5077, 5262, 5263, 5265, 5267) Flag falls for GP attendance at residential aged care facility (90001, 90002, 90005, 90020 90035, 90043, 90051, 90054) Telehealth Services (92027)

For the latest list of MBS items relevant to RACH care see MBS Online. A list of all GP ACI MBS items is provided in the GP ACI Program Guidelines and on the Services Australia website.

*Note these MBS items are not exclusively for patients of RACHs.

2.4 Registration for GP ACI

This section outlines the steps required to register your practice and patients for the General Practice in Aged Care Incentive (GP ACI). It provides a summary on how to navigate the registration process, manage patient registration and extract necessary data to ensure effective participation in the initiative.



2.4.1 Practice Registration

Registering your practice for GP ACI requires several steps. **It is important you carefully read and follow the instructions in the resources for registration to update your practice information and register responsible providers**. Once you've followed these steps, you can proceed with, registering patients for GP ACI, assigning responsible providers, and de-registering patients (e.g. due to patient death, practice closure, or provider capacity).

Step-by-step guidance to register your practice and add patients to GP ACI is available here:
MYMEDINFO7-Steps required to add the MyMedicare General Practice in Aged Care Incentive

Resources for registration

- Adding the MyMedicare General Practice in Aged Care Incentive Indicator
- Service Australia – MyMedicare eLearning

2.4.2 Patient Registration

GP ACI registration is completed by the practice but **first requires the patient to be registered for MyMedicare**. Therefore, the focus for practices engaging patients is to explain MyMedicare and ensure the patient completes their MyMedicare registration.

Step-by-step guidance to register patients for MyMedicare is available here: MYMEDM02-Managing patient registrations

Note that if you are registering a new GP ACI patient late in the GP ACI quarter (not in the first month of the quarter), you may opt to set their date of registration for the GP ACI incentive as the first day of the following quarter. This can ensure that your practice has sufficient time to deliver the required 2 visits in separate calendar months.

2.4.3 Patient resources to explain MyMedicare and GP ACI

Patient Videos
Introducing MyMedicare | Australian Government Department of Health and Aged Care
Registering in MyMedicare | Australian Government Department of Health and Aged Care

Patient Brochures
mymedicare-dl-brochure.pdf (health.gov.au)
Aged Care Resident MyMedicare brochure

2.4.4 Assisting Patients to complete MyMedicare Registration

- Depending on practice staff capacity, one or more of the following processes may be implemented to assist eligible patients with MyMedicare registration:
- Pre-complete a MyMedicare Patient Registration form for each RACH patient prior to their next visit. Have them sign the form when you next visit them, or mail pre-completed forms to patients or their nominated carer or decision maker for signature.
- Have a conversation with your patients and their family when you visit the RACH. Provide a letter explaining MyMedicare and MyMedicare Registration form inviting them to participate.
- Engage with Residential Aged Care Homes you visit, and discuss the option of having them include the MyMedicare Patient Registration form in their resident on-boarding packs and admission checklists and processes to help streamline care access.
- Identify all RACH patients due to receive care in the next 2 - 4 weeks:
    - Initiate registration by sending a pending registration request to a patient. A pending registration request prompts a patient via the patient's Medicare Online Account or Express Plus App to complete the registration with the practice digitally. Invitations are only valid for 30 days.
    - Invite patients via SMS to register with your practice using their Medicare Online Account or Express Plus App or complete a MyMedicare Patient Registration form.

Note that all MyMedicare Patient Registration forms completed by patients, are returned to the general practice they wish to register with, and need to be entered by the practice in HPOS.

2.4.5 Other important registration considerations:

Practitioner Capacity

Consider how many RACH patients your practice will register with each Responsible Provider. This will be informed by their RACH visit schedule, workdays and clinic days. This may increase if you use other members of the care team to support RACH visits such as other GPs, nurses, nurse practitioner or Aboriginal Health Practitioners.

Patient Journey

- At what point throughout the patient journey will the practice raise awareness about MyMedicare,
- Discuss the benefits and discuss patient registration (e.g. at patient check-in, with the clinical health care team at the time of the patient's appointment)?

Staff Education and Awareness

- Ensure all practice staff including GPs are confident to discuss the benefits of registering for MyMedicare with patients.
- Ensure all GPs who are willing to participate in MyMedicare are registered in the Organisation Registered in PRODA so that patients can select them as their preferred general practitioner.
- Ensure your practice administration team are familiar with how to check GP ACI compliance using PRODA, and have a good understanding of GP ACI service requirements to support appointment scheduling for Responsible providers, patients and other members of the practice team

Patient Eligibility

- Ensure non-clinical staff understand patient eligibility requirements and the process to check patient eligibility prior to discussing GP ACI and MyMedicare benefits with patients, and their carers or decision makers.

Section 3 - Delivering care to meet GP ACI service requirements

This section focuses on the practical aspects of providing care under the General Practice in Aged Care Incentive (GP ACI). It outlines the requirements for delivering eligible services to registered aged care residents, ensuring proactive, continuous, and patient-centred care.

3.1 GP ACI minimum care requirements

Under the GP ACI, general practices must deliver a minimum of two care planning items per year, along with eight regular visits in different calendar months each quarter. For more information about the requirements of the GP ACI visit
General Practice in Aged Care Incentive | Australian Government Department of Health and Aged Care

3.2 GP ACI MBS User Guide

Primary Health Networks (PHNs) have developed a user guide for Medicare Benefits for the General Practice in Aged Care Incentive (GP ACI).

This resource can be used to inform and plan delivery of care and MBS billing to meet the service requirements for GP ACI. Care planning items suggested for completion in the first billing quarters following patient registration in GP ACI prioritise comprehensive care plans and include care planning items that trigger other MBS Items that support multidisciplinary team care/referral (for example practice nurses, aboriginal health practitioners, allied health and medicines reviews).
Follow this link to access the GP ACI MBS User Guide: GP ACI User Guide

Here are some ideas your practice can consider applying the GP ACI MBS user guide for your patients that are permanent residents living in aged care homes:

- Identify the **Sample Schedule** and **Example Annual Cycle** billing scenario that best suits your practice team and setting. Print these or share them with your practice team to inform care planning for the General Practice in Aged Care Incentive.
- Review your historical use of MBS items for residential aged care home patients and use the guide to develop a quick PDSA (Plan – Do – Study – Act) to identify any improvements you could make to billing and care practices.
- Plan care for your residential aged care patients 3–6 months ahead by booking appointments for residential aged care visits each month using the Example Annual Cycle as a guide. Consider how you can group visits to a residential aged care home in your practice booking system to maximise the efficiency of clinician time.
- Meet with your practice team to reflect on the guide, and identify opportunities for practice nurses, Aboriginal health practitioners and other doctors to support or deliver care. For example, could practice nurses work alongside doctors at aged care visits preparing documentation for care plans to make visits more efficient for your practice, residential aged care homes, and patients/residents?

A snapshot of the MBS User Guide is provided below.

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GP ACI MBS User Guide

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GP ACI RACH Visits - Sample Schedule - RESPONSIBLE PROVIDER + ALTERNATIVE PROVIDER

Other GP / Prescribed medical practitioner / Nurse practitioner + Practicing in MMM 4-7 where telehealth appointments can by used as follow up

Quarter 1	Quarter 2	Quarter 3	Quarter 4
Contribution or review of Multidisciplinary Care Plan MBS 731 suggested to be co-claimed with: MBS 232 - Contribution to or review of Multidisciplinary Care Plan	**Comprehensive Medical Assessment** MBS 703-707 OR MBS 224-227 Comprehensive Management Plan (CMA) - Health Assessment item ***Item choice depend on length of assessment and type of practitioner***	**Residential Medication Management Review** MBS 903 OR MBS249 ***Item choice depends on practitioner type***	**Case Conference** MBS 235-24 OR MBS 735-758 Multidisciplinary Care Conference ***Item choice depend on length of conference and type of practitioner***

Across the 12-month period must provide 2 of the above Eligible Care Planning Items

These can be claimed at any point across the 12-months. Claiming MBS 731 early in the cycle (Q1) enables other MBS items and referrals. MBS 731 can be co-claimed with other items.

Quarter 1	Quarter 2	Quarter 3	Quarter 4
2x Eligible Regular Services 1x Responsible Provider + 1x Alternative Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 OR MBS 90093-900096 OR MBS 90188-90215 OR MBS 82205-82215 OR after hours non-urgent OR Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	2x Eligible Regular Services 1x Responsible Provider + 1x Alternative Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 OR MBS 90093-900096 OR MBS 90188-90215 OR BS 82205-82215 OR after hours non-urgent OR Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	2x Eligible Regular Services 1x Responsible Provider + 1x Alternative Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 OR MBS 90093-900096 OR MBS 90188-90215 OR BS 82205-82215 OR after hours non-urgent OR Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter	2x Eligible Regular Services 1x Responsible Provider + 1x Alternative Provider **Must be claimed in separate calendar months** MBS Items 90035-90054 OR MBS 90093-900096 OR MBS 90188-90215 OR BS 82205-82215 OR after hours non-urgent OR Can use MBS 91800 - 91803 Telehealth Service as follow up appointment in the quarter

NOTE: Completing 2 Regular Visits with your patient per quarter triggers the incentive payment to both the Responsible Practitioner and the Practice. Payments will not be triggered if the two visits are not completed within the quarter in two separate calendar months. Triple Bulk Billing applies with eligible patients.
Also note, the **RESPONSIBLE PROVIDER must complete 4 of the eligible regular services - 1 per quarter** across the 12-months, another GP or Nurse Practitioner can provide the other regular visits. **Note this visiting schedule is only relevant for practitioners in MMM4-7 areas. Can claim up to 4 telehealth consults across the 12-months**

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Example Annual Cycle inc. estimated billing - Responsible Provider Only MMM4-7

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Quarter 1			Quarter 2		
January	February	March	April	May	June
Eligible Care Planning Item MBS 731 + MBS 705	**1x Eligible Regular Visit Responsible Provider MBS 90043 20-40min**	**1x Eligible Regular Visit Responsible Provider MBS 91801 20+ mins**	**Eligible Care Planning Item Case Conference MBS743 40+Mins**	**1x Eligible Regular Visit Responsible Provider MBS 90043 20-40min**	**1x Eligible Regular Visit Responsible Provider MBS 91801 20+ mins**
$80.20 + $216.80 = $297	$82.90	$82.90	$229.65	$82.90	$82.90
Other eligible items available depending on the patient's needs. Start the annual cycle with item 731 to ensure have best access to MDT requirements.	Other items are available for shorter or longer regular visits, after hours Note regular visits need to be in separate calendar months,	This item represents a telehealth appt. Other items are available for shorter or longer regular visits, after hours and face to face.	A Case conference can be used to engage with care team members from RACH, allied health, specialists and care team members from your practice. Provides an opportunity to collaborate	Other items are available for shorter or longer regular visits, after hours	This item represents a telehealth appt. Other items are available for shorter or longer regular visits, after hours and face to face.
Quarter 3			**Quarter 4**		
July	August	September	October	November	December
Eligible Care Planning Item - Med Review MBS 903	**1x Eligible Regular Visit Responsible Provider MBS 90043 20-40min**	**1x Eligible Regular Visit Responsible Provider MBS 91801 20+ mins**	**Eligible Care Planning Item Case Conference MBS743 40+Mins**	**1x Eligible Regular Visit Responsible Provider MBS 90043 20-40min**	**1x Eligible Regular Visit Responsible Provider MBS 91801 20+ mins**
$120.80	$82.90	$82.90	$229.65	$82.90	$82.90
Other eligible Items available depending on the patient's needs MMRs aim to help people to get the most benefit from their medicines and minimise their risk of medicines-related harm - National Commission on Safety & Quality in Healthcare	Other items are available for shorter or longer regular visits, after hours	This item represents a telehealth appt. Other items are available for shorter or longer regular visits, after hours and face to face.	A Case conference can be used to engage with care team members from RACH, allied health, specialists and care team members from your practice. Provides an opportunity to collaborate	Other items are available for shorter or longer regular visits, after hours	This item represents a telehealth appt. Other items are available for shorter or longer regular visits, after hours and face to face.

Annual Billed Amount in this example: $1540.30 + incentive payment of $300 (Responsible GP incentive) + $130 (practice incentive) = $1970.30 (noting incentive paid quarterly)

Noting that the practitioner may visit the patient more frequently in the year for additional care needs to bill for follow up telehealth appointment, or bill for longer appointment items depending on patient's individual care needs, therefore the billed amount for the patient may be more or less - example only.

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3.3 GP ACI Services Australia compliance and forecasting tools

3.3.1 Forecasting Tools for GP ACI

Access to forecasting tools provided by Services Australia helps monitor patient tracking and compliance under GP ACI. You can find all these infographics on the HPE MyMedicare page.

Practices

a. Forecast eligibility for MyMedicare Incentives for an Organisation site/Practice
b. Search for and view eligibility assessments for MyMedicare Incentives for an Organisation site/Provider

Responsible Providers

a. Forecast eligibility for MyMedicare Incentives as a Provider
b. Search for and view eligibility assessments for MyMedicare Incentives as a Provider

The Patient Monitoring and Tracking Tool offers essential data for managing care efficiently.
Patient monitoring and tracking tool | Australian Government Department of Health and Aged Care

3.3.2 Checking quarterly compliance with GP ACI for patients

Services Australia tools support practices to forecast eligibility and track quarterly compliance for MyMedicare Incentives. An education package is available explaining how to use these tools here:
MYMEDINFO5-Forecast eligibility for MyMedicare Incentives for an Organisation site (servicesaustralia.gov.au)

3.3.3 Scheduling care for GP ACI patients

Coordinating care effectively is crucial under GP ACI. Suggestions for care scheduling include:

- Practices should pre-book appointments for patients that include:
  - Notifications for family or carers if required with the dates/time of the appointment
  - Details of MBS items applicable to visits for each patient.
- Visit schedules may need to be adjusted depending on the unique circumstances of delivering care within each residential aged care homes (RACHs).
- Collaboration with RACH staff is essential for ensuring smooth care delivery and alignment with GP ACI requirements.

3.4 Coordinated GP ACI Service Delivery

Delivering care to meet the GP ACI guidelines to patients living in residential aged care homes requires:

- clear team roles and responsibilities
- using data to monitor care delivery, billing and compliance
- care coordination
- information exchange, and

Use the following table to guide your GP ACI service delivery and planning.

Team Roles	
Responsible Provider	The Responsible Provider is the patient's usual doctor and is accountable for overseeing the patient's care, coordinating with the practice team and RACH staff, and ensuring adherence to GP ACI requirements. Responsible providers are required to complete care planing, and conduct RACH regular visits.
Administrative	Practice administration staff are crucial for managing appointment scheduling and changes. They serve as the first point of contact for inquiries regarding GP ACI and ensure that appointments are arranged efficiently, facilitating communication between the practice, RACHs, and patients/families. They setup and populate clinician diaries to plan and schedule MBS items for each patient appointment at RACHs and maximise effective use of time. Admin staff also process the billing of MBS items related to GP ACI services, and play a vital role in checking compliance with GP ACI for each patient using forecasting tools.
Nurses and Other Visiting Providers	Other doctors, nurses and Aboriginal Health Practitioners (AHPs) in your practice team may also contribute to patient care as part of a multidisciplinary team. Nurses and AHPs play a vital role in care planning support activities, assisting with patient assessments, and delivering routine care.
Care Planning Nurse Support Activities	Nurses and AHPs involved in care planning collaborate with GPs to develop and implement individualised care plans for residents, addressing their unique health needs.
Main Contact for GP ACI Enquiries	Designate a primary contact person in your practice who will handle all GP ACI-related inquiries from RACHs, ensuring a streamlined communication process.
Using extraction tools and reports	
Data extraction	Familiarise your team with the extraction tools and reports available to monitor patient data effectively. These tools are essential for tracking compliance with GP ACI requirements and assessing patient eligibility.
Care coordination and logistics	
Coordinating Care with RACHs and Patients	Establish processes for collaborating with RACHs and patients to ensure continuity of care. Develop agreements, or coordination protocols that document expectations for both RACHs and your practice. This includes creating patient registers within your software to

	maintain accurate records of residents.
Appointment Scheduling	**Focus on logistical aspects** for appointment scheduling. Ensure clear contact and communication arrangements specific to outreach services. **Nominating a Primary RACH Contact:** Agree on a primary contact with each RACH for all appointment scheduling matters, enhancing communication and efficiency. **Including Family Members and Carers:** Involve family members and carers in appointments when relevant, especially in cases where the patient has diminished decision-making capacity. Discuss telehealth and face-to-face options to accommodate their participation. **Face-to-Face and Telehealth Visits:** Coordinate patient appointments and visit rounds with the RACHs on-site clinical care team. Ensure clear communication of changes to care and provide updates after both planned and unplanned appointments.
Information Exchange and Communication	
Ongoing Care and Care Planning	Establish mechanisms for regular information exchange about patients, using resources like the Silver Book to facilitate appointments, care planning and adjustments.
Coordination with Family/Carer Communications	Create standard communication protocols with RACHs, families, carers, and residents to ensure everyone is informed about care plans and changes.
My Health Record & Provider Connect	Leverage My Health Record and Provider Connect Australia to enhance how you share information with other care team members.
After-Hours and Urgent Care	Develop contact protocols for after-hours and urgent care situations, using telehealth and other mechanisms to ensure timely access to care.
Collaboration with Other Healthcare Members	Maintain open communication with all members of the healthcare team to coordinate care effectively, ensuring that patients receive comprehensive and cohesive treatment.
Billing and Compliance	
Checking Billing and Compliance:	Regularly review billing and compliance reports from Services Australia, Clinical Information Systems (CIS), and Health Data Management (HDM) systems to ensure adherence to GP ACI requirements.

3.5 Reviewing your GP ACI delivery approach

- There are many ways that practices can deliver care that meets the GP ACI service requirements. Ideas you may like to consider include:
- Practice nurses and Aboriginal health practitioners can support the Responsible Provider to deliver a high standard of care to more patients, encouraging the efficient use of practice time and resources by coordinating visits with RACHs, developing care plans and doing workups for patients at a RACH visit.
- Other clinicians (e.g. other doctors, nurses, nurse practitioners, Aboriginal health practitioners) at the practice can deliver regular services to share the workload among the practice team.
- Conduct visits as 'ward rounds' with RACH clinical staff or use clinical rooms available on site to improve the coordination of care and enhance care quality.
- Discuss ideas for improvement to care processes at RACHs with your practice team, RACHs and your patients - small improvements can make a big difference to patient outcomes.
- Case conferences provide a unique opportunity to coordinate care for patients with complex health or social needs and enable the care team to learn from each other.
- We recommend you use the Model For Improvement to explore improvement ideas and you may wish to involve your Quality Improvement Consultant at Murray PHN (gpsupport@murrayphn.org.au) who can help you work through change ideas and develop PDSA cycles to implement.

Section 4 - Maintaining QI Momentum

Use the following checklist of good change management tips to maintain your QI momentum.

Sustainability checklist to maintain change

Cyclical nature of PDSAs- Adopt, adapt, abandon	• **Adopt: excellent work, embed that change.** • **Adapt: determine if a change is needed to the plan and start a new PDSA.** • **Abandon: Rethink the next PDSA** • **Lessons can be learned from PDSAs that are abandoned. Keep a record of learnings.**
Document your improvement activity: Record your completed QI activities to meet PIP QI guidelines and CPD requirements	• Record your completion. • Documentation must be kept for 6 years for evidence of PIP QI if your practice is audited by the Department of Health and Aged Care. • Clinical Audit QI activities can be recorded and contribute to RACGP Measuring Outcomes CPD Activities.
Sustaining project outcomes. Consider which practice documentation may need to be updated to include the change:	• Updates to Policy and Procedure manual. • Specific task procedures. • Local signs or instructions. • Staff work practices. • Position descriptions. • Staff induction. • Staff skills development or education.
Communication is key to finishing a successful project. Consider:	• QI project outcome feedback to staff. • Discuss project strengths and challenges. • Feedback to patients, where appropriate.
Celebrate success	• Celebrate your outcomes and achievements by sharing morning tea with your team. • Consider sharing your practice improvement activity efforts with your patients through practice newsletters, website or RACHs you work with e.g. displaying 'run charts' to demonstrate change over time.
Review and reflect	• Discuss project strengths and challenges. • Annually review the PDSA outcomes to ensure activities are still being adhered to and completed • Annually review and audit your data related to this activity. Identify gaps, areas for improvement and set new targets if needed. • Where to next on your continuous QI journey? • Consider potential topics for a new QI activity, and how your experience with this activity can help you to be more efficient and effective

Section 5 - Best Practice Care for Older Australians

5.1 PHN Resources and Tools

Murray PHN has produced quality improvement resources and information for general practices to support the delivery of best practice care for all people including older people. These resources can be found at: Quality improvement for general practice - Murray PHN

Murray PHN has a dedicated MyMedicare GP ACI webpage which provides information and links to resources and tool to support general practices with the implementation of the GP ACI.

Murray PHN GPACI webpage - General practice in aged care incentive - Murray PHN

5.2 RACGP Silver Book

The RACGP Silver Book provides a comprehensive guide to primary care for older people.

5.3 HealthPathways

HealthPathways are available to support best practice care in your local area, including hospital and specialist service referrals. The following HealthPathways are particularly relevant to care for older people in residential aged care, and are localised for the Murray PHN region:

Link to older persons health index page (Murray HealthPathways)

- Aged Care Community Assessment
- Before Entering a Residential Aged Care Home (RACH)
- Comprehensive Medical Assessment (CMA) for RACHs
- Cognitive Impairment and Dementia
- Medication Management and Polypharmacy in Older Adults
- Geriatric Medicine Referrals
- Dementia Support and Resources

Access to Murray HealthPathways can be requested by completing the form here: Request to access Murray HealthPathways

5.4 Department of Health and Aged Care GP ACI Best Practice Resources

The Department of Health and Aged Care have produced a range of resources to support best practice care for older people, specific to the General Practice in Aged Care Incentive.

- GP and Practices Information Kit
- Care plan contribution template
- Patient front sheet template
- Patient monitoring and tracking tool
- GP ACI Incentive Payment Structure

Appendicies

Appendix 1 – Getting Ready QI Checklist

Task	Subtasks	Action Notes
☐ **Identify your QI change team**	• Identify the lead and practice team members to drive quality improvement work (e.g. one nurse, GP [operating as a Responsible Provider], admin, Practice Manager). Consider allied health, visiting clinicians and others that may form part of the team. • Consider the roles of the team members, and assign roles and responsibilities according to staff skill, interest and position • Ask yourself the question, what motivates a team member to want to be part of sustaining change and making improvements? This is an important step as team members have different skill sets, interests, scope of practice and levels of authority. • Document your team in the Quality Improvement Template below.	•
☐ **Identify your 'why'**	• Document and discuss 'why' your team are doing this QI activity to ensure team members understand the importance and necessity. • Use the Quality Improvement Template below to document your problem statement.	•
☐ **Allocate QI team protected time**	• Ensure each member of the QI team has dedicated time to perform required tasks for QI (1hr per week is a good start!).	•
☐ **Set up QI team meetings**	• Plan frequency of planning meetings for QI team and send out appointments and a standing agenda • Distribute minutes/action points following any meetings held and ensure staff are aware of any follow-up needed.	•
☐ **Setup your QI team collaboration zone**	• Setup a workspace or folder/file structure for the QI team to document their work, where they can share files and collaborate on activities • Provide access to project files and related policy and procedures	•

Task	Subtasks	Action Notes
☐ **Plan communication with the wider practice team**	• Identify who will need to be kept informed. • Identify the method(s) that will be used to inform and update all staff of any changes as a result of the QI activity e.g. staff/Clinical/Admin/Nurse meetings, email, noticeboard, group chat. • Ensure all staff are advised of the chosen communication(s) method. • Provide monthly updates to all staff of ongoing changes e.g. add QI to staff/Clinical/Admin/Nurse meetings. • Allow staff to contribute ideas and provide opportunities for staff feedback.	•

☐ **Plan communication with other important stakeholders**	• Consider the **GP ACI** Stakeholder Benefits and Responsibilities and consider the role that other stakeholders outside the practice team have in GP ACI and what communication you may need to do to engage with them including:
	  ○ Residential Aged Care Homes
	  ○ Patients and their carers/family
	  ○ Medical Specialists and Allied Health providers
	  ○ Hospital and Ambulance Services
		•

Appendix 2 – Model For Improvement and PDSA Template

1.0 Model for Improvement and Plan-Do-Study-Act Cycle

Start by documenting your practice QI team and define your problem and specified a robust ***Problem Statement*** using the Quality Improvement Template. Next, consider Model for Improvement.

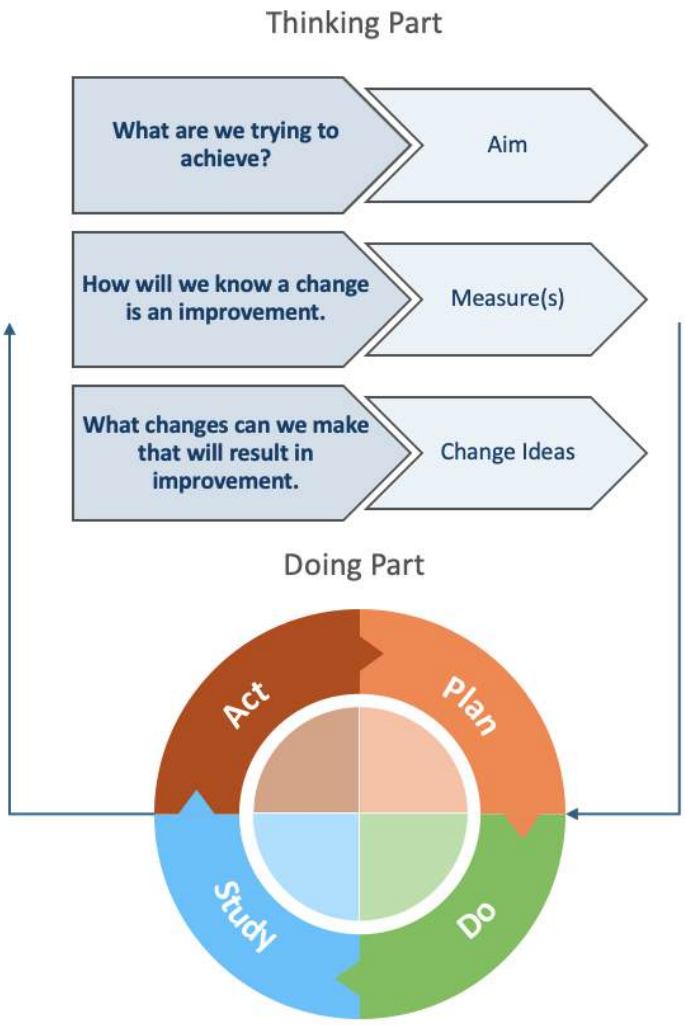
In the Model for Improvement, the **'Thinking Part'** focuses on the overall improvement strategy, while the **'Doing Part'** implements changes through the Plan-Do-Study-Act (PDSA) cycle. This model uses PDSA cycles to test changes, ensuring measurable and sustainable improvements. Click here for a short video explaining the Model for Improvement and PDSAs.

Step 1: Thinking Part - Model for Improvement

1. **AIM: What are we trying to accomplish?** Develop a S.M.A.R.T. (Specific, Measurable, Attainable, Realistic, Time-bound) and people-crafted ***Aim Statement***.
2. **MEASURE: How will we know that a change is an improvement?** Identify what good looks like and develop a measure(s) of success.
3. **CHANGE IDEAS: What changes can we make that will result in an improvement?** Engage the whole team in formulating change ideas using tools such as brainstorming, driver diagrams or process mapping. Each change idea may involve multiple small rapid PDSA cycles.

Step 2: Doing Part - Plan-Do-Study-Act (PDSA)

1. **PLAN:** Describe the change idea (what, who, when, where). Predict outcomes and define the data to collect.
2. **DO:** Carry out the plan. Collect data. Consider what worked well and why? Document any unexpected observations, events or problems.
3. **STUDY:** Analyse results, compare them to predictions, and reflect on what you learned.
4. **ACT:** Based on what you learned from the test, consider what you will do next (e.g. adopt, adapt or abandon)? How does this inform the plan for your next PDSA?



Source: Langley, G., Nolan, K., Nolan, T., Norman, C. & Provost, L. 1996, The Improvement Guide, Jossey-Bass, San Francisco, USA

For guidance and support in conducting quality improvement, contact your Murray PHN Quality Improvement Consultant via email: gpsupport@murrayphn.org.au

1.1 Quality Improvement Template

Practice name:	*Add your primary healthcare service name here*	**Date:**	*Add date of commencement here*
QI team:	*List the team members involved*		
Problem:	*Describe why this work is strategically important. What problem is the team addressing? What does our data indicate about it, and what are the causes?*		
Problem Statement:	*Document your succinct problem statement here*		

*Once you have completed the QI template, move onto the **Model for Improvement** (the Thinking Part)*

For guidance and support on conducting quality improvement in your primary healthcare services, contact your Murray PHN Quality Improvement Consultant: gpsupport@murrayphn.org.au

1.2 Model for Improvement Template

Step 1: Thinking Part - Three Fundamental Questions

Complete the Model for Improvement (MFI) as a whole team.

AIM	**1. What are we trying to accomplish?**
By answering this question, you will develop your GOAL for improvement. It important to establish a S.M.A.R.T (Specific, Measurable, Achievable, Relevant, Time bound) and people-crafted aim that clearly states what you are trying to achieve.	

MEASURE(S)	**2. How will we know that a change is an improvement?**		
By answering this question, you will develop the MEASURE(S) you will use to track your overarching goal. Record and track your baseline measurement to allow for later comparison. ***Tip: Use a Run Chart to plot trends.***			
Baseline:		**Baseline date:**	

CHANGE IDEAS	**3. What changes can we make that will result in improvement?**
By answering this question, you will develop IDEAS for change. ***Tip: Engage the whole team in formulating change ideas using Institute for Healthcare Improvement QI tools such as brainstorming, driver diagrams or process mapping. Include any predictions and measure their effect quickly.***	
Idea 1	
Idea 2	
Idea 3	
Idea 4	
Idea 5	*Add other rows if needed.*
Next steps:	*Each idea may involve multiple short and small PDSA cycles.*

*Once you have completed the **Model for Improvement,** shortlist your ideas and start to put them into action using the **Plan-Do-Study-Act** (PDSA) cycle to plan, test, and review changes.*

1.3 PDSA (Plan-Do-Study-Act) Template

Step 2: Doing Part - Plan-Do-Study-Act

Once you have completed the Model for Improvement (MFI), use the template below to document and track your PDSA cycles (i.e. small rapid tests of change).

Idea	Plan		Do	Study	Act
#	Plan the test	Prediction	Do the test on small scale	Analyse the results	Make a plan for next step
	__How__ will we run this test? __Who__ will do it and __when__? __What__ will we measure?	*__Prediction__ or hypothesis on what will happen.*	*Was the plan completed? Yes or No. Collect data. Consider what worked well and why? Document any unexpected observations, events or problems.*	*Analyse results, compare them to predictions, and reflect on what you learned.*	*Based on your learnings from the test, what will you do next (e.g. adopt, adapt or abandon)? How does this inform the plan for your next PDSA?*
Change idea 1.1	*Specify*				
	Keep adding rows and cycles as needed.				
Change idea 1.2	*Introduce a new change idea is required.*				
	Keep adding rows and cycles as needed.				
Summary of Results					

Appendix 3 - Improvement Ideas for GP ACI Quality Improvement

Practice name:	Bluey's Family Practice	**Date:**	4 November 2024
QI team:	Dr Chilli Heeler - Responsible Provider, GP Bluey Heeler - Practice Nurse Bandit Heeler - Receptionist Bingo Heeler - Practice Manager Lucky – Clinical Services Manager at New Tricks Park		
Problem:	Bluey's Family Practice are deeply committed to providing care for their ageing community that have recently taken up residence at New Tricks Park, the local Residential Aged Care Home. Doreen, Mort, Bobba, Granny Gladys, Granny Janet, Madge, Chris and the Old Pug are all existing patients of the Blue's Family Practice that have moved into New Tricks Park together to keep each other company and these new residents need ongoing primary care! Blueys Family Practice need to work out how they are going to organise their care delivery to meet GP ACI requirements for all the new residents New Tricks Park (visiting fortnightly at a minimum), whilst keeping up with delivering care to meet the needs of their regular patients at the general practice clinic.		
Problem Statement:	Organise the practice to deliver services that meet GP ACI requirements to eight existing patients of the practice that have moved into residential aged care.		

Model for Improvement

Step 1: Thinking Part - Three Fundamental Questions

Complete the Model for Improvement (MFI) as a whole team.

AIM	1. What are we trying to accomplish?

By the end of the month, Bluey's Family Practice will implement a bi-weekly visiting schedule for Dr. Chilli Heeler, to provide primary care to all eight residents at New Tricks Park, ensuring 100% of visits are completed and GP ACI requirements are met, while maintaining care for existing clinic patients, and assessing patient satisfaction regularly.

- **Specific**: Bluey's Family Practice will establish a structured care delivery plan to ensure that all eight residents of New Tricks Park receive primary care from Dr. Chilli Heeler at least once every two weeks, while also maintaining adequate care for existing clinic patients.
- **Measurable:** Track the visits made to New Tricks Park bi-weekly, aiming for 100% completion of scheduled visits for all residents over the next six months. Each Quarter, each resident will receive one Care Planning GP ACI MBS-eligible service, and a minimum of 5 GP ACI MBS-eligible Regular Visits. Additionally, monitor patient satisfaction scores from both the new residents and existing clinic patients.
- **Achievable:** Coordinate with New Tricks Park to schedule visits, ensuring that Dr. Chilli Heeler, Bluey Heeler, and Bandit Heeler can effectively manage time and resources, allowing for seamless integration of care for both groups of patients.
- **Relevant:** This goal aligns with the commitment of Bluey's Family Practice to provide comprehensive care to the aging community and meet GP ACI requirements, ensuring that the needs of both new and existing patients are met.
- **Time-bound:** Implement the care delivery plan by the end of the current month, and review progress monthly for the next six months to make any necessary adjustments based on patient feedback and care needs.

MEASURE(S)	2. How will we know that a change is an improvement?

By answering this question, you will develop the MEASURE(S) you will use to track your overarching goal. Record and track your baseline measurement to allow for later comparison.
Tip: Use a Run Chart to plot trends.

1. Registration in MyMedicare and GP ACI (number of patients)
2. Bi-Weekly Visit Log
3. Patient Satisfaction Surveys
4. Care Needs Assessment (completion rates)
5. MBS billing and GP ACI compliance tracking
6. Resource Use Tracking (staff time)

CHANGE IDEAS	3. What changes can we make that will result in improvement?
The following are examples of IDEAS for change. Use ideas using Institute for Healthcare Improvement QI tools such as brainstorming, driver diagrams or process mapping.	
Idea 1	Registration in MyMedicare and GP ACI: ○ Action: Nurse Bluey Heeler to work with Lucky – Clinical Services Manager at New Ticks Park to explain benefits of MyMedicare and coordinate completion of MyMedicare forms. Bandit Heeler (receptionist) to register each resident in GP ACI, designating Dr Chilli Heeler as Responsible Provider. ○ Measurement: Registration of all eight residents in GP ACI to be actioned on 2 October 2024, allowing the full GP ACI quarter from 1 October to 31 December 2024 to meet GP ACI Quarter service requirements.
Idea 2	2. Bi-Weekly Visit Log: ○ Action: Receptionist Bandit Heeler to create a summary log to record each visit to New Tricks Park to be completed by Dr Cilli Heeler, including dates, MBS services delivered, the number of residents seen, and follow-up actions required for the practice and the RACH. All clinical and service information will continue to be recorded in the practice clinic software. ○ Measurement: Before implementing the visiting schedule, Nurse Bluey Heeler will record the number of visits made to New Tricks Park over the past month to establish a baseline. Aim for 100% completion of scheduled visits for all eight residents every two weeks.
Idea 3	Patient Satisfaction Surveys: ○ Action: Bingo Heeler will distribute a Short Patient Satisfaction survey to both New Tricks Park residents and a sample of 20 regular clinic patients at the end of each quarter. ○ Measurement: Conduct regular satisfaction survey for both new and existing patients every 3 months. Bingo will collate and document the responses and average scores at regular intervals. The practice team will include the scores at their monthly practice meeting and use the feedback from patients to identify and test new improvement ideas. ○ Develop a question to use. For example- *Did you have an opportunity to mention all of the concerns you hoped to discuss at your most recent visit?* (1 = yes definitely, 2 = yes somewhat, 3 = no.). Aim for an average score of less than 2. Include an open follow up question *"Please provide any further information explaining why you chose this score?"* Ref- Developing Actionable Survey Questions to Improve Patient Experience - Jeffrey Millstein, Anish Agarwal, 2021

Idea 4	**Care Needs Assessment:** ○ **Action: Dr Chilli Heeler will conduct an initial Comprehensive Medicare Assessment (705 or 707) with each of the eight residents in the first month (October) of the GP ACI Quarter, documenting any chronic conditions, medications, important patient goals for health/life and any specific concerns or special care requirements.** ○ **Measurement: Nurse Bluey Heeler will review the records each fortnight to monitor changes in residents' health status and update their records after each fortnight's visit.**
Idea 5	MBS billing and GP ACI compliance tracking: ○ Action: Bingo Heeler and Bandit Heeler will schedule MBS care items in the diaries of Dr Chilli Heeler (Responsible Provider) and Nurse Bluey Heeler in Best Practice 3 months ahead of visits. ○ Measurement: Following RACH visits, Bandit will review the MBS billing for each resident using the GP ACI tracking and forecasting tools monthly to identify any missed MBS care items, and document them. Bingo will meet with the practice QI team to review the findings, discuss the possible causes and identify improvement ideas.
Idea 6	Resource Utilisation Tracking: ○ Action: Bingo will monitor the time spent on visits to New Tricks Park versus regular clinic patients, tracking hours worked and resources used (e.g., travel time, staff time for each member of the practice team, equipment). ○ Measurement: Bingo will review the workload for each member of the team to ensure the practice maintains a balanced workload, with no more than a 20% increase in time spent on the aged care home visits.
Next steps:	*Each idea may involve multiple short and small PDSA cycles.*

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National MyMedicare PHN Implementation Program
phn COOPERATIVE An Australian Government Initiative

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